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TEL.: (207) 289-1670

April 15, 1988

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

TO: Commission Members

FROM: Annika Lane

RE: Responses to Survey

Enclosed is a list of respondents to the February 19 survey.

Analysis of the responses provides an overall picture of how the respondents perceive various issues concerning Maine's Health Care system. **However, please note that this was not intended to be a statistically significant survey.** The survey is merely exploratory, intending to produce a range of responses. It would therefore not be appropriate or effective to associate any particular responses with any particular subgroup within the population. The responses are anecdotal at best.

However, this survey could be used as a basis for developing a random, statistically valid survey that would allow statements to be made about population subgroups. Commission members may wish to consider this option.

The survey is not statistically valid for the following reasons:

1. The sample of interested parties was developed by an ad hoc, rather than a systematic random method. It is based on names already on file, those submitted by individual Commission members and interested parties, and existing health, business, labor, insurance and community organizations around the State.

2. The questions are broad - soliciting respondents' perceptions of health care issues in their particular areas. The information collected only represents the opinion of those responding and could not be used to make statements about how the total population of parties interested in health care perceive the system.

3. The response rate is low - 200 were sent out
56 were received = 28%
51 were summarized = 25.5%

5057m

4/15/88

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES SURVEY

RESPONDENTS

HOSPITALS = 12 = 23.5%

HOSPITAL	TOWN	COUNTY	SIZE
URBAN:			
Osteo Hospital of Maine	Portland	Cumberland	Large
So. Maine Medical Center	Biddeford	York	Large
H.D. Goodall Hospital	Sanford	York	Med
York Hospital	York	York	Med
Millinocket Regional Hosp.	Millinocket	Penobscot	Small
Parkview Memorial Hosp.	Brunswick	Cumberland	Small
New England Rehab. Hosp. of Portland	Portland	Cumberland	Small
RURAL:			
Miles Memorial Hospital	Damariscotta	Lincoln	Small
Sebasticook Valley Hosp.	Pittsfield	Somerset	Small
Van Buren Community Hosp.	Van Buren	Aroostook	Small
SOLE COMMUNITY PROVIDER:			
Calais Regional Hospital	Calais	Washington	Med
Rumford Community Hospital	Rumford	Oxford	Med

OTHER HEALTH CARE FACILITIES = 3 = 5.9%

Dixfield Health Care Center
100 Weld Street
Dixfield, ME 04224

Viking ICF
126 Scott Dyer Road
Cape Elizabeth, ME 04107

Jerry S. Koontz
President,
Northeast Health
108 Elm Street
Camden, ME 04843

BUSINESSES/INSURANCE = 3 = 5.9%

Maine Merchants Association

Chamber of Commerce and Industry

Blue Cross and Blue Shield of Maine

AGING = 15 = 29.4%

Advisory Council
So. Maine Area Agency on Aging
237 Oxford Street
Portland, Maine 04101

Jean Gardner, RN, BSPA
North Berwick Nursing Home
P.O. Box 6730
N. Berwick, Maine 03906

Aroostook Area Agency on Aging
P.O. Box 1288
Presque Isle, ME 04769

Paul A. Cyr
Presque Isle Nursing Home
162 Academy St.
Presque Isle, ME 04769

Caribou Nursing Home
10 Bernadette Street
Caribou, ME 04736

Margaret P. Brown, Admin.
Oceanview Nursing Home
Lubc, ME 04652

Jane G. Morrison, Director LTC
Western Area Agency on Aging
465 Main Street
Lewiston, ME 04243-0659

d'Youville Pavilion N.H.
102 Campus Avenue
Lewiston, ME 04240

Ellen E. Dutton
Southern Maine Senior Citizens Inc.
6 Margaret Circle
Saco, Maine 04072

R.H. Newton
Southern Maine Senior Citizens Inc.
Kennebunk, Maine 04043

Beatrice Wehmeyer
Southern Maine Senior Citizens Inc.
R.R. 2, Box 126
Kezar Falls, ME 04047

Arlene Cooper
Gorham Manor N. H.
30 New Portland Rd.
Gorham. ME 04038

Wendell Dennison
Penobscot Nursing Home
Penobscot, ME 04476

St. Joseph Nursing Home, Inc
Upper Frenchville, ME 04784

Aroostock Home Care Agency, Inc
18 Birdseye Avenue
P.O. Box 488
Caribou, ME 04736

HEALTH CARE ORGANIZATIONS = 8 = 15.7%

Maine State Nurse's Association

Special Select Commission on Access to Health Care

Western Maine Health Care Corp.

Maine Chapter Multiple Sclerosis Society

Health Policy Advisory Council

Northern Maine Rural Health Program

American Lung Association

Katahdin Area Health Education Center

SOCIAL SERVICE AGENCIES = 1 = 2%

York County Community Action

OTHER = 9 = 17.7%

Hester Bemis
Cornish, Maine

Madeline Freeman
P.O. Box 70
Brewer, ME 04412

Walter W. Hichens
424 State Road
Eliot, Maine 0390

David L. Hall, M.D.
Family Medicine
P.O. Box 95, Rte. 1
Glen Cove, ME 04846

Robert Hoffman, M.D.
1 Evergreen Woods
Bangor, ME 04401

4 Unidentified Responses

OTHER RESPONSES, NOT SUMMARIZED

Maine Hospital Association

American Lung Association of Maine

DHS Bureau of Medical Services

Maine Health Care Association

New England Rehabilitation Hospital of Portland

Maine Medical Association

5027m

John R. McKernan, Jr.
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

April 5, 1988

TO: Elaine Fuller, Director, Bureau of Medical Services

FROM: Hilary Fleming, Assistant Director, Bureau of Medical Services

RE: Blue Ribbon Commission Survey

Attached is the final version of the Study for the Blue Ribbon Commission.

I believe comments from all the Bureaus within the Department have been addressed. I have also incorporated the changes discussed with Dr. Greenburg.

HF/nsm

1. Is there a problem in your area with regard to the availability of affordable health insurance coverage? If so, please describe:

Based on a limited study by the University of Southern Maine Center for Research and Advanced Study in October 1986 13.2% of Maine's population aged 18-64 (93,200 individuals) were uninsured. 9.6% of these people had been uninsured for the previous 12 months. The reasons for not carrying insurance were premiums were unaffordable (41%), people were unemployed (29%), insurance was not offered at their job (10%) and 5% did not believe in insurance coverage.

Of the people who responded to the survey 2/3 of those uninsured have incomes below $15,000.00 and 13.2% have incomes less than $7,000.00. These folks do not meet Medicaid eligibility or AFDC criteria.

In reviewing the Capsule of Maine Health Information published by the Department of Human Services the following trends in coverage by Medicare, Medicaid, Blue Cross and Blue Shield from 1980 - 1985 as a percentage of the Maine population each year:

	Medicare					
	PART A	PART B	MEDICAID	BLUE CROSS	BLUE SHIELD	OT.CARR'S
1980	13.7	13.7	9.7	48.8	47.4	Not
1981	14.2	13.9	9.2	48.1	46.5	Available
1982	14.1	14.0	8.4	47.9	46.3	
1983	14.3	14.1	8.3	48.1	45.2	
1984	14.3	14.1	8.3	48.2	44.8	
1985	14.4	14.3	8.6	48.8	45.5	

Maine has 150,000 people over the age of 65. 98% of these people are covered by the Medicare program. However, Medicare pays less then half of the health care costs of an individual. The elderly, espically the low income folks, have difficulty paying the $25.00/mo. premium for Part B, let alone an additional $40.00/mo. for a Medi-gap premium to cover any co-insurance or deductible they are responsible to pay. If they do not buy a "Medi-gap" policy the elderly must pay the first $75.00 each year for physician services and $340 for each new spell of illness which requires hospitilazation.

