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Policy Issues Affecting Maine's Hospitals

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Issue Brief

Policy Issues Affecting Maine's Hospitals

Overview

Maine's 42 general and specialty hospitals provide a wide range of inpatient, outpatient, emergency, psychiatric, rehabilitation, and long term care services. Thirty seven are acute care medical-surgical hospitals, four are specialty psychiatric hospitals, and the remaining facility is a rehabilitation hospital. The figure shows the distribution of hospitals across Maine. In terms of organizational structure, the majority (33) operate as not-for-profit entities. Of the remaining hospitals, three are church operated, five are government operated (e.g., Federal Department of Veterans Affairs, state, municipal, or hospital district), and one operates as a partnership.

Distribution of Maine Hospitals

All 37 acute care hospitals provide 24 hour emergency services, with 10 hospitals additionally designated as trauma centers and two operating as part of trauma systems. In addition to the four psychiatric hospitals in the state, eight of 37 provide inpatient psychiatric and four provide inpatient alcohol and drug abuse services.

Fifteen hospitals are designated as Critical Access Hospital (CAHs) by the Centers for Medicare and Medicaid Services (CMS).¹ CAHs are small (25 beds or less), low volume hospitals that must be located in rural areas; meet federal program requirements related to distance between hospitals and limitations on average length of stay; and maintain an affiliation with a larger support hospital. In exchange, CAHs receive cost-based reimbursement from Medicare and MaineCare. Cost-based reimbursement, a payment methodology better suited to the volume fluctuations experienced

by these facilities, provides CAHs with a degree of financial stability.^{2,3} An additional four hospitals are designated as Sole Community Providers (SCPs), defined as being 35 miles or more from the nearest similar provider. SCPs qualify for special formulas which result in higher payments.

Most Maine hospitals are located in small towns or rural areas and have less than 100 beds. Only three have 200 or more beds. Twenty-three hospitals are associated, under different arrangements, with one of three large hospital systems. MaineHealth has five member (i.e. owned) hospitals, five affiliate hospitals, and one joint venture with HealthSouth. Eastern Maine Health Systems has seven members and two affiliates. The Central Maine Medical Family has three member hospitals. Mercy Hospital in Portland is part of a regional health system, Catholic Health East. Six independent hospitals in Maine contract with QRH of Brentwood, Tennessee for management services.

Underpayment of Maine Hospitals by Medicare and MaineCare

While Medicare and MaineCare enrollees use 58% of hospital services in Maine, the two programs account for 43% (33% by Medicare and 10% by MaineCare) of hospital payments.⁴ Reports commissioned by the Maine Hospital Association estimate that Medicare pays 88% of costs for hospital services while MaineCare pays 75%. To recoup these shortfalls, Maine hospitals increase their charges to commercial insurers, who in turn pass these costs on to their subscribers.⁵ Known as cost-shifting, the practice is a difficult policy issue. The extent to which cost-shifting contributes to increases in prices for commercial insurers and private pay patients in Maine has not been quantified. A

Fast Facts

- Maine's hospitals provide a range of inpatient, outpatient, and emergency services as well as free and reduced price care, community health education, and workforce initiatives.
- Hospitals struggle with low payment from Medicare and MaineCare, while these sources represent an increasing share of patients.
- Current and future challenges for hospitals stem from federal and state regulations, trends in physician practice, and emerging payment models.

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2006 study of the impact of cost shifting in California estimated that cost shifting accounted for 12.3% of the total increase in private payer prices from 1997 to 2001.⁶ The New Hampshire Center for Public Policy Studies estimated that the impact of cost shifting due to Medicare and New Hampshire Medicaid rates ranged from 8% in 2001 to 10% in 2006.⁷ Based on these studies, cost shifting from Medicare and MaineCare likely accounts for a relatively small portion of premium increases in Maine with the remainder accounted for by underlying service utilization, changes in enrollment, changes in health plan and hospital margins, and cost-shifting due to the provision of uncompensated care to uninsured and low income patients.

A major factor in the underpayment of hospitals by Medicare is the hospital wage index. Medicare reimburses relevant acute care hospitals using the acute inpatient prospective payment system (IPPS) which pays a per-discharge rate for illness episodes based on national base payment rates for operating and capital expenses. The base rates are adjusted to account for the patient's condition, treatment needs, and market conditions in the facility's location. Medicare assigns discharges to discharge related groups (DRGs) which are groups of clinical problems that require similar levels of hospital resources. Each DRG is weighted to reflect the relative costliness of treatment for that group. To adjust for market conditions, the base rates are adjusted to reflect variations in input-prices using the local market's hospital wage index and other factors, such as resident training programs, disproportionate number of low-income patients, certain transfers and extraordinarily costly cases.

Each area's hospital wage index is intended to reflect expected differences in local market prices for labor and is revised each year based on wage data reported by IPPS hospitals. According to the MHA, low Medicare payment rates in Maine are due to Medicare's failure to adjust its payments to accurately reflect wages paid in Maine. MHA estimates that the Medicare Payment Advisory Committee's (MedPAC) recommendations for revising the wage index, if implemented, would net an additional \$10 million in Medicare payments for Maine Hospitals. Maine's 2008-2009 State Health Plan calls for the development of an Ad Hoc Medicare Equity Work Group to analyze this issue and work with MedPAC and CMS to increase the wage index for Maine hospitals.

