Commission to Study Maine's Hospitals
Report to the Legislature

February 2005

Report of the Commission to Study Maine's Hospitals

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Executive Summary

The Commission to Study Maine's Hospitals, created by the Dirigo Health Reform Act, initiated its work in November 2003. The Commission includes representatives from hospitals, physicians, the insurance industry, employers, consumers, an economist, and a nurse with expertise in public health issues.

The Commission heard testimony from nearly 50 expert witnesses and met more than 30 times during the year. In addition, a number of subcommittees were convened, the Chair visited 25 of Maine's 39 community hospitals, and a major study was conducted by Dr. Nancy Kane of the Harvard School of Public Health regarding hospital finances. The Commission held a full day retreat to focus its work and establish an agenda based on the requirements included in the Dirigo statute. The Commission explicitly elected not to study psychiatric hospitals as issues related to them were beyond the scope of the Commission's capacity.

The report was finalized after the Commission held public hearings January 6th and 7th in Portland, Augusta, and Bangor. Over 160 people attended the hearings, and the Commission received oral or written testimony from 50 people, 28 representing hospitals and 22 representing themselves or other organizations

It is important to put the work of the Commission in perspective as part of the broader Dirigo Health reform initiative. That law recognized that Maine has a health care cost crisis that is driven by many different factors such as high rates of utilization, supply and distribution of health care services, cost shifting, insurance costs, high rates of uninsured who cause bad debt and charity care and high rates of chronic illness. The Hospital Study Commission was charged to look at one aspect of the health system; the broader reform addresses the other drivers of health care costs.

Specifically, utilization is being addressed by the State Health Plan and its effort to make Maine the healthiest state in the nation; the Maine Quality Forum is designed to help assure best practices are used in all health care delivery; the Fund for Healthy Maine is protected to continue to invest in health and wellness and the Chronic care initiative is designed to improve management of chronic illness among Mainers. In addition, the law calls for studies of rates paid by MaineCare and of medical malpractice costs. Dirigo health reform also strengthens the certificate of need program, establishes new rate regulation in the small group insurance market and requires additional disclosure and reporting by Maine's health insurers. Finally, the law established the Study Commission, as part of the comprehensive strategy of reform, to look exclusively and in depth at hospital issues only, as a critical piece of the entire reform agenda.

This draft report has been developed by a Commission unanimous in its respect for the contributions physicians, nurses and other health professionals make each day and the tremendous results normally achieved by Maine's hospitals.

Maine's hospitals are a $2.7 billion annual industry in Maine providing just under one-in-twenty of the jobs in Maine -- roughly 26,300 jobs in 2003. The network includes 6 teaching hospitals, 3 tertiary care centers, 10 critical access hospitals, 9 sole community hospitals and 2 psychiatric hospitals, all of which are non-profit. There are 3,600 acute care beds licensed in the State, approximately 70% of which are staffed. About three-quarters of Maine's hospitals are affiliated with one of the State's major hospital systems.

The Commission concluded that health care spending must be addressed in Maine. From 1996-2002 the cost of a family policy for Maine businesses and employees increased by 77% while median household incomes increased by only 6%. Health care spending, as a percentage of personal income, ranks Maine the 6th highest in the nation. This high rate of spending has a chilling effect on economic growth: as businesses pay higher health insurance premiums, they are less likely to hire new workers.

The Study Commission's statutory charge, as noted above, was to focus on hospitals, while other initiatives of the reform law addressed other aspects and cost drivers in Maine's health system. Hospital spending accounts from slightly more than one-third of all health care spending, so slowing the rate of growth in hospital spending can play a significant role in slowing the rate of growth in health care spending. While there are ongoing debates about data, the Commission concluded based on an independent and objective analysis that Maine's per hospital-visit costs are high by northeastern and national standards even when adjusted for variations in wages and the age of our population. The Maine Hospital Association (MHA) submitted data which contradict these observations. In the final analysis, the Commission used objective data produced by Dr. Kane and the data reported in the State Health Plan . The reader may wish to review Appendix 1 to understand the issues surrounding different data measures. The Commission appreciates the difference of opinion about data and calls for reporting that will help address some of the discrepancies. In the final analysis, the Commission is convinced that, regardless of which data one uses, there is room for increased efficiency in Maine's hospitals and this report is presented in that spirit, and none of the recommendations in this report would change if the MHA's numbers had been utilized.

The Commission also found that there is considerable variation in health care provided and in the financial health of Maine's hospitals statewide. The Maine Health Information Center in May 2004 showed wide variation in payments for the same services made to 36 different hospitals by members of the Maine Health Management Coalition even after taking into consideration differences due to patient mix. Dr. Kane's study showed significant variation in the financial health of Maine's hospitals.

While the Commission concluded that cost-shifting -- payment at rates lower than costs by Medicare and Medicaid offset by higher charges to other payors -- was a factor influencing the pricing of hospital care in Maine, the Commission also found that hospital costs (how efficient hospitals are at providing services) and profitability were important factors. The profit margins of two-thirds of Maine's hospitals are significantly higher than national and

northeast region medians for hospitals. The Centers for Medicare and Medicaid Services informed the Commission that in 2003 Medicare reimbursed Maine hospitals for 92% of inpatient expenses, but the recent Medicare Modernization Act (MMA) is closing that gap. As a result of the MMA, most Maine hospitals' inpatient payments from Medicare will be 6% higher in 2005 than in 2004. While the Commission urges that Maine's Congressional delegation works to secure yet better reimbursement from Medicare for Maine hospitals, the Commission also concluded that lowering hospital costs – i.e., what hospitals spend to provide services – could also play a significant role in reducing cost-shifting.

Hospitals can and must improve their performance as is noted frequently in this report, but high hospital costs in Maine are driven by many factors, including major influences over which hospitals have little control in the short run. For example, Mainers are older, sicker and consume more health care services than people in most other states. These realities drive utilization and costs higher and higher each year. A significant ripple effect is that state Medicaid payments to hospitals have fallen short of the state's obligations for at least ten years due to increasing utilization rates.

To address this problem requires an upward adjustment in the prospective interim payments made by MaineCare to hospitals. In addition, the state must budget to pay for growing volume that occurred since 2002 when MaineCare enrollment was expanded and the latest change to MaineCare's hospital reimbursement policy was instituted.

While this report identifies many areas the Commission believes deserve attention and improvement, we also recognize that Maine is a challenging state in which to provide health care. Our hospitals have made considerable progress in this difficult environment over the years, for which they deserve credit. However, many more improvements are needed and the full cooperation of hospitals, government and others will be required as we attempt to move toward a better situation in the future.

Key Recommendations

1. Create the Consortium for Hospital Collaboration, a strategic alliance led by hospitals with representation from State government, to improve healthcare quality and overall efficiency for all hospitals. This voluntary network would be open to all Maine hospitals and would encourage statewide standardization of clinical protocols utilizing best practices, administrative streamlining, bulk procurements, the sharing of expertise and many other cooperative ventures. The Consortium's role should be limited to brainstorming, discussing and planning collaborative activities. Implementation of any plan may be accomplished by others after state approval through the Hospital Cooperative Act process.
2. Amend the Hospital Cooperation Act to provide for a more rapid review and to facilitate more hospital cooperation and collaboration by reducing concerns relative to anti-trust ramifications.
3. Encourage the Governor's Office of Health Policy and Finance to: (a) assure that state licensing and regulatory agencies give priority to projects generated through the

Consortium, and (b) seek funds to provide financial incentives to encourage hospital collaboration.

4. Support statewide implementation of electronic medical records with active involvement of the Maine Quality Forum and facilitate timely implementation through a significant level of state bonding to cover start-up costs, as well as modest increases in Medicaid for up to 12 months for physicians who request such consideration during transition to EMR. The objective being to implement an interconnected statewide system which should have a profound positive effect on improved quality and lower costs in the long run.

5. Revise to Bureau of Insurance Rule 850 to make it easier for insurance carriers to offer incentives for patients to use providers who have been shown to provide better quality services, even if the provider is outside Rule 850's traditional travel/distance limits. Importantly, the proposed revisions protect the consumer's right to choose whether to travel further for better quality services. Draft language is provided as an attachment.

6. Urge Maine's Congressional delegation to press for increased Medicare payments and to maintain the Medicaid program's current funding mechanism. MaineCare financing was also addressed with recognition that the State's budget would have great difficulty accommodating increases at this time. However, the State is urged to increase Medicaid payments to physicians as soon as possible and to hospitals over the next few years to cover their costs.

7. Urge Maine's Legislature to budget to pay past obligations to hospitals in a timely manner and revise future Periodic Interim Payment (PIP) estimates to include realistic forecasts of Medicaid utilization increases.

8. Hospitals and hospital systems in Maine should publish for public dissemination the total compensation received by the 5 most highly compensated executives each year beginning in 2005.

9. Hospital boards and administrators not already doing so should develop and implement strategic plans targeting annual implementation of efficiency improvements including phased cost goals and long term objectives to slow or reverse cost growth.

10. Hospitals should continue to meet voluntary profit margin and cost increase targets, with several essential refinements to the targets that had been included in the Dirigo Act. The refinements are designed to bring additional precision to the way hospitals report their performance against the targets, and to bring greater transparency to the public regarding hospital performance. The purpose of these targets is to balance the need to reduce consumers' costs with the need to ensure that Maine's hospitals generate margins adequate to maintain their financial health.

11. The Commission makes no specific recommendations relative to hospital closings or mergers but urges every hospital board to evaluate possible opportunities to minimize duplication and maximize collaboration through the Consortium noted above. The Commission also urges hospital boards to examine the Critical Access program to determine if some additional hospitals should convert from fully licensed comprehensive hospitals to Critical Access hospitals.

12. Require Maine's hospitals to submit to the Maine Health Data Organization standardized financial information annually in an electronic format enclosed as an

Appendix to this report. Information should be reported for individual hospitals to assure hospital to hospital comparisons are possible. This information should be made available to the public.

13. The Maine Hospital Association should develop a standardized definition of administrative costs which hospitals can use when establishing budgets and reporting spending on administrative categories. Such standardization of administrative costs would assure transparency and better information for comparison purposes.

