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Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

Proposed SFY 2026 -2027 Biennial Budget

February 12, 2025

Senators Rotundo and Ingweresen, Representatives Gattine 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 the portion of the supplemental budget that provides funding for the MaineCare program.

Maine's 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.

Background. As I noted in the Supplemental Budget testimony, things are very difficult for hospitals right now. From the testimony of the State, it appears their Medicaid budget has some structural challenges as well.

Our basic concern with the hospital-related items in the budget is that its unsustainable. Essentially, the Administration wants the MaineCare program to stay the same size (provide all the same people all the same services) but asks providers to finance a much bigger share of the cost.

As for hospitals, we can't.

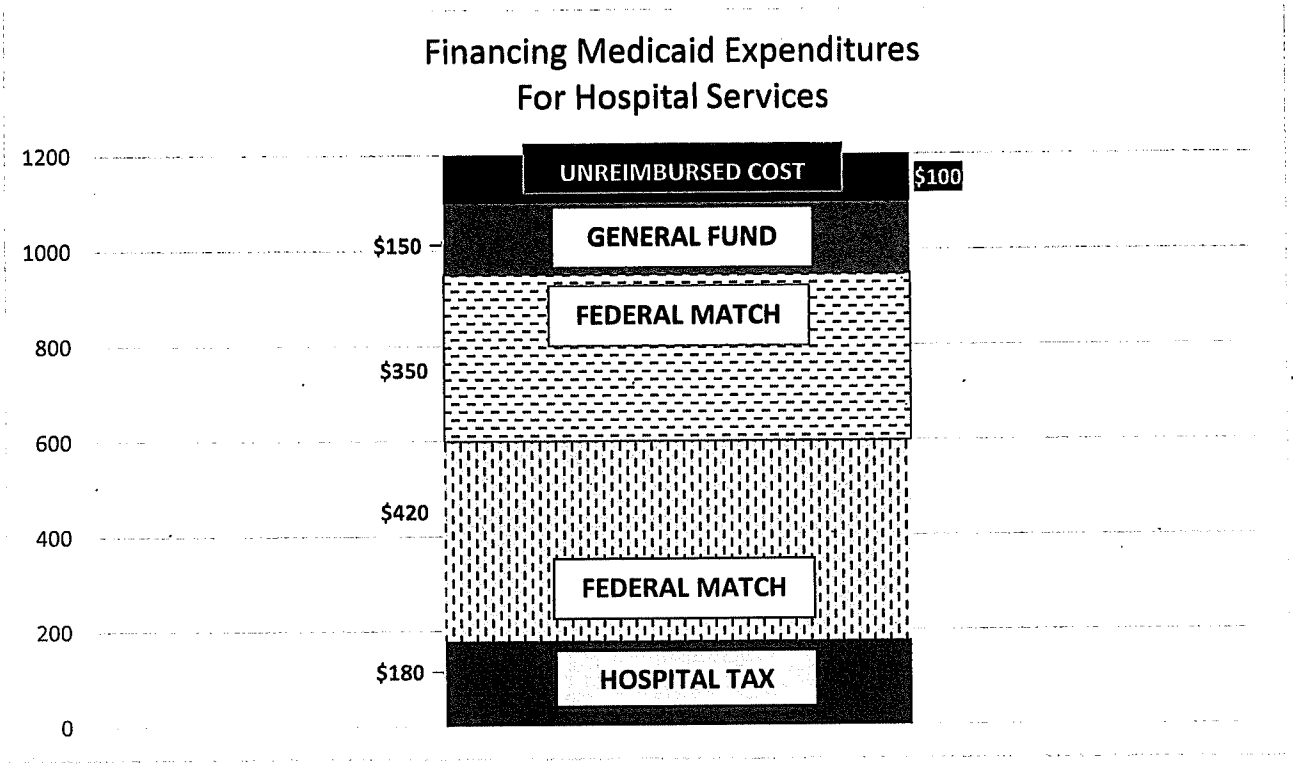
Hospitals Are Doing More than Their Fair Share to Balance Your Budget Already.

Unlike most other providers, we give you money. We accepted a controversial $55 million increase in the hospital tax in 2024 as a method for financing both hospital rate reform as well as some of the budget shortfall that you faced in your budget. That $55 million increase brings **the total amount that hospitals pay to the state annually as a result of the hospital tax to approximately $180 million per year.**

This biennial budget is still benefitting from that deal. **Page A-355 recognizes $29 million in new revenue from the hospital tax increase.** This increase in the hospital tax helps balance your budget. This is more than our fair share for this biennium.