Long term care insurance to cover residential or in-home services is either unavailable or unaffordable in Maine. These services are covered only thru Home Base Care services, Medicaid and Medicare.

2. **Is there a shortage of physicians in your area? If so, describe the extent of the shortage, and whether it is confined to particular specialists:**

According to a study published in December 1987 out of 62 Primary Care Analysis Areas (PCAA) in Maine 21 PCAA have experienced a shortage of primary care physicians and 3 PCAA have a shortage in a portion of their areas. Primary Care Physicians are defined as Family Practice, General Practice, Obstetrics, Internal Medicine and Pediatrics. With a decrease in financial support from the National Health Service it is expected that Maine will experience a greater shortage in years to come.

There has been an increasing trend of trained Obstetricians to give up their practice. These physicians continue doing Gynecology services only.

There is also a reported shortage of physicians who will care for the elderly residents of nursing homes. This reflects the need for specialized training in Geriatric medicine.

3. Is there a shortage of other health care professionals in your area? If so, describe the extent of the shortage:

Other Maine Health Care Professionals that we have information on are as follows:

DENTISTS - out of 45 defined areas there are 6 areas that fall short of dental coverage and 5 population groups are short. The areas that are short include Bingham, Gouldsboro/ Milbridge, Machais/ Jonesboro, Danforth/ Vanceboro, Island Falls and the Allagash. The population groups include the island population, students of the job corp., inmates i the prison system and the population served by the dental clinics in Cumberland and York.

OPTOMETRISTS - have 4 areas out of 45 which have shortages. These shortage areas include Blue Hill, Eastport, Gouldsboro and Machais.

MENTAL HEALTH - have 8 areas which has a shortage of Manpower by the county they are Piscataquis, Oxford, Somerset, Washington, Aroostook and various smaller sections of Northern Penobscot, North West Cumberland and the Northern tip of York.

The staff at ODAP have identified a significant shortage of both clinical, counselors and supporting health care professionals including RN's. This seems to be a statewide issue.

RN LPN & CERTIFIED NURSES AIDES - there is also a significant outcry for RN's, LPN's and Nurses Aides statewide by all health care providers including hospitals, long term care providers, home health care providers and substance abuse treatment programs. Hospiatls are updating a 10.2% vacancy rate of RN's and a 16% vacancy rate of LPN's.

SOCIAL WORKERS - hospitals are experiencing a shortage of social workers across the state. Social Services positions become vacant in the hospitals and the facilities have no applicants to fill these positons. Agencies who need social workers such as Area Agecies for the Aging have a difficult if not impossible time recruiting staff to fill their positions.

OCCUPATIONAL THERAPISTS, PHYSCIAL THERAPISTS AND RESPIRATORY THERAPISTS - are also in short supply statewide. Although no hard figures are available agencies who utilize these professions have a difficult time in finding people to fill the positions.

NURSE PRACTITIONERS - the most recent information available for nurse practitioners is 1981 data. At that time Maine had 76 active nurse practitioners in Maine. From that total we had 5 in emergency medicine, 10 in family and general practice, 8 in OB/GYN, 7 in pediatrics, 34 are unknown specialties the remaining 12 span the specialty catagories to include anesthisa, geriatric, surgery, physchiatric and forensic pathology.

PHYSICIAN ASSISTANT - the same data is available for physicans assistant (P.A.) noting the data was prepared in 1981. At that time Maine had 85 licensed and active physicians assistant across the state. There were 26 practicing emergency medicine with the largest number in Somerset and Kennebec counties then with Waldo, Penobscot and Hancock counties each reporting 3 P.A.'s active in the county. 37 P.A.'s were practing family or general practice. Only 1 P.A. was active in pediatrics and 217 with unknown specialties reported.

4. Is there a problem in your area with the unavailability of particular health care services, e.g. hospice care, home health care, mental health care or even acute care? If yes, please describe:

Health care is generally difficult to access for members of the population who are either uninsured or underinsured. These people depend on hospital outpatient or emergency room services or may go without medical attention until an emergency occurs.

Inpatient detoxification and rehabilitation services for substance abuse are available for those people with coverage through private insurance, public funds or are able to pay for it themselves. Access to these services are difficult or impossible for those people with no insurance. Outpatient counseling services for adolescents, day treatment and long term residential services fop late stage alcoholics are unavailable. Some hospitals are working toward establishing day treatment services but only as funding is available on a pilot project basis.

There are many complaints about the unavailability of home care statewide but most severe in Southern Maine. However, staff of the Department of Human Services, Department of Project review noted shortages in Hancock, Washington, Piscataquis, Northern Penobscot and parts of Oxford and Cumberland county.

Statewide public transportation services are in extermely short supply. The agencies which are available to provide transportation for medical services are available only during the daytime. Frequently they are used for routine transportataion of the mentally retarded citizens to developmental day care services leaving the needs of others who require transportation to medical services unmet. The agencies provide limited services to rural parts of the state. For instances the transportation agency may have a van available to a rural community one day a week and will only transport to a city or town within the agencies catchment area. Adequate transportation is extermely important for the elderly and the children to obtain proper health care.

People to assist with personal care as well as instrumental activites of daily living are difficult to find as are people to assist the elderly and disabled with daily, weekly or seasonal chores.

Short term inpatient care needs to be available for the elderly and chroniically ill who are able to reside at home. This service would allow for a periodic reevaluation of the medical and psychiatric needs of the patient. A beneficial side effect of such services would be a period of respite services for the care giver.

There are an insufficient number of emergency trauma centers available in Maine's rural areas. Although the human resources are available electronic communications to key trauma centers would improve initial care to the trauma patient. Electronic communication for emergency diagnostic and treatment services between rural facilities and urban diagnostic and treatment facilities would improve the treatment of the citizens of Maine.

It could be benificial and cost efficient to encourage the small rural facility to provide outpatient surgical and diagnostic services to the population they serve. If this were done it would provide a valuable service to the community plus it would encourage physicians to settle and stay in the rural area of the state and allow nresidents of these areas access to good medical services.

Maine currently has three ambulatory surgical centers available to its citizens. These centers are all located in Portland and specialize in eye care and plastic and hand surgery.

5. Is there a problem with access to or cost of nursing home care in your area? If yes, please describe:

People who are very dependent, either physically or mentally experience problems in accessing nursing home services. Hospitals are experiencing increases in days-waiting-placement while fewer beds are available in nursing homes. The Medicaid program experiences the most difficulty in placing ICF level patients in the Augusta area, Bangor and North of Bangor. There is also difficulty in placing SNF level patients in the Bangor area. Maine Medicaid reimbursement for long term care is second in New England and 5th in the nation.

Medicaid eligible people, whether hospitalized or at home waiting placement, reportedly have more difficulty with access to nursing home care then do private or self pay people.

In calendar year 1987 there were 1311 Medicaid recipients classified in need of nursing home services. During that year 130 of those people were discharged from the hopspital to go home, 41 were admitted to a skilled nursing facility (SNF), 658 were admitted to an intermediate care facility (ICF), the remaining were either readmitted to acute care or discharged to a hospice, boarding home or had expired.