14. The Certificate of Need program should be strengthened by enhancing staff capacity. The Department of Health and Human Services should develop a plan to enhance the capacity of CON staff to conduct reviews, conduct follow-up on approved CONs, and improve the CON hearing process. The Commission recommends an increase in CON application fees, if necessary after recent increases, with those revenues directed exclusively to the CON process to help support the increased staff.

15. Because the majority of capital investments (around 80%) fall below current CON review thresholds and are therefore not subject to the planning and coordination the program is designed to ensure, the Commission recommends that hospitals and non-hospital providers be required to report to the Certificate of Need unit those projects whose costs are above one-half of the current review thresholds. Such reporting would provide information about the types of projects that are not currently reviewed and would help in establishing the Capital Investment Fund and the State Health Plan.

16. The capital expenditure spending limits established in the Capital Investment Fund governing the Certificate of Need should continue at least for the near term.

17. Hospitals should be a major player in wellness initiatives. The Legislature should levy a modest fee or tax on processed food items or beverages to finance initiatives to enhance wellness programs and support the MaineCare program.

18. The Commission was concerned about the role of insurance companies in the high premiums Mainers face, and the Commission notes that insurance carriers will be instrumental in passing hospital savings on to Maine consumers. The Commission therefore recommends that the legislature charge the BOI and/or create a commission similar to the Commission to Study Maine's Hospitals to analyze insurance company finances, pricing, plan design, reserves, profits, and overall role in driving or mitigating health care spending, in order to ensure that savings are passed on to Maine consumers

19. Medical malpractice was considered by the Commission. The Commission acknowledges that the Dirigo Act required the Bureau of Insurance to conduct a study of medical malpractice and report back to the Legislature this January. The Commission urges the Legislature's review of that study acknowledging the growing concerns about medical malpractice costs in Maine.

20. Finally, the Commission requests that the Governor's Office of Health Policy and Finance establish a plan wherein each recommendation of this report will be reviewed to determine success in implementing the Commission's recommendations.

The report is supported by 7 of the Commission's 9 members; the 2 members representing hospitals have submitted a minority report that is included with the report. The minority report notes that these two members support the majority of the Commission's recommendations.

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INTRODUCTION

The Commission was created as a part of the Dirigo Health Reform legislation , as part of a comprehensive approach to improve quality, access and cost of health care, The Commission began meeting in late 2003. Most Commission members have spent a lifetime in professions directly related to health care.

To gain new insights and broaden perspectives, the Commission heard testimony from nearly 50 expert witnesses, met on over 31 different occasions and held 3 public hearings. The Chairman, who began the process with substantially less health care experience than other Commission members, also visited 25 of Maine's 39 community hospitals during 2004.

The Commission was asked to study Maine's community hospitals focusing on quality, access and costs. This report reflects the Commission's findings and recommendations following its 13 month efforts. The Commission's nine bi-partisan members included representatives from hospitals, physicians, health care services, insurers and employers, as well as one economist familiar with health care costs, and a nurse with expertise in public health issues. The final report is being submitted to the Maine legislature for its consideration.

It is important to put the work of the Commission in perspective as part of the broader Dirigo Health reform initiative. That law recognized that Maine has a health care cost crisis that is driven by many different factors such as high rates of utilization, supply and distribution of health care services, cost shifting, insurance costs, high rates of uninsured who cause bad debt and charity care and high rates of chronic illness. The Hospital Study Commission was charged to look at one aspect of the health system; the broader reform addresses the other drivers of health care costs.

Specifically, utilization is being addressed by the State Health Plan and its effort to make Maine the healthiest state in the nation; the Maine Quality Forum is designed to help assure best practices are used in all health care delivery; the Fund for Healthy Maine is protected to continue to invest in health and wellness and the Chronic care initiative is designed to improve management of chronic illness among Mainers. In addition, the law calls for studies of rates paid by MaineCare and of medical malpractice costs. Dirigo health reform also strengthens the certificate of need program, establishes new rate regulation in the small group insurance market and requires additional disclosure and reporting by

Maine's health insurers. Finally, the law established the Study Commission, as part of the comprehensive strategy of reform, to look exclusively and in depth at hospital issues only, as a critical piece of the entire reform agenda.

The Commission, relying on independent and objective data, found that health care costs in Maine are high by northeastern and national standards. This report identifies important recommendations designed to help lower future costs, while improving quality and increasing access. The MHA submitted conflicting data which reflects much better performance by Maine hospitals. The reader may wish to review Appendix 1 to understand the issues surrounding different data measures. The Commission appreciates the difference of opinion about data but, in the final analysis, the Commission is convinced that, regardless of which data one uses, there is room for increased efficiency in Maine's hospitals and this report is presented in that spirit, and none of the recommendations in this report would change if the MHA's numbers had been utilized.

Maine's community hospital network is large and complex. In March 2004, its hospitals spanned the length and breadth of our state and employed 26,300[1] people, including 1,100 new hires in the previous year. The 39 community hospitals vary in capabilities from Maine Medical Center, which ranks among our nation's leaders in medical sophistication, technology and know-how, to small rural hospitals which provide essential primary care and emergency services for those living in outlying areas, with a large number of capable hospitals lying between the two extremes. The network includes six teaching hospitals, three tertiary care hospitals, ten critical access hospitals, nine sole community hospitals and two psychiatric hospitals. Some 3,600 acute care beds are licensed in the state, approximately 70% of which are staffed.[2]

Roughly three-quarters of Maine hospitals are affiliated with one of the state's major hospital systems. Most of the hospitals that are not directly aligned have at least some involvement with those systems. The Commission heard anecdotal but convincing evidence that participation in systems has resulted in savings to members, but could find little evidence that existing systems have yet brought down total growth in hospital spending.

The Commission recognized from the outset that it lacked the time and resources to acquire a perfect understanding of Maine hospitals, how they serve the people of our state

[1] Dana Evans, State Labor Economist, Department of Labor, presentation to CSMH, May 3, 2004.
[2] Maine Hospital Association.

and how their performance might be improved. Indeed, we learned during our first two meetings that experts in the field can analyze similar data and reach quite different conclusions. Subsequent testimony confirmed the seemingly inexhaustible supply of hospital facts and figures and analysts' abilities to interpret the information to support their positions. In the final analysis, much of the data utilized in this report is similar to that reported in the State Health Plan.

While it was unrealistic to expect the Commission to gain a perfect understanding and agreement on all details and data related to hospital performance, sufficient information was presented so that members gained a good working knowledge of overall trends and opportunities for improvements within the statewide hospital network. (See Appendix 2 for individuals who made presentations.) In fact, the Commission was supplied with an abundance of helpful information on a wide variety of subjects, even though some of the data reflected contradictory opinions.

This report has been developed by a Commission unanimous in its respect for the contributions doctors, nurses and other health professionals make to our society and the tremendous medical results normally achieved by Maine hospitals. The changes recommended here are intended to be constructive and not diminish the public perception that miracles seem to happen to our fellow citizens in Maine hospitals every day. We also recognize that Maine hospitals operate in a difficult environment, and that Maine citizens are older and suffering from more sickness than those of most other states. Here, the consumption of hospital services is high and utilization is likely to continue to grow.

Despite evidence of relatively good quality by Maine hospitals, our thinking was influenced by nationwide data, as reported by the Institute of Medicine, that America's hospital error rate is far in excess of acceptable standards.[3] It is reasonable to assume that Maine hospitals have not been immune from such problems. Indeed, a report issued to the Legislature earlier this year by Maine's Division of Licensing and Certification found that there were 15 reportable deaths and 3 wrong surgeries or surgery on the wrong body part in Maine hospitals in 2004.[4] Thus this report addresses that issue as it applies to our state and

[3] The Institute of Medicine's (IOM) 1999 report, "To Err is Human: Building A Safer Health System" estimated that nationally: as many as 98,000 people die in hospitals each year as a result of medical errors that could have been prevented; medical errors resulted in between $17 and $29 billion in extra medical spending in 1998 (over half of which were direct costs); and 2% of hospital admissions are due to medical errors

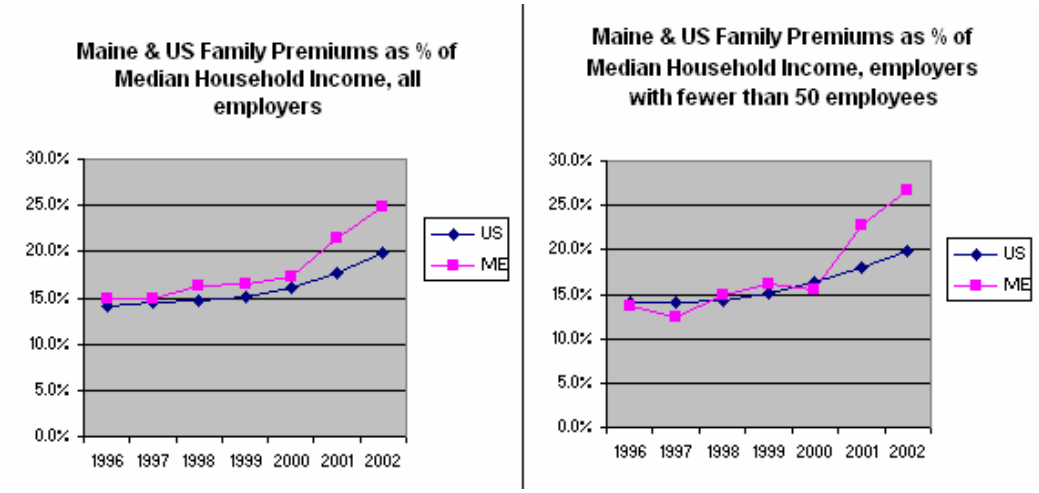
[4] Maine Department of Health and Human Services, Division of Licensing and Certification, *Sentinel Event Reporting, Annual Report to the State Legislature, CY 2004*. Enclosure C. January 2005.

suggests some important corrective action. To put this issue in perspective, a 2003 report issued by the Centers for Medicare and Medicaid Services ranked Maine hospitals third in the nation – just behind New Hampshire and Vermont – on 22 quality indicators for care provided to Medicare patients.

