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More Than 1,000 Uninsured Families Visit Maine Hospitals

All 39 of Maine's hospitals opened their doors to host Family Sign Up Day—a day that drew more than 1,000 uninsured families to hospitals throughout the state for more information and to actually enroll in the state's low-cost or no-cost health insurance programs.

Thanks to the massive statewide outreach project supported by Maine hospitals, the Department of Human Services (DHS) and the Covering Kids and Teens Campaign, hundreds of uninsured children and their parents are expected to enroll in low-cost or no-cost health insurance programs. The campaign signifies one of the state's largest and most intensive efforts to provide health-care coverage to uninsured Mainers.

"We won't have actual enrollment figures until the DHS monthly report is released in early February," said Maine Hospital Association President **Steven Michaud**. "But if our response over the past couple weeks is any indication as to the number of people who actually enroll in

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BBA Action Spells Relief for Maine Hospitals

Sweeping legislation signed into law by President Clinton in late December is expected to bring well in excess of $50 million in added Medicare payments to Maine hospitals and their affiliated continuing care facilities.

Although described generally as BBA Relief, the legislation contains a number of very helpful provisions that are not directly related to hospital efforts to gain relief from massive Medicare cuts resulting from the 1997 Balanced Budget Act.

"All in all," said MHA President **Steven Michaud**, "This legislation should provide substantial financial benefits to every Maine hospital. In fact, from a hospital and continuing care perspective, it represents the most positive and significant action by the federal government in memory."

MHA expects to have a detailed, hospital-specific analysis of the bill's impact available within the next two weeks.

Although the full impact of the legislation won't be known until then, it is clear that the bill has addressed all eight elements of MHA's federal advocacy agenda.

Thanks to aggressive action by Maine's Congressional Delegation, a number of key issues of particular importance to the state's hospitals have been included in the comprehensive federal legislation.

The majority of Maine hospitals will benefit from what may be the most critical element of the bill, which increases the Medicare reimbursement inflation update to full market basket this year. In 2002 and 2003 hospitals will see inflation updates that are slightly below market basket, but represent significantly higher rates than were slated as a result of the BBA cuts.

Rural and urban hospitals in Maine will benefit from important reimbursement improvements that affect Medicare Dependent Hospitals, Sole Community Hospitals, Critical Access Hospitals and hospital-based teaching programs.

The legislation will pump about $35 billion into the nation's healthcare system over five years, including some 12 billion for hospitals, $2 billion for nursing homes, $2 billion for home health agencies and $3 billion for other. Of this, about $2 billion is dedicated to rural providers.

MHA will continue to work closely with Maine's Congressional Delegation and AHA toward further BBA relief in the next session of Congress.

"The 1997 BBA cuts went much deeper than anyone intended," said Michaud. "This bill is part of a series of much-needed steps to close the gap between what was intended and what actually happened.

"There's no question about it," Michaud said. "We've made real progress down the path to BBA relief this year."

MHA Contact: Mary Mayhew

How Maine Hospitals and Their Affiliates Will Benefit From Passage of Eight Elements of MHA's Federal Advocacy Plan

1. **Full Market Basket Inflation Update** – Increases inflation update for all hospitals. The BBA set the annual update at market basket minus 1.1 percent in both 2001 and 2002. This legislation sets the update at the full market basket in 2001 and market basket minus 0.55 percent in 2002 and 2003.

2. **Disproportionate Share Hospitals** – Makes more equitable the treatment of rural hospitals (as well as small urban hospitals) under the Medicare disproportionate share hospital (DSH) system by expanding program eligibility and increasing DSH add-on payments for such hospitals.

3. **Medicare Dependent Hospitals** – Permits rural hospitals to choose among three cost reporting periods to determine eligibility for the Medicare Dependent Hospital (MDH) program.

4. **Critical Access Hospitals** – Strengthens the Critical Access Hospital (CAH) program by exempting CAH swing beds from SNF prospective payments; reimbursing physicians at 115 percent of the fee schedule; and paying emergency room physicians and ambulances at reasonable cost.

5. **Home Health** – Delays 15 percent cut for an additional year. In addition to creating a new prospective payment system for home health, the BBA also required a 15 percent reduction in payment limits. The BBRA delayed implementation until a year after establishment of the PPS. This provision would delay implementation of the 15 percent reduction another year until 2002.

6. **Sole Community Hospitals** – Any Sole Community Hospital would be able to elect payment based on hospital specific, updated FY1996 costs if this target amount resulted in higher Medicare payments. There would be a transition period with Medicare payment based completely on updated FY1996 hospital specific costs for discharges occurring after FY2003.

7. **Graduate Medical Education** – Adjusts teaching hospital payments for medical education. Under the BBA and BBRA, teaching hospitals' indirect medical education (IME) payment add-on was reduced to 6.25 percent in 2001, and 5.5 percent in 2002 and thereafter. This provision increases the add-on to 6.5 percent in both 2001 and 2002.

8. **Rural Ambulance Service** – The provision would provide for the full inflation update in ambulance payments for 2001. It would also specify that any phase-in of the ambulance fee schedule would provide for full payment of national mileage rates in states where separate mileage payments were not made prior to implementation of the fee schedule. The provision would specify that for the period January 1, 2001—June 30, 2001, the inflation update would be that determined prior to enactment of this provision. For services furnished from July 1, 2001—December 31, 2001, the update would be 4.7%. The provision relating to mileage payments would be effective July 1, 2001.