Uncompensated Costs of Treating the Uninsured

Closely related to the above issue are the uncompensated costs borne by hospitals for providing care to Maine's 124,000 uninsured residents. Maine law requires hospitals to provide free care to patients with income below 100% of the Federal Poverty Level (FPL). All but one of the 39 hospitals (the Togus VA facility and the two state psychiatric hospitals were excluded) responding to the MHA's 2007 survey of free care policies has extended their eligibility standards for free care to 150-200% of FPL with 62% setting their eligibility standards at 200% of FPL. Additionally, 85% offer a sliding fee scale, which allows patients to pay a portion of hospital fees based on

their income.⁸ In 2005, Maine hospitals provided \$78.7 million in uncompensated care for uninsured people.⁹ The costs of providing free and discounted care are passed on to commercial and self-pay patients through increased hospital rates (i.e., cost-shifting).

Understanding the Community Benefits Provided by Maine's hospitals

Nationally, there is a growing interest in documenting the community benefits provided by not-for-profit hospitals within the context of the tax benefits they receive due to their exempt status. Seventeen states have implemented mandatory community benefit reporting. Voluntary reporting programs have been implemented in eight states. More are expected to follow.

Community benefits are programs or activities that provide services and/or promote health in response to an identified community need. Community benefits must:

- Generate low or negative margins;
- Respond to needs of special populations (e.g., persons living in poverty);
- Supply a service/program that would likely be discontinued if based on financial criteria;
- Respond to public health needs; or
- Involve education or research that improves overall community health.

Examples include charity care provided to low income, uninsured individuals; participation in medical student or residency training programs; provision of subsidized services that are typically not self supporting such as burn or neonatal care units; health education programs; shortfalls in revenues from government payers such as Medicaid; and free care clinics.

The Internal Revenue Service (IRS) has revised its Form 990, *Return of Organization Exempt from Income Tax* to collect data on the community benefits provided by not-for-profit hospitals, based substantially on the Catholic Health Association's community benefit reporting guidelines. Beginning in tax year 2009 (with returns filed in 2010), not-for-profit hospitals will be required to provide a full accounting of cost of their community benefits. Thirty-three of Maine's 42 hospitals are not-for-profit entities and will be required to report this information (government owned and certain other hospitals are exempt from reporting).

A large portion of most hospitals' community benefits is charity care provided to individuals who meet the hospitals charity care guidelines. At the national level, Senator Charles Grassley of Iowa, ranking Republican on the Senate Finance Committee is weighing the possibility of proposing legislation in early 2009 that would require not-for-profit hospitals to spend a minimum amount on charity care, impose penalties on hospitals that fail to meet the new requirements, and set curbs on executive

compensation and conflicts of interests.¹⁰ In the past, Senator Grassley's staff has suggested that not-for-profits spend at least 5% of their patient care revenues on charity care although it is not clear that the legislation under consideration would adopt that threshold. Based on data reported to the Maine Health Data Organization, Maine's hospitals provided 1.2% of total gross revenues as charity care 2.5% of gross revenues as bad debt in 2005.¹¹ Hospitals will legitimately argue that some portion of their bad debt is attributable to individuals that would qualify for charity care if they were to provide the required financial data. The exact percentage, however, is difficult to quantify and Maine hospitals may need to improve how they qualify patients if Senator Grassley is successful. Unfortunately, no comparative data exists to determine if Maine's hospitals provide more or less charity care and bad debt than other hospitals nationally. This is an issue that bears watching.

Challenges Related to the Provision of 24 Hour Emergency Services

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals must provide 24-hour emergency services regardless of patients' ability to pay and to maintain physicians to cover those services. The New York Times reports that an increase in unemployment could significantly increase the number of uninsured people presenting for care in emergency rooms, resulting in overcrowding and an increase in hospitals' unpaid medical bills.¹² With Maine's large rural population which has higher rates of uninsurance and under-insurance, Maine hospitals may see an increase in uncompensated care costs.

A related national issue with implications for Maine is the declining ability of hospitals to secure physician coverage of emergency departments due to lack of reimbursement for these services and impingement on physicians' limited non-work hours. Historically, physicians have provided emergency room coverage voluntarily in exchange for hospital admitting privileges; however, many hospitals across the country now must pay physicians for coverage.¹³

The emergency departments of Maine hospitals are the safety net for critical services not available in the community, such as mental health and substance abuse services. This is particular challenge for Maine's rural hospitals. A national study of Critical Access Hospital (CAH) emergency room usage indicated that almost 10% of visits were mental health related.¹⁴ Nationally, 42% of hospitals reported an increase in "boarding" behavioral health patients in emergency rooms.¹⁵ Boarding refers to patients in need of inpatient psychiatric or substance abuse services remain in the emergency department until a suitable placement can be found. Maine hospitals report ongoing problems with this issue given the relative shortage of available inpatient beds, particularly for children and adolescents. Boarding of behavioral health patients in emergency rooms places a difficult burden on staff as these patients often require very intensive coverage while awaiting transfer.