In February 1988 there were 268 Medicaid eligible people waiting placement to an intermediate care facility (ICF), at the same time there were 261 vacant ICF beds in Maine. There were 16 people waiting placement to a skilled nursing facility (SNF) and 49 vacant SNF beds in Maine.

Maine does not have residential facilities for young adults with long term chronic illness resulting from degenerative, neurological or physchiatric diagnosis. There are no facilities which offer socialization and development programs needed for the enrichment of the lives of these people.

Adequate day care for the dependent adult is not available in many parts of Maine. Families who wish to keep a dependent adult at home finds little encouragement or assistance if adult caretakers must work outside the home. Many times the only option is to place the dependent adult in a long term care facility when a bed is available.

6. Do you have an insufficient volume of patients in your local hospital for the hospital to be financially viable?

If yes:

We have 2 hospitals in the state whose occupancy rate in 1986 is less than 20%, Van Buren and Taylor Osteopathic. There are 9 hospitals with an occupancy rate of 21-39% and 8 hospitals with an occupancy rate of 40-49%. This represents 19 facilities out of 45 who have had less than 50% occupancy in 1986. We have two hospitals in the state whose 1986 occupancy rate was less than 19%, Van Buren and Taylor Osteopathic. The following nine (9) hospitals had an occupancy rate between 21 and 39%,

Hospital	County
BATH	SAGADAHOC
CALAIS	WASHINGTON
CASTINE	HANCOCK
SEBASTICOOK	SOMERSET
ST. ANDREWS	LINCOLN
WESTBROOK	CUMBERLAND
C.A.DEAN	PISCATAQUIS
MT. DESERT	HANCOCK
RUMFORD	OXFORD

and the following eight hospitals experienced an occupancy rate of 40-49 %.

Hospital	County
HOULTON	AROOSTOOK
MAINE COAST	HANCOCK
MILLINOCKET	PENOBSCOT
NORTHERN MAINE	AROOSTOOK
PENOBSCOT VALLEY	PENOBSCOT
REDDINGTON - FRVIEW	SOMERSET
ST. JOSEPH'S	PENOBSCOT
TAMC	AROOSTOOK

For facilities which share a care area and one of the facilities is experiencing a low occupancy rate it would be prudent for the facilities to consider merging their services and their medical staff. Some facilities could consider conversion to a long term care facility.

a) Is your community willing to subsidize the hospital?

Hospitals have been financial viable since the Maine Health Care Finance Commission has been established. Each hospital has the ability to charge all payers enough money to financially support the facility. Medicaid and Blue Cross pay hospitals prospectively, reimbursing facilities weekly regardless of admissions.

b) What particular services is it important to preserve in the hospital?

For those hospitals with low occupancy rates it would seem to be important to maintain diagnostic and treatment services at the community hospital level. This would encourage physicians to stay in an area or new physicians to move into the area. ODAP is supportive of small rural hospital outpatient substance abuse treatment programs. It is believed that physicians are successful in identifying and intervening in situations where an individual is experiencing a substance abuse problem.

7. If Maine Health care costs are likely to increase by 25% a year, do you believe:

a) Health services should be decreased?
If yes:

Which kind of services should be cut?
To whom should the services be cut?

It is unlikely that health care costs will increase by 25% a year unless the population of Maine increases at such a rate that would cause health care to rise at 25%. Health care costs will be increasing simply because of the increase demands of wage and benefit increases by the nursing staff, the increase cost of AIDS control and prevention, mandated coverage for some diseases, new technology to name a few reasons.

To curtail the rising costs of health care Maine nees to explore better management and delivery of their health care system. Encourage preventative medicine such as seat belt laws, helmet laws. Focus on managed care, keep the people well, improve the transportation systems to get people the health care in a timely manner. Improve electronic communication for diagnostic services from rural Maine to the urban centers. We must encourage the medical community to use their offices for patient visits and avoid the use of outpatient services or emergency rooms in hospitals.

b) Health care revenues should be raised to pay for these cost increases. If yes, where should the money come from?
- Insurance premiums for privately purchased health insurance?
- Through a payroll tax?
- Through general revenues? (personal income and sales taxes?)
- Other?

The cost of health care must be shared with industry and business, health care industry, private insurance, government and self pay.

8. If you have any other comments or information which you feel would be useful to the Commission in completing its work, please indicate below or on a separate sheet.

The Department would recommend that a group be retained to study the source of health care costs. We should know the state of health of the Maine citizen as compared with the nation.

It should be noted that 1987 was a good year for the economy in the State of Maine. Per capita personal income increased 7.2% between the second quarter of 1986 and the same period in 1987, which was 2% higher then the national trend. According to the Maine State Planning Office Maine's personal income is expected to grow at 8% or better in 1988 and 1989. Perhaps now is the time to review how much disposable personal income has increased and what percentage should be used to calculate the Certificate of Need Development Account.

Quality of care in Maine needs to be addressed by reviewing such factors as morbidity and mortality rates, in and out migration, manpower affairs, the effects of educational and regulatory systems and quality assurance systems.

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April 12, 1988

BLUE RIBBON COMMISSION ON HEALTH CARE EXPENDITURES

To: Commission Members

From: Annika Lane

Re: Survey Summary

On February 19, 1988, the Commission solicited written testimony from parties interested in the Commission's work.

Enclosed is a summary of the responses that were received. Some people submitted responses that could not be easily summarized or categorized into the format that was chosen. These reponses have been attached in their original form. Articles that were submitted are also attached.

Data:
200 surveys were distributed
56 responses were received (28% response rate)
51 are summarized
5 others are attached

4970m

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TEL.: (207) 289-1670

April 11, 1988

To: Annika Lane, Legislative Analyst

From: Robert W. Dunn, Research Assistant

Re: Survey Summary: Blue Ribbon Commission On Health Care Expenditures

As you requested, I have examined and summarized the health care survey that was administered by the Blue Ribbon Commission on Health Care Expenditures. With the exception of question 8, you will find a very brief summary to each of the questions below. Question 8 is more or less a summary in its own right. In addition, I have attached a tabular summary of each of the questions, including question 8.

According to the results of the survey, it appears that the shortage of health care professionals (question 3) and shortage of nursing home beds (question 5) are major problems currently confronting Maine's health care industry.

Please keep in mind that this was not a scientific survey and therefore any statistical inferences that would be drawn from the results of this survey would be questionable.

Question 1

Is there a problem in your area with regard to the availability of affordable health insurance? If so, please describe.

62,7% of the respondents indicated that such a problem exists in their area. 21.6% of the respondents indicated that no such problem exists in their area. 15.7% of the respondents did not answer this question. The group listed most often as having been affected by this problem is individuals. The cost

of health insurance was listed most commonly as the reason for this problem. None of the respondents suggested a solution to this problem.

Question 2

Is there a shortage of physicians in your area? If so, describe the extent of the shortage, and whether it is confined to particular specialists.

58.8% of the respondents indicated that such a problem exists in their area. 29.4% of the respondents indicated that no such problem exists in their area. 11.8% of the respondents did not answer this question. Respondents indicated that virtually all types of physicians are in short supply. General practitioners, obstetricians, and orthopedic surgeons were the types of physicians listed most commonly as being in short supply. None of the respondents suggested a solution to this problem.

Question 3

Is there a shortage of other health care professionals in your area? If so, please describe the extent of the shortage.