Other Benefits Included in the Bill

Hospitals

♦ Provides greater hospital bad debt reimbursement. The BBA reduced the proportion of a beneficiary's bad debt to a hospital that is reimbursable under Medicare to 55 percent. This legislation would increase the percentage to 70 percent starting with 2001 cost reports.

♦ Raises hospital outpatient department prospective payments. Currently, hospital outpatient payments are adjusted annually by market basket minus 1 percent in 2001 and 2002. This would provide a full inflation update in 2001.

♦ Increases Medicaid payments to safety net hospitals. The BBA set state-specific caps on total Medicaid disproportionate share hospital (DSH) payments. The allotments decrease from 1998-2002 and are increased by CPI in 2003. OBRA 1993 also set hospital-specific limits so that DSH payments could not exceed 100 percent of a hospital's uncompensated care costs. This legislation provides relief to safety net hospitals by setting 2001 state-specific allotments at 2000 levels adjusted for inflation and setting 2002 allotments at 2001 levels adjusted for inflation. It also allows states to provide public hospitals DSH payments up to 175 percent of net uncompensated care costs for two years.

♦ Improves rural hospital programs. This legislation modifies and improves a series of Medicare policies that support rural health care providers.

♦ Increases payments for PPS-exempt hospitals. The legislation increases payments for rehabilitation hospitals in 2002 to 100 percent of pre-BBA levels; expand bonuses from 2 percent to 3 percent for psychiatric hospitals that meet their targets; raises the national cap on long-term care hospital reimbursement by 2 percent and increases the individual long-term care hospital target amounts by 25 percent.

Skilled Nursing Facilities & Therapy Services

♦ Increases inflation update for skilled nursing facilities. The BBA set the annual inflation update at market basket minus 1 percent in 2001 and 2002. The legislation adjusts the update to the full market basket in 2001 and market basket minus 0.5 percent in 2002 and 2003.

♦ Improving nursing staffing ratios. In order to address low staffing ratios resulting from a shortage of qualified nurses, this provision would increase prospective payment system reimbursement by adjusting the nursing component of the resource utilization groups (RUGs) upwards by 16.66 percent in 2001. To ensure that residents are fully informed, SNFs will be required to post staffing ratios.

♦ Imposes an additional year's moratorium on payment caps. The BBA limited yearly payments for physical/speech therapy and occupational therapy to $1,500 each per beneficiary. These limits are too low and force beneficiaries to incur high out-of-pocket costs for necessary therapy services. The BBRA delayed implementation of the therapy caps until after 2001. This legislation adds an additional year to the moratorium.

♦ Provides immediate increases in payment for high-cost rehabilitation therapy. This legislation ensures adequate reimbursement for rehabilitation therapy services by increasing rehabilitation RUGs by an additional 6.7 percent starting in 2002.

Home Health

♦ Increases inflation update for home health agencies. BBA set the annual update at market basket minus 1.1 percent for 2001 and 2002. The legislation provides a full market basket update in 2001.

♦ Assists rural home health agencies. The BBA disproportionately affected the financial status of rural agencies. Rural home health agencies have higher costs due to the greater travel expenses associated with rural, isolated areas. This provision would provide a 10 percent add-on payment to rural agencies in 2001 and 2002.

Here's what some hospitals have done to promote the program around the state:

• The local 'Shop and Save' grocery store near Rumford Hospital stuffed 4,000 flyers into grocery bags.

• Northern Maine Medical Center in Fort Kent asked local churches to distribute flyers to their congregations.

• Hospitals in several communities arranged for children to bring home flyers in their backpacks.

• Six hospitals in Western Maine—Bridgton, Central Maine Medical Center, Franklin Memorial Hospital, Rumford Hospital, St. Mary's Regional Medical Center and Stephens Memorial Hospital—teamed up to place full-page ads in local newspapers.

• Inland Hospital in Waterville charged each of its 300 employees to identify one family in their neighborhood, church or community group that could benefit from Cub Care or Expanded Medicaid programs.

Family Sign Up Day continued

the program, this will prove to be one of the most successful campaigns to insure Mainers in the state's history."

Based on preliminary data from hospitals and Consumers for Affordable Health Care, the organization that staffed a special toll-free telephone enrollment hotline, thousands of people were reached with information about Cub Care and Expanded Medicaid programs. The toll-free hotline received more than 500 calls in the first week of the campaign—that's 30 times the normal call volume—and over 1,000 families visited Maine's hospitals on January 10 thanks to the combined publicity efforts of the Maine Hospital Association, all of the state's hospitals, DHS and Consumers for Affordable Health Care. Efforts included:

- News conferences in Bangor, Portland and Caribou
- Distribution of thousands of posters/flyers
- Production of a television ad that aired more than 200 times
- Newspaper articles/advertisements
- Radio announcements/advertisements

According to DHS and the Covering Kids and Teens Campaign, the number of actual enrollments are more difficult to achieve at this stage—most families who are inclined to get health coverage for their kids have already done so. And although it's impossible to report how many families will actually enroll in the Cub Care and Expanded Medicaid programs, MHA estimates that hundreds of Maine families will soon receive health insurance as a result of this effort. MHA will report on the enrollment numbers as they become available.

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