This report also focuses on cost related issues, because health care costs have increased at an alarming rate and have become a huge problem for governments (i.e., taxpayers), industry and individuals. The State Health Plan and other sources report:

- Total Maine health care spending is estimated to have increased from $5 billion or 15.5% of the Gross State Product (GSP) in 1998 to over $7 billion or nearly 18% of GSP in 2004.[5]
- From 1996 to 2002, the cost of a family health policy for Maine businesses or employees increased by 77%, while median household incomes increased by only 6% (figure 1) and, in 11 of the 13 years, from 1992 to 2004, health care spending growth exceeded personal income growth.[6]

Figure 1. Maine & US Family Premiums as % of Median Household Income



Maine businesses and their employees spend more on health premiums than their peers in other states. Between 1996 and 2002, the cost of a family policy for Maine businesses and employees increased by 77%, while median household income increased by only 6%; increases for small businesses have been even steeper.

[5] See, "Maine's State Health Plan," July 23, 2004 – available at www.dirigohealth.maine.gov – pages 20 and 49 for sources and methodology.
[6]" State Health Plan," pages 18 and 49.

- Maine has added more individuals to the Medicaid roles, but still has the highest rate of uninsured citizens in New England. About 189,000 or 17% of the non-elderly, spent part of 2002 uninsured. On any given day, roughly 1 in 8 non-elderly Mainers were uninsured.[7]
- Between 1991 and 1998 (the last year 50 states' estimates were available) Maine's per capita health care spending increased faster than all other states in the nation, averaging 7.3% per year.[8]
- Health care spending, as a percentage of personal income, ranks Maine the 6th highest in the nation.[9]
- Maine's health expenditures in 2004 are estimated to be $7.7 billion, of which hospital expenditures are estimated to be $2.7 billion.[10]
- In 2002, Maine hospitals' median cost per adjusted hospital inpatient discharge was the 6th highest of 39 reporting states in the nation. Maine's median cost of $6, 917 per discharge was 19% higher than the national average and 45% higher than the northeast region's average of $4,759 (figure 2 on the next page). [11]
- Maine's average age is the 2nd oldest in the United States.[12].

The Dirigo Health Reform law recognizing that there are many cost drivers in health care and addresses each through a wide variety of activities, The Hospital Commission is one of many diverse initiatives designed to focus on a part of the overall system – i.e., hospitals – while other activities enacted as part of Dirigo are addressing other, equally important drivers.

The primary focus of this report, therefore, is on the need for change within Maine's hospital network. We believe the report contains a series of recommendations which, if implemented, will have a positive impact on hospital quality, access, and costs going forward and will help control health care cost which has become unaffordable for far too many.

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[7] Muskie School of Public Service, University of Southern Maine. Data from household survey sponsored by Maine's HRSA planning grant. 2002.
[8] www.cms.hhs.gov/statistics/nhe/state-estimates-residence/us-per-capita10.asp.
[9] State Health Plan," page 17.
[10] State Health Plan," pages 20 and 49.
[11] *The 2004 Almanac of Hospital Financial & Operating Indicators*. Ingenix, Inc. 2003.
[12] US Census.

Figure 2. Median Cost Per Adjusted Inpatient Discharge, by State

Rank	State	CPAD		Rank	State	CPAD
1	Louisiana	$7,525		21	Oregon	$5,880
2	Kansas	$7,427		22	Kentucky	$5,832
3	South Carolina	$7,016		23	Utah	$5,798
4	New Jersey	$7,013		24	North Carolina	$5,763
5	California	$6,973		25	Connecticut	$5,760
6	**Maine**	**$6,917**		26	Florida	$5,748
7	Missouri	$6,871		27	West Virginia	$5,717
8	Colorado	$6,769		28	Virginia	$5,673
9	Montana	$6,762		29	Georgia	$5,651
10	Texas	$6,605		30	Washington	$5,583
11	Oklahoma	$6,572		31	Tennessee	$5,519
12	Nebraska	$6,466		32	Ohio	$5,505
13	Illinois	$6,445		33	New Hampshire	$5,483
14	Arkansas	$6,293		34	Michigan	$5,325
15	Indiana	$6,210		35	Rhode Island	$5,274
16	Wisconsin	$6,079		36	Maryland	$5,249
17	Minnesota	$6,016		37	New York	$4,968
18	Iowa	$5,952		38	Pennsylvania	$4,504
19	Arizona	$5,933		39	Massachusetts	$3,679
20	Alabama	$5,905				

Source: *The 2004 Almanac of Hospital Financial & Operating Indicators.* Ingenix, Inc. 2003

The Commission was concerned about the role of insurance companies in the high premiums Mainers face, and the Commission notes that insurance carriers must be instrumental in passing hospital savings resulting from implementation of the Commission's recommendations and other hospital initiatives on to Maine consumers. The Commission therefore recommends that the legislature charge the BOI and/or create a commission similar to the Commission to Study Maine's Hospitals to analyze insurance company finances, pricing, plan design, reserves, profits, and overall role in driving or mitigating health care spending, in order to ensure that savings are passed on to Maine consumers.

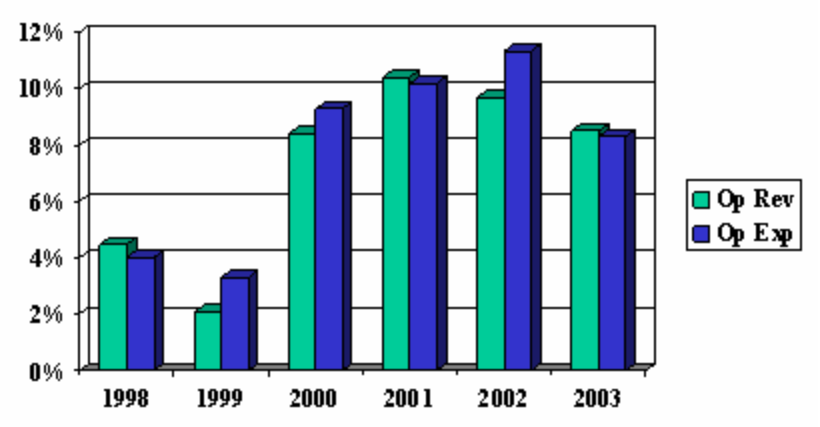
The need for changes and improvements is clear. On the quality side, hospital error reduction nationally is a high priority objective, and opportunities to generate improvements are identified in this report. One of the most appealing, yet complex possibilities, relates to the recommended universal (throughout Maine) implementation and utilization of Electronic Medical Records (EMR). This computer and internet-based technology gathers individual medical histories, including medications, allergies and conditions. Such systems

often include drug interactions and evidence-based medical protocols as well as other powerful tools which enhance overall quality and reduce errors.

In developing EMRs, hospitals hopefully will place due emphasis on efficiency gains along with quality improvements. Far too many of our citizens are unable to afford health insurance and health care cost increases have reached crisis proportions in Maine. Those paying health insurance premiums have been subjected to increases five or more times inflation rates unrelated to health care. The cost problem in Maine has evolved to the point where an adequate family health insurance plan with a modest deductible can cost thirty to thirty-five percent of Maine's median family income. In other words, for many people under age 65, adequate health insurance is unaffordable and the factors which contribute to that situation must be addressed, and hospitals, of course, are only of those factors.

Rapidly escalating health care costs have become a major national issue, and spending on hospital services play a role in these increases. As seen in Figure 3, Maine hospitals' aggregate operating revenues and expenses grew by an average of 9% and 10%, respectively, from 1999 to 2003.

Figure 3. Growth Rates in Maine Hospitals' Aggregate Total Operating Revenue and Total Operating Expenses, 1998-2003[13]



While Maine citizens are not suffering alone, it was disconcerting to learn of Maine's relatively higher costs compared to hospitals in other states. Although the

[13] Nancy Kane, September 2004 update to the Commission.

Commission was presented with sometimes conflicting data, it seems clear that hospital care and insurance rates in Maine are more expensive than in Massachusetts, the northeast, and the United States. Insurers, for example, participating in a recent survey report paying 31% more per hospital stay in Maine than they do in Massachusetts and New Hampshire. In other words, for every $1.00 that these insurers pay for a hospital visit in Massachusetts or New Hampshire, they pay $1.31 in Maine. Issues such as cost shifting and the mix of Medicaid, Medicare and insured payers impact these results, but this insurance data reinforces other data which appears to confirm that Maine hospital costs are higher.[14]

Ramifications of high health care costs reach virtually everyone in Maine – most assuredly the unemployed, individuals with low incomes, and small businesses. The Commission's sense of urgency grew rapidly as it gained knowledge over the last year. A majority of members agree that significant changes are needed to reverse or slow health care costs' extraordinary inflationary rates and should be implemented by hospitals as soon as possible, consistent with prudent planning. This report does not advocate lowering costs at the expense of patient care but reflects the Commission's attempt to balance the need for improved quality with more affordable care for all Maine citizens.

The Commission identifies key areas in this report which it believes will produce positive results, in some cases rapidly and in other instances over the next several years. The report recommends executive action and legislation. It also recommends that the Legislature provide direct financial assistance at times, financial incentives in other

[14] Numbers are taken from a voluntary survey of health plan reimbursement for commercial business in Maine, Massachusetts, and New Hampshire, conducted by Milliman Consultants and Actuaries for the Maine Association of Health Plans. The survey was sent to Anthem Blue Cross Blue Shield of Maine and New Hampshire, Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, CIGNA HealthCare, and Aetna, Inc. All carriers except Aetna contributed data. Combined, these carriers represent the majority of commercial business in each of these three states. Actual ratios between states may be different than those reported for any or all of the following reasons, or others not listed:

- In performing this analysis, Milliman relied on data and other information provided by the contributors. Milliman did not audit the data. To the extent that the underlying data is inaccurate or incomplete, the compilation of results would similarly be inaccurate or incomplete.
- Data collection and reporting within each of the companies and their systems may not be exactly equivalent. To the extent that the methods of counting services, assigning diagnoses, adjusting claims, etc. are different among the carriers, overall results could be affected.
- Not all carriers in each state contributed data. If the average charge for the noncontributing carriers is materially different than reported by these major carriers, overall results could be affected.
- Provider contracts and reimbursement arrangements may have changed since 2003.
- Cost estimates were as of the date reported for a given carrier, ultimate claim costs may not be known for certainty until a significant passage of time.