84.3% of the respondents indicated that such a problem exists in their area. 9.8% of the respondents indicated that no such problem exists in their area. 5.9% of the respondents did not answer this question. Respondents indicated that a wide variety of health care professionals are in short supply. Certified Nurses Aides, Licensed Practical Nurses and Registered Nurses were listed most commonly as the types of health care professionals in short supply. One respondent suggested implementing a 2 year curriculum for a Registered Nurse Degree as a solution to the RN shortage.

Question 4

Is there a problem in your area with the unavailability of particular health care services, e.g. hospice care, home health care, mental health care, or even acute care? If so, please describe.

64.7% of the respondents indicated that such a problem exists in their area. 19.6% of the respondents indicated that no such problem exists. 15.7% of the respondents did not answer this question. A wide variety of health care services were indicated to be in short supply. Home health care, hospice care, and mental health care were the types of health care listed most commonly as being in short supply. Geographic access, a lack of funds, and staffing inadequacy are some of the reasons listed for this shortage. Geographic access was the most commonly listed reason for the shortage. None of the respondents suggested a solution to this problem.

Question 5

Is there a problem with access to or cost of nursing home care in your area? If so, please describe.

82.4% of the respondents indicated that such a problem exists in their area. 7.8% of the respondents indicated that no such problem exists in their area. 9.8% of the respondents did not answer this question. Bed shortages, a building moratorium, cost, and the reimbursement system were all listed as reasons for this problem. Bed shortage was the reason listed most commonly. None of the respondents suggested a solution to this problem.

Question 6

Do you have an insufficient volume of patients in your local hospital for the hospital to be financially viable?

A) Is your community willing to subsidize the hospital?

B) What particular services is it important to preserve in the hospital?

37.3% of the respondents indicated that there was a sufficient volume of patients in the local hospital to make it financially viable. 27.5% of the respondents indicated that there was not a sufficient volume of patients in the local hospital to make it financially viable. 35.3% of the respondents did not answer this question.

42.9% of the respondents that indicated that their local hospital had an insufficient volume of patients also indicated that their community would be willing to subsidize the local hospital. 37.5% of the respondents indicated that their local hospital had an insufficient volume of patients also indicated that their community would not be willing to subsidize the local hospital. 21.4% of the respondents that indicated that their local hospital had an insufficient volume of patients did not answer this question. Respondents indicated that virtually all services should be preserved in the hospital. Emergency services was the service that should be preserved that was listed the most commonly. None of the respondents suggested solutions to this problem.

Question 7A

If Maine health care insurance costs are likely to increase by 25% a year, do you believe:

Health services should be decreased?

Which kind of services should be cut?

To whom should the services be cut?

23.5% of the respondents indicated that given the situation depicted in this question, 7A, services should be cut. 66.7% of the respondents indicated that given the situation depicted in question 7A, services should not be cut. 9.8% of the respondents did not answer this question. Respondents indicated that acute care beds, home health care, life supported services, mental health care, and repetitive tests are services which should be cut. Respondents indicated that services should be cut to those receiving the services listed previously.

Question 7B

If Maine health care insurance costs are likely to increase by 25% a year, do you believe:

Health care revenues should be raised to pay for these cost increases. If yes, where should money come from?

A) Increased premiums for privately purchased health insurance?

B) Through a payroll tax?

C) Through general revenues? (Personal income and sales taxes)

D) Other?

84.3%of the respondents indicated that given the situation depicted in question 7B, health care revenues should be raised. 3.9% of the respondents indicated that given the situation depicted in question 7B, health care revenues should not be raised. 11.8% of the respondents did not answer this question.

41.8% of the respondents that indicated that health care revenues should be raised indicated that they should be raised through increased premiums for privately purchased health insurance. 37.6% of the respondents that indicated that health care revenues should be raised indicated that they should be raised through a payroll tax. 72.1% of respondents that indicated that health care revenues should be raised indicated that they should be raised through general revenues. Other methods of raising revenues indicated by the respondents include cost containment federal money, and sin taxes.

Robert Dunn
Human Resources
April 4, 1988
Doc. #4854*

Question 1 - 25.5% Response Rate.

Is there a problem in your area with regard to the availability of affordable health insurance? If so, please describe.

Yes, a problem exists.	No problem exists.	No Answer
32 (62.7%)	11 (21.6%)	8 (15.7%)

Groups or Persons Affected

Employees
Indigent
Individuals
Large Employers
Private Industries
Self Employed
Single Mothers
Small Business
Unemployed

Groups Listed Most Commonly

Individuals

Most Common Reason for Problem

Cost

Suggested Solutions

None

Question 2 - 25.5% Response Rate.

Is there a shortage of physicians in your area? If so, describe the extent of the shortage, and whether it is confined to particular specialists.

Yes, a problem exists.	No problem exists.	No Answer
30 (58.8%)	15 (29.4%)	6 (11.8%)

Types of Physicians in Short Supply

Virtually All Types of Physicians

Types of Physicians Listed Most Commonly

General Practitioners
Obstetrics
Orthopedic Surgeons

Suggested Solutions

None

Question 3 - 25.5% Response Rate

Is there a shortage of other health care professionals in your area? If so, please describe the extent of the shortage.

Yes, a problem exists.	No problem exists.	No Answer
43 (84.3%)	5 (9.8%)	3 (5.9%)

Types of Health Care Professionals in Short Supply

Certified Nurses Aides
Licensed Practical Nurses
Occupational Therapists
Pharmacists
Physical Therapists
Registered Nurses
Respiratory Therapists
Speech Therapists
X-Ray Technicians

Types of Health Care Professionals Listed Most Commonly

Certified Nurses Aides
Licensed Practical Nurses
Registered Nurses

Suggested Solutions

Implement a 2 year curriculum for a Registered Nurse Degree

Question 4 - 25.5% Response Rate

Is there a problem in your area with the unavailability of particular health care services, e.g. hospice care, home health care, mental health care, or even acute care? If so, please describe.

Yes, a problem exists.	No problem exists.	No Answer
33 (64.7%)	10 (19.6%)	8 (15.7%)

Types of Health Care Services in Short Supply

Acute Care
Adult Day Care
Home Health Care
Hospice Care
Mental Health Care
Occupational Health Care
Psychiatric Care
Substance Abuse Care

Types of Health Care Services Listed Most Commonly

Home Health Care
Hospice Care
Mental Health Care

Reasons for Shortage

Geographic Access
Lack of Funds
Staffing Inadequacies

Reasons for Shortage Listed Most Commonly

Geographic Access

Suggested Solutions

None

Question 5 - 25.5% Response Rate

Is there a problem with access to or cost of nursing home care in your area? If so, please describe.

Yes, a problem exists.	No problem exists.	No Answer
42 (82.4%)	4 (7.8%)	5 (9.8%)

Reasons for Shortage

Bed Shortage
Building Moratorium
Cost
Reimbursement System

Reasons for Shortage Listed Most Commonly

Bed Shortage

Suggested Solutions

None

Question 6

Do you have an insufficient volume of patients in your local hospital for the hospital to be financially viable? - 25.5% Response Rate

A) Is your community willing to subsidize the hospital? - 7% Response Rate

B) What particular services is it important to preserve in the hospital? - 10.5% Response Rate

Sufficient Volume	Insufficient Volume	No Answer
19 (37.3%)	14 (27.5%)	18 (35.3%)

Will Community Subsidize Hospital?

