

Maine's Healthcare Trustee



Gov. writes to CEOs, trustees

Gov. John E. Baldacci has sent a letter to all hospital CEOs and many hospital trustees describing the administration's expectations concerning the cap on hospital cost increases that is part of Dirigo Health Plan legislation.

The legislation, which became effective Sept. 13, establishes a voluntary cap of 3.5 percent on hospital cost increases. This target was based on recent increases in the national medical consumer price index.

Cost increases will be measured using the change in expense per case mix adjusted discharge (CPAD) over a 12-month base year period. Hospitals are also asked to hold their consolidated operating margins to no more than 3 percent in their first fiscal year beginning on or after July 1, 2003. The "base year" benchmarking period will be the fiscal year immediately preceding the first fiscal year beginning on or after the July 1 date. The specific methodology for measuring performance against these targets will be developed cooperatively by the MHA and Baldacci's health policy staff.

"I want to emphasize the voluntary context of these limits," Baldacci said in his letter. "We know that hospitals are subject to a host of external factors than can impact operational costs. We also recognize that, when comparing the performance of different hospitals, structural differences between institutions need to be considered, as well as differences in patient and payer mix.

"There may be instances where an institution falls short of meeting the cost control targets," Baldacci's letter continued. "In those cases, a report of the experience of the hospital along with supporting documentation and data will provide us with important information as we advance our state planning and budgeting processes."

Please see Governor on page 2

Program provides trustee orientation and refresher

"Welcome to the Board: An Orientation and Refresher for Maine Hospital Trustees" will feature a comprehensive set of presentations and group discussions aimed at helping hospital trustees become more informed, effective board members.

There will be two sessions, Thursday Oct. 28 at the Sheraton Four Points Hotel in Bangor, and Wednesday, Oct. 29 at the Regency Hotel in Portland. Both sessions run 9 a.m. to 3 p.m.

The agenda includes: The Nature of Governance, The Fundamental Activities of the Board, the Relationship of Health Care Institutions and Their Physicians, A Legal Primer and A Finance Primer.

Please see trustee on page 2

NEHA hosts trustee conference

The New England Healthcare Assembly (NEHA) is hosting its 24th Annual Trustee Conference Thursday and Friday, Nov. 13 and 14 at the Boston Marriott Copley Place.

"Quality Care & Financial Imperatives: The Role of the Board" offers a choice of workshops to hospital trustees. Workshops range from "Considerations of Cost and Quality as a Function of Hospital Size" to "A Finance Primer for the Healthcare Trustee."

Friday's session will include a Quality Initiative Panel that will identify and outline implementation strategies for best practices to minimize medical errors, assist in developing public reporting meas-

Please see NEHA on back page

*Representing
community hos-
pitals, healthcare
organizations
and the patients
they serve.*

OCTOBER 2003

MHA is currently finalizing and seeking comment from hospital members on the methodology for the CPAD and will be discussing both the methodology and the timetable for reporting on the voluntary compliance with the administration. Additionally, MHA will be working with the administration on the other reporting requirement established by the Dirigo Health Plan for reporting on hospital charges, cost efficiency measures and consolidated operating margins. This work will focus on the time table, format and methodologies for the report with the final agreement required by January 1, 2004.

MHA Contact: Mary Mayhew

New laws took effect in September

New laws affecting hospitals took effect on Sept. 13.

For instance, a provision in the Dirigo Health Plan requires hospitals to develop price lists for the public (see related story). Other new laws direct insurance companies to change the way they do business with providers. LD 423, now **Public Law 108**, requires carriers to make credentialing decisions within 60 days of receiving a provider's completed application if there are no questions associated with the application. The law allows the carrier to extend the deadline for another 120 days upon written notice to the provider if information within the application needs verification. It requires carriers to review the application and return it once for all corrections and clarifies that the application is not complete until all corrections are made. The law gives authority to the Department of Professional and Financial Regulation, Bureau of Insurance to amend its rules to conform to these requirements.