Additional detail and discussion are available in Milliman's report, available at www.dirigohealth.maine.gov.

situations, and call for voluntary controls in other circumstances. And, in certain instances, the Commission calls on hospital boards to take responsible action on a voluntary basis. A prudent mixture of state incentives, new initiatives, cost and profit targets, and hospital board cooperation will be required to produce essential results in a timely manner. The MHA is reporting that total hospital revenues for 2004 grew at only 4.7%. If that early growth rate holds and was not the result of extraordinary events, then that result could be an important signal that hospital cost growth rates have slowed.

Hospitals are unanimous in their concerns that Medicare payments are too low and create significant cost shifting and unfair distortions for other payers. The Center for Medicare and Medicaid Services (CMS) told the Commission that in 2003, Medicare reimbursed Maine hospitals for only 92% of the inpatient expenses of providing services to Medicare patients. The source of this problem appears to be a combination of high Maine hospital costs and federal payments which are too low. Closing the gap between Maine's costs and costs in other states will reduce a portion of the Medicare shortfall.

The remainder of the shortfall is due to the formula used to determine payments. CMS explained to the Commission that the recent Medicare Modernization Act (MMA) will help hospitals in all states, particularly rural hospitals. CMS told the Commission that 57% of Maine's hospitals are classified as rural, and that the absolute effect of the MMA is that Medicare payments to Maine's acute care, non-Critical Access Hospitals (CAH) are projected to increase from $485 million in 2004, to $514 million in 2005, an increase of 6.0%. Recently, two additional hospitals have been designated as CAHs, bringing the total in the state to ten.

As noted, health care cost problems in Maine have been severe, and large cost reductions across the health care system are required to re-establish a reasonable measure of affordability. While this report proposes some sweeping changes within the hospital network, an important and complimentary recommendation relates to minimizing cost shifting. For example, increasing Medicare payments up to 100% of costs (which is the national average for states) would result in one important step toward much more competitive and equitable treatment for Maine citizens. This report proposes an all out effort to achieve that objective.

The Commission also recognizes an issue with MaineCare payments to hospitals. MaineCare pays Maine's hospitals prospectively on a weekly basis through Periodic Interim

Payments (PIP). When the fiscal year closes, hospital records are audited. At audit the hospitals' actual costs are reconciled against MaineCare PIP payments and settled. Since the early 1990's, the state's PIPs have been significantly lower than hospital experience with MaineCare utilization and have not been adjusted upward. This has resulted in large settlements and delays in hospital payment for services rendered.

Currently a number of hospitals are contesting settlements they believe are owed to them from 1993-2002. In addition more recent audits (2003-2004) are being completed, and it is anticipated that additional settlements will be due to hospitals. Hospitals have also requested that the State increase its PIP payment schedule in the future so hospitals receive more realistic interim payments; this would reduce the size of settlements at audit, allow more timely payment of MaineCare's hospital costs, and improve cash flow to hospitals, which should help mitigate the need for price increases.

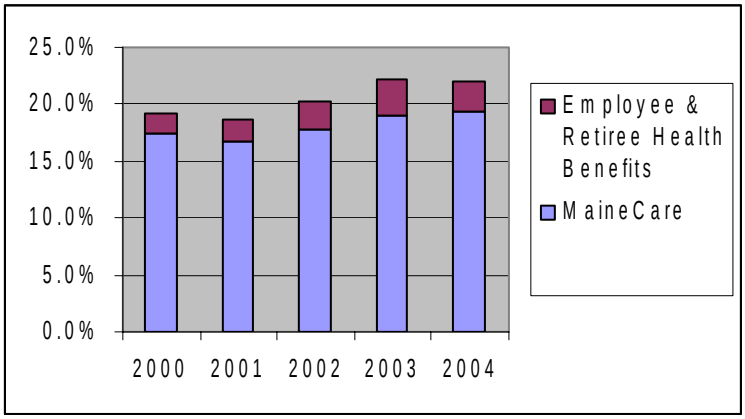
The precise amount of settlements owed hospitals is pending court action and finalization of audits and/or negotiations. The PIP underpayment problem, which results in slow payment to hospitals from MaineCare, has developed over the last decade. The Baldacci Administration reports a plan to address PIP issues even amidst challenging budgets. The Commission urges continued vigilance on remedying these large and multifaceted problems.

The health care cost situation in Maine has reached a point of extremis, and related insurance rates have become an unacceptable burden to our citizens and the state. The consequences are:

- 17% of non-elderly Maine people are unable to afford health insurance.
- More Maine people are being driven into bankruptcy because of health care debts.
- Fewer Maine employers can afford to offer health insurance and more are on the verge of terminating coverage.
- Many employers that do offer insurance have increased their workers' contributions for premiums, coinsurance and deductibles and plan to further increase their employees' financial obligations if premium rates continue to rise. One direct example of the problem was the widely reported debate in 2004 between Shaw's and its union.
- State tax revenues are not increasing as fast as the state's Medicaid obligations and state employee health care premiums. Therefore, millions of dollars of increased

state payments for health care forces reductions in support for other state programs, reductions in rates paid to health care providers, or both (figure 4).

Figure 4 – Health Care Spending as a Percentage of General Fund



Source: State Budget Office

Given the dire effects of cost growth related to health care, the Commission is recommending increased transparency of certain hospital and insurance company financial information. With far too many citizens and businesses suffering under the burdens of excessive health care costs (or no coverage at all) it is important that Maine people have enough insight into costs, executive compensation, organizational structures, reserves and profits to assure that no organization or individual is taking unfair financial advantage of the situation.

Indeed, presentations by Dr. Nancy Kane, financial analyst for the Harvard School of Public Health, helped the Commission understand the importance of standardizing hospital financial data. Standardized data will provide the public with a clear, understandable means to compare the financial health of different hospitals, as well as to understand the reasons for varying levels of financial health. Dr. Kane's presentations showed differences among hospitals in our state, with two-thirds of hospitals generating operating margins well above northeast region and national medians – and with one-third of Maine's hospitals tending to have negative operating margins. Importantly, the data revealed that the percentage of patients covered by Medicare and Medicaid does not explain differences between profitable and unprofitable hospitals, and that hospitals that are struggling financially appear to be doing so because of (a) low patient volume and/or (b) a high proportion of patients with ambulatory care sensitive conditions which might, in many

cases, be best treated in an outpatient setting. Findings such as these are valuable insights in that they can provide the public – local hospital boards, communities, consumers, employers, and the legislature – with a base upon which to make public policy and other decisions. Without an objective analysis of transparent and standardized data, sound decision-making would be more difficult.

Hospitals today work with a multitude of varying requirements from different payers. Medicaid requirements differ from Medicare and private insurers have their own unique specifications, and each party often insists on use of its own standards and procedures. The billing process, for example, is extremely complicated and costly, to cite just one of the consequences. Recent legislated changes have helped, but the Commission is pressing for far more standardization to reduce administrative effort and costs. More streamlined administrative procedures must be adopted by providers and payers, and the State of Maine should help in that process..

A major underlying premise in this report is that to improve quality, increase access and lower hospital costs, everyone must begin thinking in terms of Maine's 39 community hospitals functioning as an integrated and affiliated network, structured and managed to serve the best interests of all Maine's people. Since these non-profit institutions are largely financed by state and federal taxpayers, plus private insurers, each hospital should become more focused on its most effective role within Maine's overall hospital network. The proposed shift in emphasis is toward more cooperation and coordination, while retaining the primary features of autonomous organizations at the local levels.

Even though hospitals should reflect and react to local needs, the time has passed when an individual hospital's behavior should be solely influenced by its role in the local community – either as the primary health care provider or as the engine driving the area economy. The luxury of maintaining and expanding local hospitals at any expense is no longer affordable because it creates excessive duplication, feeds inefficiencies, increases costs to all taxpayers, and can result in unacceptable quality. While sensitive to their local needs, each hospital board and administrator should also act in ways which assure that the local hospital is operated in a manner consistent with achieving the maximum positive impact (quality, access and cost) within Maine's comprehensive hospital network. Local interests should be balanced with the need to achieve optimum effectiveness of Maine's overall community hospital network if we are to progress.

Some hospitals may resist this fundamental change in thinking, but such changes are essential if hospital costs in Maine are to be brought under control and become competitive with hospitals in other states, while still improving access and quality for Maine citizens. In some cases, what we are suggesting will modify the culture surrounding operation of the local hospital, and cultural changes are often difficult to accept. However, no change is intended to shift control of a local hospital or hospital system to another authority.

Having made these observations, the Commission confirms its recognition of the vital importance of the local hospitals and is not recommending any closures of Maine hospitals.

One very important recommendation noted earlier is that Maine hospitals and physicians should proceed as rapidly as possible to implement Electronic Medical Records (EMR) on a statewide basis.

The Commission became convinced that there are tremendous potential benefits related to the quality of care and cost effectiveness if a fully interconnected system can be implemented in Maine and if every citizen has an EMR.

We are recommending significant financial support for this ambitious and expensive project, through state bonding, to provide one important piece of the funding required. Such state support could be the stimulus needed to encourage Maine to become a national leader in this area.

Many of the Commission's recommendations are designed to improve efficiency and lower costs over the long run. In that context, helping hospitals shift into more cost effective administrative practices is an important objective, is possible and can be accomplished with no negative impact on patient care. Since hospital utilization rates in Maine have been increasing and those trends are likely to continue into the future as Maine's population expands, people age and medical practices improve, there will be a substantial opportunity to improve cost effectiveness as volume increases during the latter half of this decade. With 16% -25%[15] of most hospitals costs related to administrative functions, the potential to improve in this area is large. As volume increases, the cost per unit of service should decrease in most cases, and hospital managers should continue to aggressively seek such results.

[15] Medicare Cost Reports tend to report administrative costs in Maine's hospitals being 16-17% of costs. However, a number of hospital administrators indicated to the Chair of the Commission that they estimate that administrative costs are 20-25% of their total costs.