Yes	No	No Answer
6	5	3

Services That Should Be Preserved

Virtually all Services

Services That Should Be Preserved Listed Most Commonly

Emergency Services

Suggested Solutions

None

Question 7A - 25.5% Response Rate

If Maine health care insurance costs are likely to increase by 25% a year, do you believe:

Health services should be decreased?

Which kind of services should be cut?

To whom should the services be cut?

Services should be cut.	Services should not be cut.	No Answer
12 (23.5%)	34 (66.7%)	5 (9.8%)

Which Services Should Be Cut?

Acute Care Beds
Home Health Care
Life Support Services
Mental Health Care
Repetitive Tests

To Whom Should Services Be Cut?

Those receiving services listed above.

Question 7B - 25.5% Response Rate

If Maine health care insurance costs are likely to increase by 25% a year, do you believe:

Health care revenues should be raised to pay for these cost increases. If yes, where should money come from?

A) Increased premiums for privately purchased health insurance?

B) Through a payroll tax?

C) Through general revenues? (Personal income and sales taxes)

D) Other?

Health Care Revenues Should be Raised	Health Care Revenues Should Not Be Raised	No Answer
43 (84.3%)	2 (3.9%)	6 (11.8%)

Increased Premiums	Payroll Tax	General Revenues
18 (41.8%)	14 (32.6%)	31 (72.1%)

Other Methods of Raising Revenue

Cost Containment
Federal Money
Sin Taxes

Question 8 - 11.5% Response Rate.

If you have any other comments or information which you feel would be useful to the Commission in completing its work, please indicate below or on a seperate sheet.

- State mandated health care benefits are in part to blame for the increases in health care costs.
- State officials must create an environment which is conducive to providing primary and secondary health services at the local level.
- The current tax system can be utilized to pay for health care. The state must change the areas in which it spends tax revenues.
- Part of the cost increases are due to the increased paperwork required of health care providers by both the federal and state government.
- Incentives for primary care physicians should be established thus encouraging individuals to practice in those specialties.
- User fees or taxes need to be imposed on all programs in order to eliminate those persons who live off the system yet do not contribute to the system.
- Hospitals need to operate in more of an unregulated environment and must be able to recoup their financial investments made for equipment and services.
- Regulations mandating that physicians visit nursing home patients every 60 days, regardless of the need to be seen, create an unneccessary financial burden on the patient.
- Nursing shortage can be addressed by recruiting nurses from overseas.
- The state should institutionalize associate degree nursing programs at the VTI's throughout the state.
- The assumption that the current system of hospital revenue regulation guarantees solvency for effective hospitals must be questioned.
- Maine Health Care Finance Commission regulations fail to recognize the added cost of providing more services to a growing community
- Spending should be shifted from remedial programs to preventive programs.

March 18, 1988

Cathance Lake
Cooper, ME 04638

Annika Lane, Legislative Analyst
Office of Policy & Legal Analysis
Room 101/107 State House Station 13
Augusta, ME 04333

Dear Ms. Lane:

I only received your questionnaire today - the day it is due. Therefore, I am completing it in a rather hurried manner and as an individual rather than in my professional role as there is no time for my standard feedback/review loop.

I believe I've covered most of the major areas of need that I'm aware of. I am certain that others could provide additional data, if they were asked.

I would be interested in knowing how the commission solicited input, both on this survey and in general, from people in the northern five counties of the state. If there are additional avenues for participation, I would like to be informed.

I am enclosing F.Y. I some materials on the Katahdin A.H.E.C., which I was actively involved in developing as a partial response to health manpower education, recruitment and retention problems in northeastern Maine.

Please feel free to call me if I can provide more information or otherwise assist you.

Sincerely,

Bo Yerxa

Bo Yerxa

Enclosures

New England Rehabilitation
Hospital of Portland

13 Charles Street Portland, Maine 04102 (207) 775-4000
The Edward LeRoux Group, Inc. Medical Division

March 21, 1988

Ms. Annika Lane
Legislative Analyst
Office of Policy and Legal Analysis
Room 101/107
State House Station 13
Augusta, Maine 04333

Dear Ms. Lane:

Last week I sent you a letter in response to the Blue Ribbon Commission on Health Care Expenditures request for comment. I would like to submit to you the enclosed article as substantiation for some of the points that I made regarding the shortage of Occupational and Physical Therapists in Maine and the salary escalation.

Thank you for your help.

Cordially,

Gregg Stanley
Executive Vice President/C.E.O.

GS:mfh

Enclosure

Money Matters

Recruiters Fight to Fill Vacancies

By Vern Enge

Shortages of health care workers are spiraling salaries dizzily upward throughout the Northeast Region and radically changing recruiting practices as facility after facility finds itself engaged in rugged competition to attract and retain staff members.

Increasingly the shortages are affecting fragile budgets as personnel directors are opening their checkbooks to outbid the competition from across town, from out of state, and from nearby communities.

Some states, already in crisis situations, are mounting all-out attacks to stave off disaster, even as hard-pressed institutions take their labor shortages public, gaining plenty of attention in the media.

Facilities with scant cash reserves are finding their backs against the wall in the bidding wars where money spells the difference between curtailing or expanding services.

There are always those willing to risk an expansion project and enter the fray. Taunton State Hospital, Taunton, MA, is one such facility. Currently their occupational therapy department is comprised of three COTAs. They are looking for eight OTRs and three additional COTAs and are offering salaries ranging from $26,415 to $39,666 for OTRs; and of $16,300 to $20,472 for COTAs.

Meanwhile, VTA of New York City and surrounding boroughs is offering $65,000 to $75,000 annually with parttime OTs earning $50 an hour.

Philadelphia is also in the bidding wars. Pennsylvania Hospital has postponed $3.5 million in capital improvements to fund a 25 percent increase for some salaries. RNs in the hospital earn a maximum of $45,406 currently and expect a huge pay boost in the months ahead.

Despite their efforts, Philadelphia hospital recruiters expect to lose staff to private agencies who are willing to pay even more.

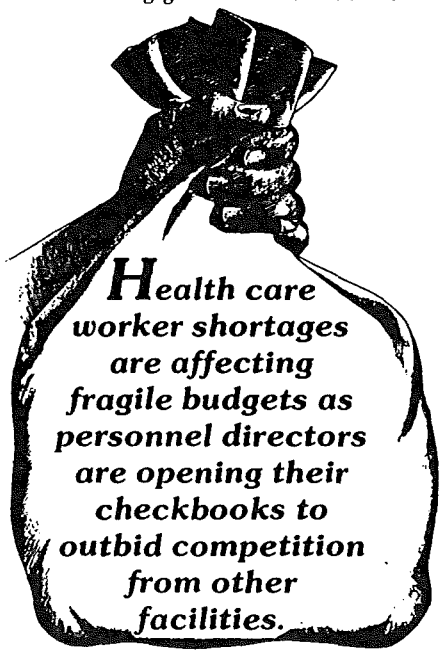
Because of the fierce competition, some have bowed out of the race entirely. In Maryland and West Virginia. For example, two medical centers have abandoned, at least temporarily, their plans to hire occupational therapists to fill vacancies after intensive recruitment campaigns failed to elicit applicants.

In New York, medical facilities are increasingly shifting emphasis in their recruitment campaign strategies, attempting to lure experienced professionals from competing health care staffs by offering higher salaries, sign-on incentives, and in some instances affordable housing for workers willing to relocate. The hiring competition for medical staff personnel is so intense in the state that private hospitals are being drained of their best talent, according to a Syracuse, NY, newspaper.

