Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

Proposed FYs 2024 & 2025 Supplemental Budget

February 26, 2024

Senators Rotundo and Baldacci, Representatives Sachs and Meyer, 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 support for some elements of the budget as proposed and in opposition to two parts.

Maine's 35 acute care and psychiatric hospitals are nonprofit, community-governed organizations. Maine is one of only a handful of states in which all of its acute care hospitals are nonprofit.

1: Rate Reform and Hospital Tax Increase Proposal.

MHA supports the elements of the rate reform and hospital tax increase in the supplemental budget. While this is not a perfect plan from our perspective, no compromise ever is. We believe this is a positive deal for hospitals. It is also a very good deal for the state.

Those four elements include:

1. Hospital Tax Increase: The last initiative on A-66;
2. Hospital Medicaid Reimbursement Increase: The first initiative on A-67;
3. Elimination of one-time GF funding for hospitals: The fourth initiative on A-67;
4. Ongoing GF funding for hospitals: The second initiative on A-68.

We take no position on the related item of funding for the elimination of PNMI's from the service provider tax.

Additionally, there are five language pieces to the proposal; found in Parts JJ (pages 63-64) and LL (page 66):

1. Elimination of Critical Access Hospitals (CAHs) from the hospital tax: Part J-1;

2. Increase in the hospital tax rate: Part J-2;
3. Re-base of the hospital tax year: Part J-3;
4. Dedication of 100% of the revenues produced by future re-basing to hospital reimbursement: Part J-4.
5. CAH reimbursement rate reduction: Part LL.

The Proposal. The essence of the proposal is that PPS hospitals[1] would finance two initiatives with a $60M annual increase in the hospital tax.

The first use of the hospital tax revenue is to fund PPS hospital rate reform. As you may know, hospital inpatient reimbursement rates (also known as DRGs) have not increased in roughly 15 years. The rates are the same as they were in 2010. This has been quite burdensome on our members. The supplemental budget funds an increase in Maine's inpatient and Maine's outpatient rates (also known as APCs). Roughly $25M of the hospital tax is going to this purpose. The state is putting in $8.7M general fund toward hospital rates in this budget. We appreciate that support. But to be clear, hospitals are funding the majority of "state" reimbursement for hospitals which leverages the federal dollars for the majority of the remainder.

The second use of the hospital tax revenue is to back-fill a large portion of the General Fund revenue the state lost with the removal of PNMI's from the service provider tax. We really hope this part of the deal is clear to you. The hospital tax is increasing to cover the state's loss of revenue from the PNMI tax change. This is roughly $25M per year hospitals are going to bear in tax increases to help the state. This is a tough one for our members to accept. But we have and we accept the deal.

When fully implemented, the net positive impact for hospitals will be roughly $50M per year. We are giving you a <u>net</u> figure once this proposal is fully implemented in SFY 2026 and beyond. The Department's figures are for SFY 2025 – the only budget year before you in the supplemental budget – and we understand why that is being done. But, we also think you should see where the dust settles when fully implemented.

For context, the recently released MHDO data demonstrates that the 13 PPS hospitals that will see their rates increased by the supplemental budget, lost a total of $200 Million in 2022 alone. The $50M will help, but the hospitals receiving this increase will still have a long way to go.

[1] There are basically two categories of general hospitals: Smaller, rural hospitals are frequently CAH (Critical Access Hospitals) and the larger hospitals are Prospective Payment System (PPS) Hospitals.

Important Elements to Highlight

1. **CAH hospitals are being removed from the hospital tax program.** There are 16 small, rural hospitals that have qualified for the federal designation of "Critical Access Hospital" or CAH. These hospitals currently pay the tax and a portion of the tax is used to finance CAH reimbursement in the Medicaid program. The proposal removes CAH hospitals from the program. One of the elements we negotiated with the department was the degree to which CAH reimbursement would be decreased to roughly match the reduced cost CAHs would bear due to their no longer paying the tax. For those of you with an independent CAH, you will likely hear that they have a net loss in revenue. Generally speaking, these hospitals do experience a net loss. Those CAH's that are a part of a health system will have their loss offset by the gains from the PPS hospitals. But there are 6/7 independent CAHs not in a system who do not. For those of you from districts with those hospitals, we are happy to meet and go over the issue with you.

2. **York Hospital.** York Hospital has some unique challenges associated with the proposal. I believe they are going to be represented by outside counsel who will present their concerns to you.

3. **Patients Stuck in Hospitals.** One of the most vexing operational issues for hospitals is when patients get "stuck" at the hospital who would more appropriately be placed in other settings. The two arch-type patients are elderly patients occupying inpatient beds who need a placement in a nursing home, or, an adolescent who is in the emergency room with significant behavioral health challenges who needs a placement in a specialized residential facility. The Department has committed to reviewing the potential reimbursement for patients stuck in hospitals as part of hospital rate reform. While unsettled, this is an important element of this agreement.

4. **Revenue from Future Re-basing.** This is probably the most positive element of the proposal for hospitals. Language Part JJ-4, re-orients all of the increased revenue that will be generated in the future by re-basing the tax to hospital reimbursements. This is different than in years past. One principle that DHHS is committed to as part of its rate reform efforts is ongoing COLAs for reimbursement rates. As I mentioned earlier, hospital inpatient rates have not increased for 15 years. Hospital rates are supposed to receive COLAs as have other providers who have gone through rate reform. The revenues generated by re-basing the hospital tax every two years will help provide for COLAs. Furthermore, there are unreimbursed services – like care for patients stuck in hospitals – that have still not been addressed. These revenues can be available for those unreimbursed services as well. We need full legislative commitment to this section; it is essential to our support for this proposal.

II: Other Items in the Supplemental Budget

There are two additional hospital-specific items I'd like to comment on.

1. **Critical Access Hospital Conversions.** A hospital may convert to CAH status, a federal designation, if it meets the federal standards. The language in Part KK on page 65 adds a new, state-level conditions to CAH conversions and we have concerns with it.

2. **Upper Payment Limits (UPL).** We don't understand the purpose or effect of the proposed UPL language in Part MM on page 66.

Conclusion. We accept the proposal from DHHS as contained in the supplemental budget. We negotiated this issue with them for over a year. It was not easy and we appreciate their patience and good faith. We urge your full adoption of the elements that comprise the hospital rate reform proposal.

Thank you.