As a critical aspect of quality improvements and cost reduction efforts, the Commission supports wellness and disease prevention initiatives which should be expanded to reduce the need for hospital care. Fundamental transformations in behavior patterns of many Maine citizens are required. More comprehensive and effective wellness programs are needed throughout Maine. Recommendations in this report are intended to help hospitals play an expanding role in wellness efforts across our state without incurring added financial burdens.

The Commission also recognizes that research shows that when RNs have fewer patients, there are better patient outcomes.[16] There is also evidence that the savings from avoided complications when RNs are added can offset the cost of additional RN care. The Commission understands that the Maine Quality Forum recently concluded a study of nurse-to-patient ratios and found that the challenge is knowing at exactly what point additional RN hourly input ceases to bring additional cost efficiencies. The Commission further understands that the MQF is in the process of promulgating Rule 270, which will implement the collection of 7 nurse-sensitive indicators from the National Quality Forum, including nursing hours per patient day, nursing skill mix, and voluntary turnover rates. The Commission supports this data collection effort. The Commission encourages hospitals to ensure that their direct RN to patient ratios are adequate at all times to provide safe, quality, cost-effective care.[17]

Most recent forecasts project total Maine hospital revenues approaching $2.7 billion per year. Clearly, Maine's hospital network in and of itself is a very significant factor within our state's economy.

We believe the fairest and most appropriate way to evaluate the economic impact of Maine hospitals, however, is in the broadest possible statewide context. How the state's 39 hospital network affects Maine's overall economy (as opposed to local economies) is most

[16] See, for example, (1) www.ahrq.gov/research/nursingstaffing/nursestaff.htm, (2) Leape, L. et al., Systems Analysis of Adverse Drug Events. Journal of the American Medical Association. 1995. 274(1):35-43. (3) McCue, M., et. al., Nurse Staffing, Quality and Financial Performance. Journal of Health Care Finance. 2003, Vol. 29(4) , 54-76. (4) Needleman, J., et. al. Nurse-Staffing Levels and the Quality of Care in Hospitals, New England Journal of Medicine. May 2002, 346(22):1715-22. (5) Rogers, A. et al., The Working Hours Of Hospital Staff Nurses And Patient Safety. Health Affairs, Vol 23, Issue 4, 202-212.

[17] Commission member Pat Philbrook, RNC, NP, Executive Director of the Maine State Nurses Association, writes that "from the direct care nursing perspective, this section on nursing indicators reflecting safe staffing RN levels does not reflect the true spirit of LD 616 (RN to patient ratios). There are several proven nursing indicators that were discussed but not included, such as the 2 million nosocomial infections reported annually and none were included."

important to the majority of Maine people. Escalating health care costs and prices have already produced severe negative economic consequences within Maine for individuals, businesses and government. Those who pay the bills have been squeezed as health care costs (of which hospitals contribute only one-third) have increased year after year at rates several times faster than the trends of most broad based national indices. Indeed, federal, state and local governments (i.e., the taxpayers) have suffered through increased costs, reallocations and program losses as government agencies struggled to absorb health cost increases.

Private sector impacts have been more severe. Inordinate pressures on business costs have proven harmful to the competitive positions and profitability of large and small companies in Maine. Although it is difficult to calculate a direct correlation between excessive health care cost increases and employment levels in Maine, leading economists have often stated their belief that health care cost growth has had a negative impact on job creation and retention. In the public sector, diverting increasing percentages of state budgets to health care coverage has become an economic reality and Maine's commitment as a percentage is already fourth highest in the nation. Nationally, the U.S. Bureau of Labor Statistics has reported that employee benefits spending by private sector employers rose 24% over the past four years, primarily because of escalating health care premiums, while wages increased only 15%.

There are many examples of employees receiving a pay raise of 2 or 3 percent but netting less take home pay because health insurance cost increased faster than pay was raised. Worse yet have been the circumstances of Maine people who have lost all health insurance and become wholly dependent on free care or public assistance for health care.

A substantial number of Maine people have experienced some lifestyle degradation, in an economic context, because health care cost growth has out-stripped inflation to such a degree. And, hospital costs represent approximately 37% of health care costs in Maine.[18]

The extent to which broadbased health cost problems impact Maine has grown to such proportions that changes are essential throughout the system, in this case throughout the hospital network. Many of the changes suggested in this report are intended to standardize, combine or mechanize administrative procedures (i.e., steps that speed up processes and/or eliminate duplication of effort) reducing costs while improving quality. As

[18] State Health Plan.

quality also improves through implementation of clinical and/or medical recommendations contained in this report or as originated by the Maine Quality Forum, more cost savings can be expected.

The Commission hopes to have the full cooperation of every hospital in Maine in pursuit of goals related to lower costs and increased efficiency. Maine's overall economy will strengthen as health care cost growth is reversed and insurance rates flatten or are reduced. Achieving efficiency improvements and related savings within the hospital network are so critical to Maine citizens that individual hospitals are urged to support quality improvement initiatives and cost reduction efforts.

Lower and more competitive hospital costs will give a boost to Maine's overall economy and the state's economic outlook. Under current circumstances, many businesses are faced with difficult tradeoffs related to the increased costs of maintaining current employee benefit levels versus job creation throughout Maine's economy. That is a choice employers should not be required to make, but the economic consequences of health care costs are major concerns in Maine and across the country. Richard Wagoner, Chairman and CEO of General Motors said recently, "The health care cost trends in the U.S. are really out of control. It's a big issue for G.M.; it's a big issue for the U.S. economy as a whole." And, he could have added, it's a big issue in Maine.

Health care is changing rapidly, and it is difficult to predict with any certainty what hospital operations will look like in the years ahead. Just as more and more hospital services are now performed in out-patient settings, so the future will bring new demands, new technology and efficiencies that will create new opportunities. Maine hospitals, through their governing boards and not this Commission, are best equipped to implement the recommendations in this report and make other decisions which assure that Maine's hospital network becomes more cost effective and affordable over time. Hospital boards must take the lead by insisting that strategic hospital planning focuses attention on a balance of high quality and cost effective objectives. A clear majority of Commission members do not favor a general increase in government controls over Maine hospitals or increased regulations applying to our hospitals.

The Commission did not review mental health hospitals. However, it is unanimous in its view that those hospitals receive attention as soon as possible and is recommending such an approach to the Governor and to the Legislature.

The Commission is hopeful that the legislature and hospitals will be able to embrace the majority of its recommendations and do so with enthusiasm. Obviously, the cooperation of hospitals and their medical staffs will be essential to achieve the needed improvements sought by the Commission. Likewise, the Commission urges the legislature to act soon on its recommendations where legislative action is required.

Recognizing there will be differences of opinion and believing prompt action is imperative, the Commission is prepared to work with any interested party to help clarify its recommendations and/or assist with the implementation process. The Commission's work has been challenging, but the majority of its members believe that within the following recommendations are tools which can eventually improve quality results, increase access and lower operating costs by hundreds of millions of dollars per year for Maine hospitals. Hopefully, the results achieved will be well worth the Commission's efforts and will pay dividends for years within our hospital network and for Maine citizens.

In closing this introduction, the Commission is sensitive to feedback from hospitals during public hearings that the tone of this report paints a negative and unfair picture of Maine hospitals. What is intended and obvious to the careful reader is to fairly describe major concerns with health care costs in Maine. The reader must understand that the extent to which hospitals contribute to the problem is heavily influenced by Maine people (our average ages and physical conditions); our demands for increasing level of service; confusing administrative requirements; the impacts of defensive medicine; government compensation policies, and finally, hospital practices themselves. Simply stated, there are many variables which drive hospital cost, quality and access issues and many changes are required to enable hospitals to function more effectively and overall health care results to improve.

COOPERATION, COLLABORATION, AFFILIATION AND/OR CONSOLIDATION WORKING TOGETHER TO IMPROVE RESULTS

Maine's network of community hospitals has evolved over decades. Indeed, virtually all were first established in times much different than the early years of our new century. Transportation then was much poorer, medical knowledge in its relatively early stages and technology vastly inferior to today's state-of-the-art. Family doctors and local hospitals were the primary sources of health care for a large majority of Maine's people.

In that environment, most hospitals functioned as independent units – with perhaps some ties to a larger hospital in Portland or Boston. Hospital care had a strong local flavor, except for the most complex and difficult medical challenges. Local hospital boards, administrators, medical staffs, employees, and area citizens made extraordinary commitments to their local hospital, and they continue to make those commitments today.

In recent years, Maine has seen an evolution in attitudes and beliefs regarding hospital functions and relationships, as new working and business relationships among several different groups of hospitals have emerged – notably, the systems and affiliations which have grown around Maine Medical Center, Central Maine Medical Center and Eastern Maine Medical Center. Decisions to affiliate with other hospitals have been made by local boards as they have considered how the local hospital can best serve its community. Sometimes relationships between hospitals have developed over a number of years.

While relationships within each of the state's major hospital systems appear to be structured in a unique manner -- with various levels of affiliation within each system, ranging from full membership and economic integration to different levels of clinical, administrative, and/or support service affiliation -- senior managers appear consistent in their favorable views of clinical improvements and cost benefits achieved. From these and other examples of effective affiliations, the Commission has seen and heard evidence here in Maine (albeit based on relatively small samples) that hospital cooperation, collaboration, affiliation and/or consolidation produces positive results. Today, roughly three-quarters of Maine's hospitals are affiliated with one of the State's major hospital systems.

The Commission has also heard expert testimony and has made personal observations where excessive competition between and among hospitals has failed to lower costs. Moreover, there have been instances where competition in communities served by

two hospitals appears to have resulted in unnecessary duplication of services and facilities, or created excess capacity.[19] History has demonstrated conclusively that, under circumstances where there is excess capacity, that doctors visits increase, bed use increases, and high technology equipment utilization increases beyond levels required to assure high quality medical care, according to an expert witnesses.[20] Under those conditions, costs increase without any commensurate improvement in patient care.