In New Jersey, the state's only four year OT college program has gone on the offensive, attempting to keep its limited number of students in the state by discouraging out-of-state affiliations, despite the fact that shortages of OTs are drying up available affiliation sites.

Recruiters leave no stone unturned in their quest to fill vacancies. In Maryland, many COTA and OT baccalaureate degree college students approach graduation day with firm job offers, even before they have completed their affiliations.

Up and down the East Coast, innovative recruiting gimmicks flow from creative personnel offices. AtlantiCare Medical Center, Lynn, MA, is offering a $1,000 recruitment bonus. The New York Hospital-Cornell Medical Center is including in its employee benefits package attractive, affordable housing, and BOCES of Rockland County, NY, offers a 10-month work year. And salaries countinue to gain strength.



On the downside, however, the morale is reaching an all-time low among workers who watch their ranks thin and their caseloads fatten while coworkers move to more lucrative jobs.

There can be a turn-around in a facility fast. Workers in place one day can be gone tomorrow, lured elsewhere by higher salaries. And the higher salaries often result in budget cuts for other expenditures in the department. "We can't even get a locked cabinet in our area," lamented one OTR.

Rural areas in general and the entire Northeast Region in particular have been particularly hard hit but the dwindling numbers of allied health professionals, according to V. Blandon Melton, director of the American Society for Healthcare Human Resources Administration.

He feels the shortage of rehabilitation professionals is far greater than the shortage of nurses.

The demand for services is only going to intensify as a result of the passage of Public Law 94-142 which encourages "mainstreaming" of disabled children into educational programs in the public school system. There will be increased opportunities for health care workers in a far expanded network.

New York, already facing major shortages in health care workers, including nurses, occupational therapists, pharmacists and lab technicians, is bracing for even more shortages in the near future.

Edward Salsberg,director of the New York State Health Department's Bureau of Health Resources Development, said recently the situation is only going to get worse.

To better prepare for current and future health needs of the state, the NY Health Department assembled a Task Force on Health Personnel in April 1987 and expects to release the final draft of its report this April. That report is expected to contain the following broad recommendations:

- Working conditions and job compensation need to be improved;
- There needs to be greater emphasis on retaining existing workers;
- Career ladders and career mobility need to be encouraged;
- More creative use must be made of available workers;
- Immediate steps need to be taken to strengthen health career recruitment;
- There needs to be improved interaction between health planners and educational facilities so manpower needs can be met more easily.

According to the task force report, nurses comprise the biggest shortage in New York and the therapy groups are second on the list. The figures are based on a recent survey distributed to over 1,000 medical facilities in the state - a survey which drew a response rate of nearly 43 percent.

While the task force report addresses the entire health care industry, there are components addressing occupational therapy specifically. According to a task force survey, occupational therapy has the highest percentage rate of vacancies among allied health care professions.

(Cont'd on page 14)

Related Problems Trouble CP Patients

(Cont'd from page 13)

deformities and/or to support body weight in ambulatory patients. Most of the braces used are AFO's. In the upper extremity, braces most commonly used are the wrist cock-up and the opponens splint.

In addition, Matheny rehabilitation engineers fashion adaptive devices, ranging from simple modifications with no moving parts to highly sophisticated electronically activated switches. Among the devices are individually designed wheelchairs and seating systems and laser-directed communication equipment. Speech and OT departments work together to create alternative communication systems for the non-verbal.

Medical treatment of spasticity is important to the management of the CP child, according to Dr. Ursua. Valium appears to be the most helpful medication in alleviating some aspects of severe hypertonus, but it sometimes has a sedative effect. Other medications have hepatotoxic effects when used over an extended period.

Alcohol nerve blocks to selected areas such as thigh adductors or the gastrocnemius are effective for 4 to 6 months and may be used to evaluate the feasibility of surgery. An unpleasant side-effect may be parathesias. This technique can be used to forestall surgery which is usually not done before the age of 5 or 6 years, except for subluxations.

The most common procedures are adductor tenotomy and hamstring releases, and Achilles tendon lengthening. Surgery is generally more successful in spasticity than athetosis.

Strabismus should be attended to early, according to Dr. Ursua, and yearly eye exams are imperative if this condition exists. Surgery or remedial optometric exercises may be prescribed.

Orthopedic and urological follow-ups should be done as needed. If seizures occur, medication is prescribed and regular follow-up exams scheduled.

In addition to the individual patient's needs, it is vital to address the additional stresses put on the family, according to Dr. Ursua. These family needs might be met through parent support groups and individual counseling.

The "Cause and Effect" series will continue with an additional session on cerebral palsy in April; a conference on Lesch-Nyhan Disease on May 2; and a conference on spina bifida on June 6. All sessions will be held at Matheny School from 9 to 11 a.m. Cost per date is $25.

Ruth W. Krinsky, OTR, who holds degrees in occupational therapy and journalism, is disability retired from OT and does freelance writing. Her book reviews often appear in ADVANCE.

Book Review

(Cont'd from page 12)

good management skills. His examples perhaps could be used as models for program development.

This well-referenced book is not a "cookbook" problem solver. It is an organization and administrative textbook geared toward administrators in human service agencies, a resource book administrators may want to have in their libraries.

The extensive charts, legislation and resource bibliographies very well may be useful for those working with the developmentally disabled adult.

The main emphasis of good programming cannot be understated. At the present time services for the developmentally disabled are growing by leaps and bounds. Obviously, using strong administrative principles can only facilitate agency growth and development. Program growth means client growth, and that's the bottom line!

•

Martha L. Boyle, OTR, is a consulting occupational therapist to the Niagara County Association for Retarded Children Day Treatment Program and Intermediate Care facility in Niagara Falls, New York.

Services for Developmentally Disabled Adults is available from Pro-Ed, 5341 Industrial Oaks Blvd., Austin, TX 78735.

Worker Crunch Curbs Some Expansion Plans

(Cont'd from page 7)

That figure is currently at 18 percent in hospital settings and 12.7 percent in nursing homes.

"The percentages are significantly higher than other therapy categories," said Vida Behn, assistant director of the health department's Bureau of Health Resources Development.

There is a lower vacancy rate among COTAs. Those include a 10 percent rate in hospitals and 8 percent in nursing homes.

By comparison, the vacancy rate for physical therapy is 15 percent and for technicians the rate is 6 percent.

According to the New York Department of Labor, there were 3,043 occupational therapists licensed in the state in 1986, and 2,181 show up on employment tallies. Those figures, however, do not take into account OTs who may be self-employed or are employed by groups or agencies that do not file reports with the department.

Nor are the OT ranks swelling with graduates. Some 148 OTs graduated from New York's four-year programs in 1986 (a decrease from 177 in 1980), and an additional 75 completed graduate and post-graduate programs in 1986 (an increase from 51 in 1980).

The shortage of workers has arrived simultaneously with an increased demand for medical personnel. Ms. Behn said "The Baby Boom is over," and there are fewer recruits available for every field, not just those medically related.

The worker crunch is also putting expansion plans on hold. Beds in some facilities are not currently being used because there is not adequate staff to provide services.

The situation, according to Ms. Behn, is "a major concern of the Department." "A lot of attention and time is going into it," she added.

The NY Health Department is still working on additional statistics to augment its report. Ongoing questions include impact on the medical field of those who are reaching retirement age, the impact on the field of those who may be gravitating to out-of-state positions, and the impact of changes from traditional to non-traditional service settings.