Maine's Certificate of Need program

Maine's Certificate of Need (CON) program is designed to contain costs among health care providers through the formal review and approval of proposals to add new services and construction.¹⁶ Reviews are required for proposals to transfer of ownership or licensure, acquire major medical equipment and make capital expenditures over a certain dollar threshold, and add new health services and facility beds.¹⁷ The program had been praised for covering an appropriate range of services and for its well-defined procedures and recorded decision-making process. It has also been criticized for operating outside of state health planning activities, its lack of monitoring and enforcement of decisions, and the size of its staffing resources given the magnitude of health spending to review.^{18,19} Addressing at least one criticism, the CON process is now required to use the State Health Plan as a basis for assessing projects.²⁰

The Capital Investment Fund (CIF), enacted in 2003 as part of the Dirigo Health legislation, is another aspect of the CON program that has come under criticism. The CIF, one of the only cost containment tools available in state law, was implemented to cap spending for projects approved under the CON statute. It places a cost limit on how much may be added to the health care system each year by capital investments approved under CON. The CIF establishes a measure of affordability against which CON decisions about need can be made; it balances need and affordability, recognizing that supply of health care services increases utilization and that increased utilization does not necessarily improve health outcomes.

The CIF's formulas have been set out by regulation which requires any amount over \$2 million for a project's third year operating costs to be debited against subsequent years' CIF cap. This results in surplus amounts from prior years being carried over under the current CIF cap, limiting the amount available for current projects with CON approval. For 2008, the CIF cap for large hospital projects is \$8.7 million; however, due to debits from previous years, this amount has been reduced to \$3.4 million. As a result, the amount available varies year to year and the potential result is that only small projects move forward and other large projects must be re-reviewed under the CON process.²¹ Hospitals are concerned that the current CIF process makes it difficult to conduct strategic planning because the available CIF amount can vary significantly from year to year.

An advisory committee of hospitals representatives, consumers, and employers was assembled to review the CIF and make recommendations.²² Over the summer of 2008, the committee worked with the Governor's Office of Health Policy and Development to develop recommendations and language to revise the CIF. These groups have proposed rules that will:

- Set the CIF according to straightforward formula (0.31% of statewide operating expenses);
- Facilitate effective health system planning by setting the CIF once every three years for a three year period; and

- Enhance the ability of DHHS to ensure economic and orderly development of the state’s health care systems by giving DHHS a better sense of all projects that providers wish to undertake.

Financial Incentives Linked to Clinical Performance

To re-align reimbursement with clinical performance, public and private payers are implementing pay-for-performance initiatives, where payment is tied to providers’ quality improvements. These incentives may be positive when enhanced payments are made to hospitals achieving established quality targets. They may also be negative when payment is withheld from hospitals that fail to meet acceptable quality standards. These changing reimbursement incentives, while clearly designed to improve the performance of the health care system, have implications for many of Maine’s small hospitals as successful implementation requires resources and information technology that may not be available to these facilities. Many incentive programs are based on volume assumptions that may not apply to small rural facilities as one or two poor outcomes can significantly impact their public rating.

Pay-For-Performance Initiatives

As part of a larger effort to improve health care quality and the information available to consumers about that quality, CMS has implemented Hospital Compare, a program in which hospitals publicly report their performance for four conditions. Their participation is tied to each hospital’s annual payment update. Hospitals, with limited exceptions, are required to submit quality data on ten core measures or face a 0.4 percentage point reduction in their annual payment updates. (While CAHs are not required to participate, many do so.) The ultimate goal for these measures is that they will be reported by all hospitals and accepted by all payers. CMS is also sponsoring a three-year demonstration that pays hospitals bonuses based on their performance on quality measures selected for inpatients with specific clinical conditions. In response to employer demands, a growing number of commercial health plans have established pay-for-performance initiatives, covering 23% of the insured population in 2007. Reporting on pay-for-performance measures can be burdensome for hospitals, particularly since measures vary widely by payers, and can impact public image.²³

Hospitals “Not Paid for Preventable Complications”

In a further effort to improve quality, CMS is no longer paying hospitals for Medicare patients who develop any of eight preventable complications that hospitals may be expected to prevent through quality improvement and tracking systems. These “preventable complications” include objects left in patients after surgery, hospital-acquired urinary tract infections, central line associated bloodstream infections, administration of incompatible blood products, air embolism, patient falls, mediastinitis after cardiac surgery, and pressure ulcers. CMS

may expand that list in 2009. Hospital advocates have pointed out that it is not necessarily possible for hospitals to eliminate all preventable complications. For some issues, accurate diagnosis is complicated and may result in false-positives. At the same time, the evidence conflicts on how well these conditions respond to prevention. As a result, full implementation may be premature.²⁴

Conclusion

Legislators and other policymakers will be continually challenged to balance the needs of hospitals for appropriate reimbursement and oversight with supporting their provision of important services to local communities.

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