Further, the Commission heard little testimony indicating that competition in Maine has driven hospital prices down. Rather, there is strong evidence that patients select a hospital based on its location, a doctor's recommendation or its reputation. It is possible, with more transparent data, that pricing will become a more significant factor in the hospital selection process in the future, but in the near term only a very small percentage of patients are likely to be influenced by pricing as they select a hospital. There seems little justification to continue such a high emphasis on competition in the hope of influencing pricing or hospital selection decisions.

The Commission therefore believes that the competitive environment among Maine hospitals should be modified to improve quality, access and costs overall. The Commission is not suggesting, however, that all vestiges of competition be eliminated. For example, although maximizing cooperation should prove very effective, pricing collusion must not be permitted.

The Commission recognizes that circumstances differ considerably from one situation to another in Maine -- and what appears needed and helpful in one area may already exist in another. However, among the potential benefits to be gained by implementing a broader cooperative environment overall within Maine's entire hospital network would be these:

- More effective statewide hospital planning.
- Improved relations between hospitals at board and senior management levels.
- Reorganizations that results in less duplication and lower costs.

[19] In recent years the Certificate of Need (CON) process seems to been inadequate to control hospitals determined to add capacity irrespective of the overall consequences, due largely to insufficient state resources for CON review.

[20] Dr. David Wennberg, citing Wennberg JE, Cooper MM, eds. The Dartmouth Atlas of Health Care in the United States. The Center for Clinical and Evaluative Studies. Dartmouth Medical School. AHA Press, 1996. Chicago, IL

- More consolidated and efficient administrative functions, such as payroll, billing, purchasing, etc., which lower costs.
- Standardized and increased use of software and electronic technology which would improve quality and has the potential to spread computer related acquisition costs over more hospitals and reduce operating costs.
- Combined procurements of bulk commodities and high quantity items offers the advantages inherent in larger quantity purchases and improved inventory control.
- Standardized clinical protocols to implement best practices throughout Maine.
- Coordinated procurement and utilization of expensive equipment and systems to minimize unnecessary duplication.
- Optimal use for each of Maine's 39 community hospitals.
- More effective use of providers in support of hospitals and increased returns for providers.
- Improved medical coverage by sharing qualified personnel among Maine's hospitals.

To achieve the important objectives noted above, one long range approach would have Maine's 39 community hospitals remain independent but function as one cohesive network structured and operated to provide uniformly high standards of quality for all Maine people, at the lowest possible cost. Hospitals or hospital systems would remain autonomous, but all Maine hospitals would be encouraged to cooperate, collaborate and affiliate whenever feasible to optimize quality, access and cost within their area of influence.

The Commission notes that state and federal laws today reinforce the notion that hospitals should be competitive and that antitrust laws have often been perceived as an impediment to cooperative thoughts and actions -- especially those related to business issues – and that fear of legal action has slowed development of cooperative relations between and among hospitals.

Therefore, as one important step toward implementation of a more cooperative strategy, the Commission recommends legislation (following this section) which legalizes the change from an environment encouraging maximum competition to one permitting maximum cooperation, collaboration, affiliation and/or consolidation among all of Maine's community hospitals under appropriate circumstances.

This will not be a subtle shift in emphasis toward maximum cooperation, but an important change for many Maine hospitals which will evolve over a period of years. When implemented to full effectiveness, overall quality should improve to a substantial degree and the potential will exist to generate cost savings through maximized cooperation within the community hospital network. To achive a broad level of the cooperation envisioned, each hospital is encouraged to enter into a formal affiliation or collaborative relationship with other Maine hospitals with the statewide consortium described below.

The thrust of this recommendation is to stimulate a change in some instances from long held habits, toward more productive relationships among Maine hospitals by:

- Encouraging more hospital network-wide cooperation.
- Reducing anti-trust impediments through legislation.
- Providing incentives to hospitals which cooperate and achieve improved results.

To a growing extent, Maine hospitals are supported by Maine taxpayers for whom they provide an absolutely vital service. This recommendation reflects the Commission's belief that the time has come when all hospitals should balance their local interests with participation in a broad and fully cooperative hospital network to best serve all the people of Maine.

Creating Cooperative Affiliations

Collaborative efforts should improve the quality of care and reduce cost with no degradation to hospital access. This recommendation to broaden cooperative affiliations is made with the full recognition that virtually every Maine hospital is already working with other hospitals in one or more special relationships. Substantial additional improvements are possible, however, because many Maine hospitals today still operate in a decentralized manner, performing their own planning, handling their own administrative functions and relying on their medical staffs for clinical direction. More formalized communications among hospitals and more cooperative operations should improve efficiency and produce superior results.

Existing hospital systems' organizational structures differ, with some tied together through ownership or tight contractual terms and others by less formal working relationships. In still other cases, individual hospitals have joined forces through managerial agreements to gain the benefits of larger size, broader capabilities, greater expertise, increased flexibility and/or stronger management.

Those who manage hospital systems in Maine report advantages and gains related to the quality of care, cost savings attributable to the development of computer systems, and many other collaborative operating arrangements. Despite such reports, cost savings thus far have not resulted in lower overall hospital pricing. Participants in collaborative relationships suggest that such results were probably because inflationary or utilization increases have more than offset savings generated.

The preponderance of evidence suggests that the advantages of establishing a cooperative hospital arrangement throughout Maine outweigh the disadvantages. Future improvements produced by broader cooperative agreements should exceed those already credited to the systems now in place. Specifically, while ongoing hospital systems deserve credit for producing administrative efficiencies and quality of care improvements, the systems themselves have not yet constrained health care cost growth to a sufficient extent or reached their potential effectiveness. Indeed, Maine's health costs grew faster than the nation's during the years Maine's hospital systems were developing. These observations are not intended to be critical of existing systems which have generated improvements, but rather to reflect the reality that it takes considerable time and energy before hospital systems evolve into optimum effectiveness.

Maine's hospital network appears well suited for a cooperative statewide alliance encompassing all of its community hospitals. Our state has many relatively small independent hospitals in outlying areas which enjoy strong community bonds and long years of service to their areas. Those hospitals stand to benefit tremendously when the rewards of more cooperative relations become fully evident. Improved access to managerial and technical expertise, coupled with the best medical guidance available, clinical standards employing best practices, and all the benefits related to economies of scale, represent significant opportunities for smaller hospitals to produce improved overall results while retaining local autonomy. Thus, creating a statewide hospital affiliation in Maine, while retaining Maine's tradition of independent hospitals, and encouraging full participation is a high priority recommendation of this report. Equally important to cost savings, will be the health care quality improvements more cooperative relations should produce throughout Maine's hospital network.

The basic concept proposed will require a limited governance structure with well defined responsibilities and a small team of managers to optimize overall results.

The Commission proposes the creation of the Consortium for Hospital Collaboration, a strategic alliance led by hospitals to establish and achieve a statewide standard of efficiency, care and financial health that all hospitals, with government support, should work together to achieve.

The Commission recognizes that there is considerable variation in the health care provided across our state and in the financial health of Maine's hospitals. For example, the Maine Health Information Center report of May 2004 showed wide variation in payments for the same services made to 36 different hospitals by members of the Maine Health Management Coalition. The average payment per discharge in 2002 at the highest-paid hospital ($8,785) was almost twice the average payment at the lowest-paid hospital ($4,420), after taking into consideration differences due to patient casemix.
Likewise, Dr. Kane's study reported significant variation in the financial health of Maine's hospitals, with one third experiencing financial difficulties while another third reported very good levels of profitability. And, research by the Maine Quality Forum and the Maine Medical Assessment Foundation demonstrates that where one lives in Maine often determines how a particular medical condition would be treated.

The Consortium envisioned would be expected to work with participating hospitals to help smooth any undesirable variations and help assure that all Mainers, no matter where they live, receive high quality care at affordable prices from financially viable hospitals.

Changing demographics in Maine require a hospital system that reflects such change and still provides the best, most efficient services in all parts of the state. Where out-migration is a reality, at least for the present, resulting low volume usage of hospital services challenges the financial health of some hospitals in those areas. The Commission believes that Maine needs all its rural hospitals, designed to specifically address local needs, but that each should participate as part of the proposed statewide collaborative. By voluntarily working together in the Consortium, each Maine hospital would become more knowledgeable and the better equipped to reduce inappropriate variations and improve the efficiency and effectiveness of services.

The State Health Plan would be informed by the work of the Consortium, and the plan will take steps to facilitate activities identified by the Consortium. The Consortium's focus in part would reflect the needs identified in each biennial State Health Plan with specific, hospital based strategies to address them when appropriate.

The Commission proposes that the Consortium Board membership include:

Hospitals (12):[21]

6 - Representatives of hospital systems – at least 1 member from each hospital system (3 from Maine Health, 2 from Eastern Maine Health, and 1 from Central Maine Health);

5 - The 18 hospitals unaffiliated with a system, will elect 5 members;

1 - Member from Maine's Hospital Trustees organization (from a hospital that is not affiliated with a system);

Physicians (2)

Nurses (2), including a direct care nurse

Government (2):

1 - Member from Governor's Office of Health Policy and Finance

1 - Member from the Maine Quality Forum

Consumer (2)

Insurer (1)

Employer (2)

The Consortium should elect a chair from among its members and create subcommittees to facilitate its work.

The Consortium should begin its work investigating a pre-determined list of specific objectives and issues. Hospitals would be encouraged to use the Consortium as a forum to generate and explore ideas to enhance collaborative, cost effective, quality care initiatives among Maine's hospitals The recent action by hospitals to combine resources to develop a statewide solution to disposal of hospital waste is an excellent example of collaboration and the Consortium should serve as an incubator for such ideas to expedite and implement related work. It is anticipated that the Consortium would have access to consultants from across Maine and the nation to help the Consortium develop, plan and implement its

[21] The allocation of membership is designed to roughly reflect the proportion of the state's hospital care provided by each system (42% by Maine Health, 20% by Eastern Maine Health, and 8% by Central Maine Health), while ensuring that unaffiliated hospitals – who provide the remaining 30% of the state's hospital care – are adequately represented.