Additional information is expected to be added to the task force report after findings are discussed at a series of public meetings tentatively slated to be held in Albany, Buffalo and Syracuse in late spring and early summer.

With a shortage of medical staff in all fields, some hospitals are investigating the possibility of operating their own educational programs.

Some are already in the education business, says Ms. Behn, and they have the expertise to expand their operations in programs coordinated by the state education department.

Others seeking to duplicate the educational process will find the going a little tougher, especially if they are starting from scratch and are unfamiliar with educational requirements and lack the expertise of operating their own programs.

New England Rehabilitation
Hospital of Portland

13 Charles Street Portland, Maine 04102 (207) 775-4000
The Edward LeRoux Group, Inc. Medical Division

March 15, 1988

Ms. Annika Lane
Legislative Analyst
Office of Policy and Legal Analysis
Room 101/107
State House Station 13
Augusta, Maine 04333

Dear Ms. Lane:

I am writing in response to your letter of February 19th regarding the questionaire distributed for the Blue Ribbon Commission on Health Care Expenditures. The New England Rehabilitation Hospital of Portland, the State's only free standing rehabilitation hospital, acknowledges and endorses the Maine Hospital Associations response to your request for information. In addition, we would like to offer the following observations:

1. We believe the severity of the nursing shortage will only increase. We have taken creative steps to deal with the shortage as best we can but in most instances I believe these steps lead to increased costs and an increasing fragmentation of the delivery of care. In the last few months we have implemented a policy of two twelve hour shifts on the weekends for forty hours pay. This is in hopes of being able to attract a full time weekend nursing work force that will then allow us to attract a coterie of nurses who only have to work a Monday through Friday shift.

In addition we have added new levels of staff to our nursing department. We now employ Unit Helpers in addition to returning to an increased reliance on Nursing Assistants and Licensed Practical Nurses. This is fragmented care.

We are extremely concerned about the shortage of nurses and despite our efforts the supply is such that we cannot meet our needs. We are alarmed at the rates of pay that non-regulated companies and industries are offering for nurses. We have lost staff nurses to Blue Cross/Blue Shield, UNUM Insurance Company and L. L. Bean. In each case they earn the same or more than they did here and they work a Monday through Friday schedule with all holidays and weekends off. How can we compete?

We would like, at this time, to bring up another potential problem. The scheduled implementation of an all BSN work force in the state of Maine in 1995. This is an extreme concern to us because we believe it would lead to an increase in the shortage of nurses. We are also concerned that recent studies show that the average person who is attracted to nursing is also a person who is not attracted to a four year college education. This comes at a time where we

have dismantled our diploma schools and have done nothing to increase the associate degree programs. If something is not done to increase the availability of programs and make it easier for people to receive the training that they need I fear that we will hit a crisis of proportions never before seen in this country.

2. As a rehabilitation hospital we have an extreme need for Occupational and Physical Therapists. We employ approximately twenty of each professional which is a level often found only in large teaching hospitals. We have to compete nation wide for these people. If you would please take the time to find copies of the publications OT Forum and PT Forum you will find graphic evidence of the depth of the problem. The average starting salary is $30,000 and above for these individuals. Relocation expenses, huge bonuses etc. are all being paid to recruit these professionals. We currently pay approximately 70% of the average starting salary throughout the country.

Since we opened in December of 1986 we have twice had to limit admissions due to a lack of therapists. We have had to curtail our out-patient level of service to one third the original estimated demand because of a lack of therapists even though our originally predicted demand was there and more.

We can all argue about the reasons for the increased cost of health care but I would argue that the country and particularly the state of Maine has received a bargain for many years due to the artifically depressed salaries of an industry that is 83% female. If we expect these people to work in an environment where they are exposed to life threatening diseases such as Aids on a daily basis and must make split second decisions affecting the care of seriously ill patients I fear that this country is going to have to accept the fact that the cost of health care will continue to rise dramatically out of an absolute necessity to do so. We are a labor intensive industry and until someone can invent machines to do what indivduals do on a daily basis we are going to have to attract more and different kinds of people into health care careers. If the International Paper workers in Jay, Maine can average $30,000 a year what is so outrageous about a staff nurse with a four year college degree earning more than $19,000, which is our staring rate of pay now.

I was born and raised in the state of Maine but I spent five years as a Vice President of an acute care hospital in western New Hampshire. I was always embarassed at that time about how easy it was for us to recruit out of the University of Southern Maine School of Nursing and Westbrook College School of Nursing. That was approximately five years ago and at that time New Hampshire started all nurses at three weeks vacation annually whereas Maine hospitals started them at two weeks annually. In addition, the rate of pay was $1.00 to $2.00 an hour higher than southern Maine hospitals were paying their nurses and New Hampshire had no income tax which meant that take home pay for New Hampshire nurses was approximately 20 to 25% higher than their Maine counterparts. I think a review of where nurses who are trained in Maine end up working would give us a better understanding of what region Maine hospitals compete in for nurses.

4. Question 4 asked about the unavailability of health care services in the area. We have noticed three extremely critical shortages of services. One is the complete lack of any alternative for the long term care of brain injured patients. As a rehabilitation hospital they are a large group of our admissions each year. Many of the patients, although they make great strides in a rehabilitation program, will never be able to live in a nonsupervised environment. When we opened the hospital in Maine we had patients who were here almost a year due to a lack of availability of long term residences for these people. It has lessened only slightly with Medicaid's agreement, at our insistance, that they recognize for payment the Nu-Medico system for long term care of head injury patients. They are not based in the state of Maine but are based in both New Hampshire and Massachusetts. There was great reluctance to approve an out of state provider but there was no viable alternative. Many of these patients need to spend the rest of their lives provided with the type of care normally associated with mental patients or the severly retarded yet they have different needs as well. The availability of that kind of care in the state of Maine is wanting greating.

The second area where we find a great shortage of health care services is home health care. In more than a few instances since we have opened we have discharged a patient home with services to be provided by a local home health agency. In far too many cases that patient has been readmitted to this facility because, despite the best efforts of the home health agency, they were not able to deliver the services in the frequency prescribed.

The third area of extreme shortage is the access to nursing home care. If a patient is private pay at a nursing home than placement is not difficult. If a patient is a Medicare recipient than it averages two-three months in a hospital bed in order to place that patient in an ICF nursing home bed. If they are Medicaid it is virtually impossible to find an intermediate care bed for these patients. I am only an 80 bed hospital but I currently have twelve patients out of a census of 55 who are Medicaid awaiting placement at an ICF facility.

I believe, at least in southern Maine, that the continuation of the current regulatory system will create a two tiered health care system for the people of Maine. If technologies and services are not available in this state as they are in neighboring states then those with financial resources will simply seek out that care in those neighboring states. Those without financial resources to do so will simply go with out. I suggest that we look at the level of dollars flowing out of the state of Maine to seek healthcare in other states.

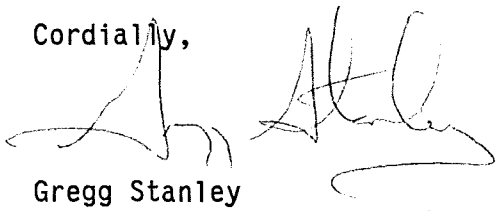
It is becoming increasingly frustrating to be a hospital administrator in the State of Maine. I know of administrators who have left the state primarily because of the regulatory environment and the extreme frustration it causes all of us who are merely trying to satisfy public demand. I do not believe,and would vehemently argue with anyone, that this is an industry that creates demand. The public creates the demand.