LD 897, now **PL 218**, requires carriers to give providers 60 days' notice of substantive amendments to provider agreements with certain exceptions. The parties may waive the notice requirement by mutual agreement. The law further requires limits on health insurers' retrospective denials of previously paid claims to 18 months from the date of payment with certain exceptions. The law permits carriers to refuse to accept claims not submitted on standardized claim forms approved by the federal government. Providers with 10 or more full-time-equivalent employees must file claims electronically in order to claim interest if an undisputed claim is not paid within 30 days of submission, beginning in 2005. Finally, it permits the superintendent of insurance to adopt rules that set a minimum amount of interest payable to health care providers.

Other laws deal with public health issues. **PL 438**, formerly LD 846, gives hospitals the same limited civil immunity during extreme public health emergencies that require involuntary prescribed care such as forced immunization, quarantine, etc. **PL 418**, formerly LD 363, limits charges for medical records up to \$10 for the first page of medical records and 35 cents for each additional page.

LD 1356, now **PL 419**, provides limitations on the authority of the Department of Human Services to recover overpayments, amends the informal appeal process, allows arbitration and restricts the sanction of total recoupment. It requires MaineCare provider relations personnel to assist MaineCare providers in addressing and resolving disagreements and corrects outdated language. It requires rulemaking to define the ownership and control relationships that apply in MaineCare offset situations. It requires a report from the Department of Human Services and the Department of Behavioral and Developmental Services on recommendations regarding complaint resolution and the hearing process.

In addition to the new laws, there are two resolves of interest to hospitals. **Resolve 35**, which was LD 532, directs the Maine Health Data Organization to evaluate the current system of annual assessments and user fees and make recommendations for improvement to the Joint Standing Committee on Health and Human Services by January 30, 2004.

Resolve 70, formerly LD 767 directs the Department of Human Services, Bureau of Health to adopt rules requiring the development of protocols regarding the use of latex gloves. It directs the Bureau of Health to report back to the Joint Standing Committee on Health and Human Services regarding the rules, the development of protocols, the anticipated impact of the protocols and whether legislation is required to further address allergies to latex gloves by January 30, 2004. It designates the rules as routine technical rules. It removes responsibility for rulemaking regarding latex gloves protocols for commercial and industrial sites and state agencies from the Department of Human Services, Bureau of Health and instead requires the Department of Labor to study such uses and recommend legislation.

Please contact MHA with questions about any of these new laws.

MHA Contact: Mary Mayhew

In addition to talks from MHA's General Counsel **Sandra Parker** and Vice President of Financial Policy **David Winslow**, the program will feature **Eric Lister**, MD.

Lister is a physician and consultant to health care organizations. His expertise lies in the development of leadership effectiveness and organizational cohesion. This work focuses on building clarity of purpose inside the board, creating efficient and sustainable structures and decision-making processes inside the executive team and developing crucial leadership skills throughout the ranks of leadership.

A registration form can be found in the Education section of MHA's web site at <http://www.themha.org>.

MHA Contact: Carol Sinclair

National effort addresses 75 percent rehab rule

Discussion during a recent conference call with the American Hospital Association (AHA) focused on a two pronged approach to dealing with the recent proposed CMS rehab rule.

The current rule states that 75 percent of a rehabilitation center's cases have to be within 10 diagnoses. Critics argue that the percentage is too high and the diagnoses are outdated. A revised rule published this spring failed to substantially address hospital concerns.

AHA remains disappointed with CMS's recent proposed rule, which failed to modernize the current list of 10 diagnoses. In fact, the association stated that the proposal is a step backwards. The proposed rule is more restrictive than current practice.

AHA is arguing not only for modernization of the diagnosis list but also for permanent lowering of the threshold. The organization is pushing for an independent clinical analysis to modernize the list and understand the experience of patients at rehabilitation hospitals to better establish a more appropriate threshold.

The association is focused on two bills: HR 2246: "To Direct the Secretary of Health and Human Services to Modify Treatment Categories for Qualification as a Rehabilitation Hospital or Unit for Purposes of Reimbursement under the Medicare Prospective Payment System for Inpatient Rehabilitation Facilities" and SB 1222: "Medicare Beneficiary Access to Rehabilitation Facilities Act of 2003."