Source: Maine Hospital Association: Distribution of Hospital Expenses, 12 Months Ending 9/30/04, taken from Quarterly Financial & Statistical Report, as presented to the Commission by Scott Bullock. Excludes Waldo County, New England Rehab, Acadia, & Spring Harbor Hospitals.

agenda. The Consortium would develop new tasks over time, with the goal being collaboration to achieve a consistent high quality and cost effective network of hospitals throughout our state.

Among the issues the Consortium might tackle are:

- Implementation of clinical protocols (i.e., employing best practices) to assure statewide commonality and reduce variations in care.
- Coordination of other medical practices where appropriate, to enhance the quality of care, access and cost effectiveness.
- Optimizing medical capabilities, facilities and equipment to avoid excessive duplication, consistent with best medical practices and concern for the well being of patients.
- Creation of Centers of Excellence in such areas as radiology and pathology, for example, where new technology permits the rapid transmission of images and data, and where consolidated efforts appear feasible to providers.
- Planning, including coordination of large capital investment decisions, where feasible.
- Guidance related to computer/software technology to assure broad based standardization, cost effective installations, optimal results and statewide connectivity among hospitals and physicians.
- Consolidation of administrative functions such as payroll, billings, purchasing, etc., (in some cases statewide) where economies can be generated.
- Assisting local hospitals in efforts to secure required financing on the best terms available.
- Sharing special hospital management expertise throughout the state.

The move toward a meaningful and broad based degree of cooperation, guidance and coordination will represent an important change for some of Maine's community hospitals, even though the majority of our hospitals are already involved in collaborative efforts. But, the potential to generate essential improvements through coordinated efforts is so large that the Commission urges hospitals and their medical staffs to embrace the concept and implement it with enthusiasm. The ultimate beneficiaries of better coordination and

more cooperation among hospitals should be the entire medical community and all Maine citizens.

This recommendation is not intended to create a situation where one or several individuals dominate hospital control functions in Maine. Likewise, no local hospital board or administrator will be expected to answer to a higher authority under this suggested approach. Physicians, nurses, consumers, insurers, employers, and state government representatives will be participants in the Consortium's leadership, but hospitals will have a substantial majority of board members.

Despite the stated resistance by hospitals to this move toward widespread hospital affiliations, more cooperation within Maine's hospital network seems essential and should be pursued. Facts reported in the State Health Plan, and quoted in the introductory section of this report, paint a troublesome financial picture and must be changed. It is hoped that every Maine hospital will participate fully in the cooperative network being proposed.

Hospitals expressing concern for the consortium concept noted that Maine hospitals are already involved in many collaborative efforts and that the proposed statewide plan is unnecessary. They also expressed fear that the consortium would be a step toward more government regulation and control of hospitals.

After hearing these concerns, the majority of Commission members still support the recommendation, believing that the consortium:

- is not intended to disrupt any current relationships, but has the potential to be broader, more inclusive and to enhance the effectiveness of current structures.
- is being proposed to better support the needs of Maine hospitals on a voluntary participation basis, not to govern hospitals, as was feared by some who testified before the Commission.

Coordinating certain activities within Maine hospitals should prove to be a major step in a positive direction, if the concepts envisioned are implemented effectively. Controlled spending and measurable cost reductions translating into lower prices are reasonable long range expectations of the process envisioned, along with measurable quality of care improvements.

The Commission's hope would be creation of the Consortium in 2005 and implementation before the end of 2006.

Incentivizing Improved Performance

This entire concept requires voluntary cooperation on the part of hospitals. Therefore, incentivizing and measuring hospital performance is a critical aspect of the entire plan.

The Consortium should develop an annual workplan, select specific tasks and provide in-kind support. The Consortium should also seek grants and external funding from Foundations to help finance its initiatives. To stimulate collaboration and meaningful action within the Consortium, state government should work to develop appropriate incentives to accelerate progress. Clear benchmarks and timetables to measure performance should be included in work plans. If incentives are provided by the state, the Consortium would be expected to report semi-annually to hospital trustees and the Joint Committee on Health and Human Services of the Legislature to assure that its goals, and progress meeting them, are clear and that there is accountability..

Projects generated by the Consortium should receive timely reviews and high priority attention pursuant to the amendment to the Hospital Cooperation Act, proposed elsewhere in this report. Likewise, the Certificate of Need program and state licensing agencies should give priority to projects generated through the Consortium and Hospital Cooperation Act. And, state payers and private insurers should develop special financial ways to reward collaborative efforts that show measurable quality improvement and cost effectiveness progress. The GOHPF should support the Consortium by working with public purchasers, private insurers and businesses to establish criteria and funds to create financial incentives and/or interest free loans to encourage collaborative efforts. That organization should also support start up costs of initiatives which have good potential but where savings may take years to materialize.

To achieve those objectives, the Commission envisions that the average Maine hospital will produce significant improvements within an effective Consortium structure which encourages cooperation and coordination as well as through implementation of other recommendations in this report. Cooperative emphasis should be determined by each participating hospital, but most would be expected to focus on areas such as the following:

Hospital Planning. The Commission expects that this concept will result in fully integrated, long range hospital planning consistent with the needs of Maine citizens. Planning should be extensive enough to assure adequate and appropriate care; the

progressive cost effective development of facilities and technology, efficient administrative systems and the growth of human resources. Sound planning should also assure that excessive duplication of facilities, equipment and technology does not occur and should address all capital investment issues of participating hospitals in a manner similar to processes anticipated within the scope of an effective statewide CON process.

Clinical Protocols. There is substantial evidence that standardizing clinical protocols around proven "best practices" improves medical outcomes and lowers long term costs. One of the key recommendations of this report is that all Maine hospitals join forces with the Maine Quality Forum to assure that "best practices" are consistently employed throughout our State. While some Maine hospitals/systems have been actively pursuing this agenda for years, there are still many variations in the utilization of procedures and treatments for the same condition and it is now widely acknowledged that some treatments produce far better results than others. Variations are usually influenced by local practice patterns and individual physician decision making. As quoted in the State Health Report, "by accident of geography, a patient might be treated surgically for a condition in say, western Maine, and treated medically for the same condition in northern Maine." Since there is frequently wide agreement nationally on what constitutes a "best practice," an important coordinating goal will be to identify "best practices" and assure their implementation in every participating Maine hospital.

Standardizing Chronic Illness Care. Maine hospitals appear to be making good progress in this area, and the Consortium should strive to assure statewide employment of best overall medical approaches are utilized for the following chronic illnesses:

- Cardiovascular Disease
- Diabetes
- Chronic Lung Disease
- Cancer

Such chronic problems account for approximately 70% of Maine's deaths and the associated costs have been estimated to be in the range of $2.5 billion each year.

Coordinating Medical Support Practices. There are many medical services and functions performed on a regular basis in support of Maine's hospitals. Included are the services of traveling medical providers, emergency vehicles and emergency aircraft, to name only a few of the most obvious. It is the intent of this recommendation that statewide

coordination of such functions be achieved through consortium efforts, to assure adequate access and high quality outcomes for the lowest costs. Witnesses testified of the potential benefits of better coordination and scheduling in this important area.

Electronic Medical Records. This organization should work with the MQF in planning and assuring implementation of the most effective hospital-related software and computer hardware. They would be expected to push electronic technology forward (especially EMRs), consistent with other aspects of this report. Most important, the consortium would make certain that technical expertise is available to participating hospitals to the extent required, and that decision making results in standardization and compatibility throughout Maine to the maximum extent possible. As a minimum, electronic connectivity throughout Maine is essential and must be achieved. (See Section 3 on EMRs.)

Consolidating Business Functions. Each hospital in Maine performs administrative functions (unless consolidations have already taken place) in order to operate as a business entity. Traditional functions, such as billings, payroll and purchasing require staffing and supervision -- in some cases, large numbers of employees.

Using modern technology, administrative functions frequently lend themselves to being performed in a single Center to serve the needs of multiple locations (i.e., different hospitals in this case). If properly planned and managed, significant efficiency improvements can be gained by utilizing a centralized approach to performing many administrative functions for all participating hospitals.

Since administrative costs represent approximately 16-25% of operating costs in many Maine hospitals, there is a large potential for cost reduction in the administrative area. Where functions are centralized, significant net cost savings may be realized through the use of better technology, more experienced personnel, higher volumes and more repetition. Administrative consolidations do not guarantee improved results in every case, so utilization of this concept should be selective. And, some smaller hospitals already function with minimal administrative staffs.

In the case of multiple hospitals working together on a cooperative basis, cost savings may be generated by combining business functions from several locations to one site, and improving overall cost effectiveness. The results are often net cost reductions and net savings overall, if the process is well planned. Administrative cost savings are essential to help curtail cost growth within the overall hospital network and can be achieved with no

negative impacts on patient care or operating effectiveness, if implemented properly. In some instances such as purchasing, there are powerful economic advantages related to large quantity procurements. Utility procurements were reported to the Commission as promising targets for large volume savings. Likewise, in the coordinated procurement of pharmaceuticals for all Maine hospitals, for example, we heard evidence that there appears to be a good potential to save money – perhaps five to ten percent of $100 million per year.

Cooperative purchasing and administrative efforts are already in place in some Maine hospitals, but this recommendation envisions the broadest possible participation because of the absolute need to achieve large overall operational cost savings and pricing reductions. The potential to realize significant cost reductions in the administrative area through more collective efforts and the largest possible bulk purchases appears to be a realistic objective. Witnesses also described existing systems which effectively streamline and standardize procedures among payers to quickly and accurately verify eligibility for insurance coverage. Hospital representatives present appeared impressed by the potential benefits such systems offer. This is another administrative area with potential for Consortium action.

Creating Centers of Excellence. With the advent of new technology over the last two decades, the potential exists to partially centralize certain medical functions to improve quality and lower costs. The Commission proposes consideration of the creation of Centers of Excellence in radiology, pathology, behavioral health, and some forms of intensive or critical care services in Maine, for example, where test results can be read and interpreted by teams of highly qualified specialists.