It is frustrating when a catastrophic health insurance pool is proposed that is sorely needed but the funding comes mainly from a tax on hospital patients. This merely adds to the cost of hospital care and when somebody looks back on hospital's rates of inflation they will quickly forget that legislatatively mandated programs added to the problem.

A regulatory process is a political process. As such, the pressure is there to guarantee the public what it wants. It is the acceptance of the cost of what it wants that is the problem. Medicare has time and time again reduced its budget at the insistance of the United States Congress but those same elected representatives have been unwilling to curtail benefits. They are unwilling to tell a large voter popluation that this country cannot afford to pay for the level of care that is being demanded. They expect the health care industry to find wasy to do more with less year after year. It cannot continue.

I would simply hope that this process will look at the total health delivery system and not just hospitals. I wish to thank the Blue Ribbon Commission for this opportunity for input. These are indeed trying times for hospitals. Thank you again.

Cordially,



Gregg Stanley
Executive Vice President/C.E.O

GS:mfh

cc: James Castle, President
Maine Hospital Association

AMERICAN LUNG ASSOCIATION
of Maine

formerly called Maine Lung Association

The Christmas Seal People®

March 16, 1988

Senator Paul N. Gauvreau
Maine State Senate
State House
Augusta, ME 04333

Dear Senator Gauvreau:

The American Lung Association of Maine is pleased to respond to your request for comments on the topics being addressed by the Blue Ribbon Commission on Health Care Expenditures. Since we are a statewide agency, our comments will not address some of the local issues identified in your questionnaire. It is obvious to us that there are still plenty of people either without insurance or with such limited coverage that they are suffering physically, emotionally and financially. Although major changes in availability of primary care have been achieved through such developments as rural health centers, there are many who still have difficulty obtaining or paying for care. I am sure you will hear ample testimony that these problems still exist.

My comments will be confined to one area, preventive services. Under this title, I would include both primary prevention, those services designed to help people avoid illness and secondary prevention, early detection where potential serious problems can be identified and addressed. The system for delivering these types of services in Maine is a non-system. It consists of a wide array of public and private groups and organizations who offer various services. In some cases, quality and availability are major problems.

I am starting with the assumption that a fundamental component in the health policy of the state of Maine is prevention. We have done a fine job of bringing the best that high technology medicine has to offer to nearly every region of the state. Obviously there is still room for improvement. As an example, coronary care units with trained staff and operational budgets exist throughout Maine. These services are both expected by the community and reimbursed without question. In fact, some of these services were in place in many locations before definitive study on their effectiveness was widely accepted. This has clearly not been the case for preventive services.

More than ample documentation exists through large scientific studies to demonstrate the public health effectiveness of reducing known risk factors for disease. Environmental as well as personal risk factors account for nearly 75% of the cause of illness.

128 SEWALL STREET, AUGUSTA ME 04330
(207) 622-6394 1-800-462-LUNG

Yet we spend an embarrassingly small amount of our total health care dollars in this area. Preventive services are often held to a much higher standard of effectiveness than such commonly reimbursed services as surgery. Recently, many hospitals have responded to the financial situation by reducing the amount of money and staff they put into prevention. With a few notable exceptions, aggressive expansion in this area has been absent. Many hospitals complain that the "revenue cap" of the Health Care Finance Commission has created a disincentive to get involved in these types of efforts. I am sure you will be investigating this charge as you proceed with your work.

Upon examination of the proposed expenditures under the Certificate of Need Development Account, it appears that there is a more fundamental issue than the revenue cap. Nearly all of the money is proposed for either building projects, "high-tech" medical care or psychiatric services. Without discrediting any of these worthy needs, why are prevention services not on the list?

We are asking the Blue Ribbon Commission on Health Care Expenditures to develop incentives for spending a portion of the money in the Certificate of Need Development Account on preventive services. Eastern Maine Medical Center's Heart Disease Prevention Program may provide a model on which to build. If as state policy, we wish to limit hospitals to simply providing medical care, then we need to determine how we will pay for cost-effective measures to prevent disease from occurring. The Blue Ribbon Commission has an excellent opportunity to clarify the prevention mission in hospitals in Maine. Public health departments do not generally exist on the town and county level. Even those that exist are sorely under funded.

Can a mechanism be created through the certificate of need process or in some other manner to invest in prevention? Our current health policy portfolio is loaded with investments in the treatment of disease. If we fail to diversify into prevention, we may all go bankrupt.

Thank you for the opportunity to comment. I would be happy to address the Commission at any time.

Sincerely,

Edward F. Miller
Executive Director

cc: Annika Lane

EFM/sag

Blue Cross
Blue Shield
of Maine

Wayne R. Webster
Vice President
Finance

110 Free Street
Portland, Maine 04101
207/775-3536

MEMORANDUM

TO: Members of Blue Ribbon Commission
on Health Care Expenditures

FROM: Wayne Webster

DATE: March 31, 1988

SUBJECT: BLUE CROSS AND BLUE SHIELD OF MAINE
PAYMENTS FOR MANDATED BENEFITS

At our February 24, 1988 meeting you asked David Crowley to provide a breakdown of Blue Cross and Blue Shield of Maine's payments to providers for mandated Mental Health and Substance Abuse benefits. The attached spreadsheet details what we have paid for these mandated benefits plus mandated Chiropractic claims.

Inpatient Mental Health claims payments were made to hospitals. Outpatient Mental Health claims payments were made to free-standing mental health centers and individual practitioners. Inpatient Alcohol and Drug Abuse claims payments were made to hospitals and free-standing alcohol rehabilitation facilities. Outpatient Alcohol and Drug Abuse claims payments were made to individual practitioners. Claims payments for Day Treatment were made to hospitals and free-standing substance abuse facilities with residential and non-residential treatment.

WW:mm

Attachment

DETAILS OF INCREASED PAID CLAIMS
FOR MANDATED BENEFITS
BLUE CROSS BLUE SHIELD OF MAINE
CALENDAR YEARS ENDING DECEMBER 31,

					Percent Change From Previous Year		
	1987	1986	1985	1984	1987	1986	1985
MENTAL HEALTH CLAIMS:							
Inpatient	$ 3,447,461	$2,673,643	$1,980,734	$341,367	+28.9%	+34.9%	+480.2%
Outpatient	2,722,038	2,492,034	1,416,313	13,514	+ 9.2%	+75.9%	+10,380.3%
Day Treatment	4,666	6,414	3,944	-0-	-27.3%	+62.6%	--
Total mental health claims	6,174,165	5,172,091	3,400,991	354,881	+19.4%	+52.1%	+858.3%
ALCOHOLISM AND DRUG DEPENDENCY CLAIMS:							
Inpatient	3,135,629	3,305,564	2,274,396	474,799	- 5.1%	+45.3%	+379.0%
Outpatient	286,640	267,402	135,607	3,992	+ 7.2%	+97.2%	+3,296.9%
Day Treatment	3,690	4,538	1,910	-0-	-18.7%	+137.6%	--
Total alcoholism and drug dependency claims	3,425,959	3,577,504	2,411,913	478,791	- 4.2%	+48.3%	+403.8%
Chiropractic Claims	647,749	254,424	-0-	-0-	+154.6%	--	--
TOTAL	$10,247,873	$9,004,019	$5,812,904	$833,672	+13.8%	+54.9%	+597.3%