In addition, there are draft letters circulating Congress that focus on pressuring CMS to make greater changes in the rehab rule. Sen. **Ben Nelson** (D-NE) is pushing language in the Labor and Health and Human Services appropriations bill that would require an Institute of Medicine clinical study of diagnoses list and threshold. During the study, the threshold would drop from 75 to 50 percent and the legislation would prohibit new facilities from participating until study and recommendation are finalized.

The various national organizations with interest in this matter held a press event in Washington, DC, this week in an effort to continue to increase visibility in this matter.

AHA is gathering comments from all members to develop their final comments on the proposed rule. Final comments are due Nov. 3. AHA believes good solid middle ground that's clinically based can be found. Meanwhile, their goal in Congress is to delay implementation and revamp the rule.

MHA is working to coordinate Maine's response both to CMS and Maine's Congressional delegation.

MHA Contact: Mary Mayhew

Dirigo price list provision becomes effective

Provisions requiring hospitals and ambulatory surgical center to maintain a price list of the most common inpatient services and outpatient procedures became effective Sept. 13.

The requirements are part of the cost containment provisions of the Dirigo Health Plan. The provisions were one of several bills in the legislature that would have required hospitals to post price information. The Maine Hospital Association pushed for the language that ultimately was included in Dirigo, in order to make the resulting lists meaningful to the public.

Dirigo requires the following:

- For inpatient services, the price list must include a per diem bed charge and an average charge for all ancillary charges for the 15 most common non-emergent services involving inpatient stays. If the per diem bed charge includes all ancillary charges for a procedure, no further information is required.
- For outpatient, non-emergent procedures for which an individual would not incur a bed charge, the price list must include average charges for the 20 most common surgical and diagnostic procedures, excluding laboratory services.
- For emergency services the price list must include average charges for facility and physician services according to the level of emergency services provided by the hospital and based on the time and intensity of services provided.

Hospitals must post a statement telling patients about the availability of the price list. The list itself doesn't have to be posted, but it must be available upon request.

The price list may include a statement explaining that actual charges may vary depending on individual needs and other factors.

MHA Contact: David Winslow

ures of hospital quality performance and discuss the creation of support programs to help hospitals succeed in improving quality and safety and in gaining recognition for their efforts.

The opening keynote address will be by **Dan Roble**, partner, Health Care Group, Ropes & Gray, on “Cost and Quality: Is Balance Possible?”

The closing keynote will be by Massachusetts state senator **Richard T. Moore**, Senate chairman of the Joint Committee on Health Care. He will speak on “Assessing Healthcare Quality Initiatives from a Public Policy Viewpoint.”

In addition to the line-up of speakers, all Maine participants are encouraged to participate in a special advocacy breakfast 7:30 to 9 a.m. on Friday, Nov. 13. The breakfast will focus on legislative issues of specific concern to Maine hospitals.

Also at the conference, NEHA will present the second annual Trustee Leadership Award to honor significant contributions of a hospital trustee whose professional achievements have been of exceptional value to health care.

The conference is in collaboration with New England hospital associations, including the Maine Hospital Association. Hospital CEOs should be receiving brochures soon.

MHA Contact: Carol Sinclair

Maine’s Congressmen support market basket update increase

Maine Congressmen Tom Allen (D) and Michael Michaud (D) have both signed a bipartisan “Dear Colleague” letter urging that conferees reject a proposed market basket update reduction included in the Medicare prescription drug bill currently in a conference committee.

Maine’s congressmen are among 123 representatives who signed the letter.

“It is our belief that this provision will result in a \$12 billion cut in hospital inpatient payments due to a reduction in the market basket update,” the letter said. “We strongly oppose the House’s provision to reduce the hospitals’ market basket update and urge you to recede to the Senate on this provision.”

The letter goes on to explain that the update is a reflection of the increased prices of goods and services that hospitals participating in the Medicare program rely on to provide quality care to the nation’s seniors.

MHA has been urging opposition to the market basket update reduction and had asked hospitals to urge Allen and Michaud to sign the letter.

MHA Contact: Mary Mayhew