Conceptually, testing would still be performed at local hospitals, but results would be transmitted electronically to one or several central locations in Maine for analysis. Since most actual testing, such as X-Rays, MRIs, CAT Scans, etc., is performed by local technicians, there may be an opportunity to reduce the number of specialists spread across Maine now required to support specific hospitals, through appropriate levels of centralization, with no degradation to quality. Such decisions, however, should follow extensive discussions among medical experts including representatives of all local hospitals. And, Centers should only be created when they are able to demonstrate that quality will improve and net overall cost savings will be generated for the participating hospitals.

The Commission recognizes that, even with Centers of Excellence, a sufficient number of doctors will still be required to cover each hospital to the extent required by procedural requirements calling for onsite physicians.

Despite the need for adequate physician presence in every hospital, some Maine hospitals may be able to operate more cost effectively, utilizing the proposed Centers of Excellence. Indeed, it is reasonable to anticipate quality results to improve if more radiologists, for example, are permitted to specialize due to volume increases likely in one centralized location serving Maine versus decentralized operations where one physician is expected to address many different medical challenges each day.

The Commission believes moving toward Centers of Excellence in Maine represents a major move forward at this time. One, two or three Centers may prove to be most realistic after a thorough evaluation. Since it may be comforting to some patients, physicians and hospitals to know that medical professionals analyzing test results are located within relatively close geographic proximity, even though not on the local premises; multiple Centers may be a reasonable outcome. Indeed, there may be opportunities to sell such services to users outside Maine. Other consolidated medical Centers of Excellence may prove advantageous in efforts to improve quality and/or lower costs without impacting access. Where feasible, such Centers should be thoroughly evaluated and considered for implementation.

Assisting With Financing. Where today, most local hospitals only participate in relatively large projects requiring long term financing on rare occasions, within Maine's 39 hospital network major projects occur frequently. By creating a broad-based, cooperative group, financial experts would be expected to be fully familiar with state of the art financing vehicles producing the best financing terms available.

Sharing Expertise. Know-how is worth huge amounts of money to any business as complex as Maine's typical hospital. Standing alone, it is a tremendous financial burden for small hospitals to remain current with the rapidly evolving science, electronics and technology associated with operating a 21st century hospital from either a medical or business perspective. And the rate of change is likely to accelerate in the future.

Individually, many hospitals now acquire know-how by paying expensive consultants or undertaking a risky trial and error process. Millions are spent by Maine hospitals each year purchasing the rights to new computer and systems software. Hospitals

make such investments because the potential long term benefits associated with upgrades are so profound, but few individual hospitals possess the high tech know-how required to make proper decisions without outside guidance. Indeed, some outstanding hospital administrators have described costly lessons learned as a result of making errors selecting computer technology which best fits a hospital situation.

Working cooperatively, hospitals can share existing know-how statewide and could be expected to share any developmental cost, on a pro rata basis, of emerging new technology, so that every hospital will have the benefit of the best available information at the lowest possible cost per hospital.

In summary, there will be a wide variety of large medical and business benefits to be gained when the concepts outlined here have been implemented. It is possible to envision potential hospital network cost savings of several percent each year (compared to present operating costs) until the optimum effects of cooperation and collaboration within the hospital network have been fully achieved and the affiliated hospital group is producing maximum benefits. Any savings generated hopefully will partially offset other inevitable cost increases and are absolutely essential to contain overall hospital cost growth into the future.

The Commission has been advised that the role of the Consortium should be limited to brainstorming, discussion and planning appropriate collaborative activities. Implementation of the Consortium's plans may require approval of the State through the Hospital Cooperation Act process, as amended pursuant to the proposal contained within this Report. Since the Commission recommends that market competition should only be employed under certain circumstances, state approval and ongoing oversight, as contemplated by the proposed amended Hospital Cooperation Act, is a necessary substitute for market checks and balances, as well as a vehicle for affording antitrust immunity for appropriate collaborative activities with anticompetitive consequences. The Commission has also been advised that the "Legislative Findings and Purpose" section of the proposed amended Hospital Cooperation Act is necessary to clearly articulate that the intent of the act is to displace marketplace competition to benefit consumers as to activities covered under the Act. Without such a statement, the activities permitted under the act might be subject to federal antitrust liability.

The Commission has also been advised that much of the collaborative activity contemplated is perfectly permissible under existing antitrust laws and would not necessarily require state approval through the Hospital Cooperation Act.

While planning and discussion, prior to implementation, of agreements is generally permitted under antitrust laws, some discussions themselves are inherently dangerous or represent illegal verbal agreements (such as discussions involving desirable prices). For these reasons, it would be beneficial for the Consortium members to have the benefit of antitrust counsel at its meetings to help it determine which proposals require state approval, as well as to ensure that the planning process itself does not constitute illegal activity such as verbal price fixing agreements.

Data collection and reporting on a consolidated basis to measure trends and progress is important. Such coordinated requirements, as spelled out in the State Health Plan, should be sufficient at the outset to fulfill this requirement.

Implementation of the plan to increase cooperation, collaboration and affiliation among Maine hospitals should proceed rapidly. 2006 should be targeted as the year those concepts become operational, on the voluntary basis referenced earlier.

Attachment – Proposed Anti-Trust Legislation

Hospital and Health Care Provider Cooperation Act

Section 1. 22 MRSA § 1881-A is enacted to read:

§1881-A. Legislative Findings and Purpose.

Health care costs in Maine have increased since 1998 to 18% of Gross State Product. The cost of a family health policy for Maine businesses and employees has increased by 77%, while median household incomes have increased by only 6%. Maine has the highest percentage of uninsured citizens in New England. Its hospital utilization rates are the highest in New England, and healthcare spending as a percentage of personal income ranks Maine the 6th highest in the nation. Between 1991 and 1998 (the last year that 50 states' estimates were available) Maine's per capita health care spending increased faster than any other state in the nation, averaging 7.3% per year. Maine's average adjusted inpatient hospital discharge cost has recently been higher than the national average and higher than the northeast region's average. The escalating costs of Maine's health care system are unsustainable and threaten the well-being of Maine people.

The Legislature has determined in light of these facts that it is necessary and appropriate to encourage hospitals and other health care providers to cooperate and enter into agreements that will help facilitate cost containment, improve quality of care and increase access to health care services. The Legislature intends that a cooperative agreement for which a certificate of advantage has been issued will not violate any law governing impermissible restraint of trade and specifically intends that such a certificate will provide state action immunity under the federal antitrust laws.

Section 2. 22 MRSA c. 405-D is amended as follows:

§1881. Short title

This chapter may be known and cited as the "Hospital and Health Care Provider Cooperation Act."

§ 1882. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Cooperative agreement. "Cooperative agreement" means an agreement among 2 or more hospitals or health care providers for the sharing, allocation or referral of patients, personnel, instructional programs, mental health services, support services and facilities or medical, diagnostic or laboratory facilities or procedures or other services traditionally offered by hospitals or other health care providers, or for the coordinated negotiation and contracting with payors, vendors, or employers or for the merger of 2 or more hospitals.

2. Hospital. "Hospital" means:

A. Any acute care institution required to be licensed as a hospital under section 1811; or

B. Any nonprofit parent of a hospital, hospital subsidiary or hospital affiliate that provides medical or medically related diagnostic and laboratory services or engages in ancillary activities supporting those services.

2-A. Merger. "Merger" means a transaction by which ownership or control over substantially all of the stock, assets or activities of one or more licensed and operating hospital or health care provider is placed under the control of another licensed hospital or hospitals or health care provider or providers or the parent organization of that hospital or hospitals or health care provider or providers.

3. Health care provider. "Health care provider" means physicians and all others certified, registered, or licensed in the healing arts including but not limited to nurses, podiatrists, optometrists, chiropractors, physical therapists, dentists, psychologists, physician assistants and any corporation organized under the Maine Nonprofit Corporation Act or an organization recognized as exempt from federal income tax under 26 United States Code, Section 501(c)(3) that is engaged primarily in the provision of mental health services.

4. Reviewing agencies. "Reviewing agencies" means the Attorney General, the department and the Governor's Office of Health Policy & Finance. These three agencies have joint authority with respect to applications filed under this chapter.

§ 1883. Certification for cooperative agreements

1. Authority. A hospital or health care provider may negotiate and enter into cooperative agreements with other hospitals or health care providers in the State if the likely benefits resulting from the agreements outweigh any disadvantages attributable to a reduction in competition that may result from the agreements.

2. Application for certificate. Parties to a cooperative agreement may apply for a certificate of public advantage governing that cooperative agreement. The application must include an executed written copy of the cooperative agreement and describe the nature and scope of the cooperation in the agreement and any consideration passing to any party under the agreement. The application and copies of all additional related materials must be submitted simultaneously to the reviewing agencies.

2-A. Letter of intent. Parties to a hospital merger agreement who intend to file an application for a certificate of public advantage for the merger transaction shall file a letter of intent describing the proposed merger with the reviewing agencies at least 45 days prior to the filing of the application for a certificate of public advantage.

3. Procedure for review. The following procedures apply to the review of the application.

A. The reviewing agencies shall evaluate the application in accordance with the standards set forth in subsection 4.

B. The department shall furnish copies of any letter of intent, application or decision to a person who requests copies and to a person who registers annually with the department for that purpose. A person may provide the department with written comments concerning the application within 30 days after the application is filed. The department shall provide the Attorney General and the Governor's Office of Health Policy and Finance with copies of all comments.

C. The reviewing agencies shall hold a public hearing in accordance with rules adopted by the department. The reviewing agencies, at any time after an application is filed under section 1883, subsection 2, or a letter of intent is filed under section 1883, subsection 2 A, may require by subpoena the attendance and testimony of witnesses and the production of documents in Kennebec County or the county in which the applicants are located for the purpose of investigating whether the cooperative agreement satisfies the standards set forth in section 1883, subsection 4. All documents produced and testimony given to the Attorney General are confidential. The Attorney General may seek an order from the Superior Court compelling compliance with a subpoena issued under this section. Intervention is governed by the provisions of Title 5, section 9054.

D. The parties to a cooperative agreement may withdraw their application and thereby terminate all proceedings under this chapter without the approval of the reviewing agencies, anytime prior to the issuance of a final decision under paragraph E.

E. The reviewing agencies shall grant or deny finally the application no less than 40 days nor more than 90 days after the filing of the application. