Maine Medical Association

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TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

IN OPPOSITION TO

HOSPITAL REIMBURSEMENT AND MAINECARE COVERAGE REDUCTIONS

IN

L.D. 390, AN ACT MAKING UNIFIED APPROPRIATIONS AND ALLOCATIONS FOR THE EXPENDITURES OF STATE GOVERNMENT, GENERAL FUND AND OTHER FUNDS AND CHANGING CERTAIN PROVISIONS OF THE LAW NECESSARY TO THE PROPER OPERATONS OF STATE GOVERNMENT FOR THE FISCAL YEARS ENDING JUNE 30, 2018 AND JUNE 30, 2019

Joint Standing Committee on Appropriations & Financial Affairs
Joint Standing Committee on Health & Human Services
Room 228, State House, Augusta, Maine
Tuesday, February 21, 2017, 1:00 p.m.

Good afternoon Senators Hamper and Brakey, Representatives Gattine and Hymanson, and Members of both the Appropriations and HHS Committees. My name is Gordon Smith and I am Executive Vice President of the Maine Medical Association. I am here today to speak in opposition to cuts to hospital reimbursement and MaineCare coverage in the Governor's FY 2018-2019 biennial budget, L.D. 390.

The Maine Medical Association is a professional organization representing more than 4000 physicians, residents, and medical students in Maine whose mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens.

The biennial budget always presents legislators with some challenging policy choices and you surely will face some of those in L.D. 390. But, a state fiscal crisis is not driving the four cuts that are the subject of our testimony today – two hospital reimbursement cuts and two MaineCare eligibility cuts.

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Hospital Reimbursement Rate Cuts

MMA opposes the line item to reduce Critical Access Hospital (CAH) funding from 109% to 101% of cost in the General Fund amounts of $2.2 million in each year of the biennium (page A-339 of the biennial budget LR). MMA also opposes the line item to eliminate "provider-based" reimbursement in the General Fund amounts of $5.7 million in each year of the biennium (also on page A-339 of the biennial budget LR). These are perennial hospital rate cut proposals that come before you and MMA urges you to reject them as have previous legislatures because they would reduce access to health care in rural Maine. Representatives of the Maine Hospital Association and/or MMA could discuss the details of these programs further, if you wish, but I will simply say that the "critical access hospital" and "provider-based reimbursement" programs are two initiatives of the federal government years ago now, well before the Affordable Care Act, to help preserve access to health care in rural parts of the United States. These two programs enable hospitals and their employed physician practices to maintain a primary care base and health care safety net in much of our state.

MaineCare Eligibility Cuts

MMA also opposes the line item to eliminate MaineCare coverage for 19 and 20-year olds effective January 1, 2018 in the General Fund amounts of $3.3 million in the first year and $6.6 million in the second year of the biennium (also on page A-339 of the biennial budget LR). Finally, MMA opposes the line item to eliminate MaineCare coverage for adults between 40% and 100% of the FPL (page A-340 of the biennial budget LR). Other advocacy organizations will address the details of these proposals, but the MMA has a long-standing commitment to the pursuit of universal access to affordable, quality health care coverage for all individuals in this country through those public and private sector coverage options available now or in the future. While our country clearly is sharply divided about the means to achieve universal access, most people do not dispute that achieving universal access is critically important to addressing the problems in our current health care system and to maintaining the health and well-being of our population.

These four budget line items are not based on rational health care, public health, or economic policy. These cuts would simply shift costs elsewhere in state government, such as law enforcement and corrections, and in our economy, such as higher private health insurance premiums and emergency room costs. As background, I have attached our recently adopted *Statement on Reform of the U.S. Health Care System.*

Thank you for considering the views of the Maine Medical Association on this part of the DHHS biennial budget. I would be happy to respond to any questions you may have.

Adopted by the Maine Medical Association Board of Directors on Wednesday, January 18, 2017

Maine Medical Association Statement on Reform of the U.S. Health Care System

The Maine Medical Association (MMA) is a professional organization founded in 1853 and headquartered in Manchester, Maine representing more than 3900 physicians, residents, and medical students whose mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens.

The MMA believes that the current U.S. health care system continues to produce some of the world's most eminent clinicians and health care facilities who together provide some of the most advanced medical care in the world. But, it does not provide basic health care as well as many other developed countries and, therefore, is not serving our country or its people as well as it should. We face the problems with our current health care system in our daily encounters with patients. We believe that the United States can and must do better in providing health care to its people.

Our objective should be to achieve basic health care for every resident of Maine.

We support the "Quadruple Aim," a framework developed by the Institute for Healthcare Improvement describing an approach to optimizing the performance of our health care system. These core values are:

1. Improving the patient experience of care, including quality and satisfaction;
2. Improving the health of populations;
3. Reducing the per capita cost of health care; and
4. Improving the health and work life of health care clinicians and staff members.

Our health care system should strive to incorporate the following principles:

<u>The Physician-Patient Relationship</u>

1. Provide health care that is patient-centric and physician-directed.
2. Put the patient first and protect the sanctity of the physician-patient relationship, particularly respecting the physician's autonomy as advocate for the patient.
3. Promote the maximum possible choice in patients' selection of physicians.

<u>Structure of the Health Care System</u>

4. Support a strong and vital public health infrastructure that can collaborate fully with physicians and the health care system to advance population health.
5. Emphasize prevention and provide systemic support for healthier lifestyles, through incentives for identified health risk avoidance.
6. Stress pooling of clinical risk rather than medical underwriting.
7. Be efficient and have the ability to restrain rising health care costs at a system-wide level in the least intrusive way possible.
8. Have the ability to integrate and coordinate services in order to reduce fragmentation and the division of medical care into "silos."

9. Improve quality and minimize errors by relying upon evidence-based medicine, benchmarking, and outcome measures driven by clinicians and administrators working together.
10. Promote transparency of health care cost, quality, and outcome data.
11. Reduce the burden of administration to the greatest extent possible and include a billing system that is streamlined and consistent, as well as a payment system that is prompt and outcomes oriented.
12. Make health information technology (HIT), including electronic medical records (EMRs), more user friendly and more focused on clinical matters, rather than financial matters, and completely interoperable in order to facilitate rather than impede communication and work flow among clinicians, patients, and health care facilities.
13. Include a rational means of resolving medical liability disputes in order to restrain defensive medicine.

Public Support for the Health Care System

14. Be politically sustainable by including everyone as a participant and, therefore, a stakeholder in supporting it.
15. Be simple and fair, such that every participant can understand it and perceive that its financing burden and benefits are distributed fairly.