For context, **the General Fund is contributing roughly $150 million** to fund the cost of services provided to hospitals.[1]

Hospitals contribute more financial resources to the Medicaid program than the General Fund does for hospital services provided to MaineCare recipients!



Hospitals suffer roughly $100-150 million in annual losses treating Medicaid patients. That loss is absorbed by hospitals. In reality, **hospitals are covering <u>almost double</u> what the state is for the cost of hospital services provided to Medicaid recipients.**

There are four primary issues for hospitals in the biennial budget.

1. **<u>Massive Cut to Hospital-Based Physicians (A-356; third initiative).</u>**

The budget proposes to cut hospital-employed physicians by a significant amount. The Department has told us their estimate of the cut, once fully implemented, is $75 million; our estimate is that the cut is much larger, maybe as much as $125 million per year. This is a devastating cut that hospitals could not absorb.

There are a number of problems with this initiative.

[1] We assume a 70% blended FMAP rate.

i. Cuts Outside the Biennial.

The proposal first changes the reimbursement methodology and then cuts the rate five times in five years.

Four of those cuts are OUTSIDE this budget cycle! The budget proposes cuts in SFY 2027 (this biennium) as well as cuts in SFYs 2028, 2029, 2030 and 2031. Cuts to hospitals in SFY 2028-2031 do nothing to balance this budget. This is a gratuitous cut that should be moved out of the budget today.

ii. This Physician Cut is in Conflict with a Maine law – that the Administration Proposed.

This initiative is being submitted in complete disregard to the rate reform law that DHHS championed and you overwhelmingly supported.

Rate changes, and especially methodology changes, are supposed to go through a statutory process of review. That did not happen for this proposal. As such, the methodology change should be rejected out of hand.

Last session, we stood before you after working with DHHS for 16 months on a rate reform initiative for our inpatient and outpatient rates. It was a lot of work and it was in compliance with your law.

This initiative doesn't simply cut hospitals, it changes the methodology. We proved last year that we will work collaboratively with the Administration on rate reform and we will cooperate to finance the hospital portion of Medicaid.

It seems obvious that the Administration will use the rate reform process when it suits them and they will completely disregard it when it doesn't.

Whether or not you need to reduce hospital reimbursement in SFY 2027, you should reject all methodology changes that were not put forward through the statutory process you enacted at the urging of the Administration. We have plenty of time to review the methodology issue the right way before it would need to change to impact SFY 2027 (June 1, 2026).

iii. Hospitals Are Reimbursed Differently Because Hospitals are Different.

You are being told that the state is overpaying hospitals compared to other doctors. The reimbursement rate for hospitals is too generous, they assert, and they just want to pay us similar to other doctors.

The Administration is misleading you.

Private physicians do not treat Medicaid patients in any significant numbers. Yes, there is a private physician rate, but Medicaid doesn't pay it very often because private practices frequently don't treat Medicaid patients.

Here is a screen shot from a very large southern Maine private practice:

MaineCare for existing patients

Existing patients who become newly eligible for MaineCare (formerly Medicaid) may choose one of the plans above to continue their care with an InterMed primary care physician.

[redacted] *does not accept new patients covered by MaineCare, Tricare or Traditional Medicare/Medicare Supplements.*

The only non-hospital providers that see Medicaid patients in any meaningful way are the FQHCs. They treat Medicaid patients like we do.

If the state were to truly pay hospitals like the other providers who actually see Medicaid patients…the FQHCs…we'd take that deal all day long. Hospital-based physicians typically get paid less than do FQHCs for physician visits.

It is nothing less than deceptive to hold-up private physicians as the comparable group to hospital-based physicians.

Furthermore, as described above, private physicians don't get paid what hospital physicians get paid, because **private physicians don't pay a tax into Medicaid like hospitals.**

Since their rates are not supported by a 3% gross receipts tax[2], don't compare their rates to ours.

iv. Access Will Suffer.

The bottom line is that if you cut hospital physician reimbursement by a third or more, we will have to close practices that disproportionately treat Medicaid patients.

The practices that disproportionately treat Medicaid patients are women's health, pediatrics, and behavioral health. If you cut the reimbursement to these practices, you are responsible for the loss of access that will follow.

We oppose $75 million in cuts to the doctors who treat Medicaid patients; we oppose being cut for four years outside this biennium; we oppose being the only provider group being cut; we oppose being asked to again balance your budget when we did that last year. This is unfair.

[2] Its true that some private practices pay a corporate tax and hospitals don't. However, the corporate tax is a net tax, not a gross receipts tax. The hospital tax generates 15 or 20 times as much revenue as would a corporate tax on hospitals.

2. **New Hospital Tax to Finance a Private Business (A-386) and Part WW (page 104).**

The Department is proposing a new tax on hospitals for health information technology initiatives. We have several concerns with the structure of this proposal.

Just like with the last proposal, we were never consulted or contacted by the Department while this proposal was being developed.

First, the language in Part WW says the tax can be used for "*Health Information Technology initiatives, **including but not limited to** a state-designated statewide health information exchange.*"

That is not acceptable. We are not going to fund DHHS IT projects. That is the job of the General Fund. We have only been told that this funding is for Maine's health information exchange, HealthInfoNet (HIN). We oppose any reference in Part WW to anything other than HealthInfoNet.

The tax proposed is $1.8 million. The current amount hospitals are paying HIN in assessment fees is roughly $2.2 million. So, there is at least the potential for some modest saving by hospitals.

However, the $1.8 million hospitals will pay draws down an additional $5.4 million in federal funding. **Where are those millions of dollars going?** No one has shared with us the plan for what is being done with the federal funding the tax on hospitals generates. Again, it is incredibly inappropriate to put a tax on hospital beds to fund DHHS IT programs.

Second, currently our members voluntarily participate in HIN. This new tax is imposed regardless of whether a hospital participates in HIN. The language should be changed to make clear that the assessment is only imposed on hospitals that choose to participate in HIN.

Third, we have been told that the assessment is supposed to be in place of the current participation fee imposed by HealthInfoNet on hospitals that participate. Yet, there is nothing in Part WW that effectuates that promise. Language must be added that makes clear the participation fee may not be imposed on any hospital that is paying the new tax.

Fourth, this fee should sunset after two years to allow for a review.

Fifth, this state needs to review this issue outside the context of the budget. This is nothing less than the virtual state takeover of the entity that controls the private health information of virtually every Mainer. This kind of change to the control and access to the private medical records of Maine people deserves sober deliberation outside the chaos of the budgetary process.

We oppose a new hospital tax to fund state IT operations and this proposal needs a lot of work with respect to HIN.

3. **New Ambulance Tax (A-357) and Part TT (page 91).**

Again, this is a new tax on our members and the Department never reached out on this.

We oppose the inclusion of hospital-affiliated ambulances in this proposal. The language exempts hospital-affiliated ambulances that pay the hospital tax. However, most hospital-affiliated ambulances don't pay hospital taxes on the ambulance revenue and will be subject to this tax.

Furthermore, with specific reference to ambulance services associated with small, rural hospitals known as Critical Access Hospitals (CAHs), this proposal is a complete loser. The reason the CAH hospitals do not currently pay the hospital tax is because of the deal we cut with the Administration that was supported by the Legislature just last year. CAH's were removed from the hospital tax last year completely and DHHS should be required to honor their commitment to not tax CAH operations.

Furthermore, the budget excludes CAH ambulance services from the corresponding increase in reimbursement.

In other words, the tax increase will be paid by CAH ambulance services but the corresponding rate increase will not be received by CAH ambulance services. That's not a fair deal. There are a number of

Hospital-Affiliated Ambulance Services

PPS Hospitals

NLH-AR Gould Hospital (Presque Isle) – Crown Ambulance

CMMC & St. Mary's (Lewiston) United Ambulance

CAH Hospitals

NLH - CA Dean Hospital (Greenville)

NLH - Mayo Hospital (Dover-Foxcroft) – Sebasticook Valley

MH - Franklin Memorial Hospital (Farmington) - NorthStar

MH – Stephens Memorial Hospital (Norway) - PACE

Redington Fairview Hospital (Skowhegan)

Bridgton Hospital United Ambulance (Bridgton)

MaineHealth and NorthernLightHealth each have "transport only" services as well and those appear to be subject to this new tax.

Taxing CAH hospitals breaks the deal we had last year with the Administration to exclude CAH's from the tax. If you keep them in the tax, you must devise a different match methodology that would include hospitals in the benefit.

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4. **COLA Suspension.**

The COLA suspension (page x) applies hospitals in the biennial budget; it did not hit hospitals in the supplemental budget since hospitals don't get traditional "COLAs."

However, as part of the deal we reached with the Department last year, hospital inpatient rates were going to be subject to COLAs for the first time. For context, hospital inpatient rates had not been raised from 2011 to 2024. They were raised this year as part of the "deal" and were supposed to get COLAs hereafter.

Again, this budget represents a break of that deal by the Administration.

The Bottom Line.

The bottom line is that **this budget forces providers to bear the brunt of the cost increases in the program.**

This is unfair and unsustainable.

You must look at other revenues and/or the size of the program, not just at providers.

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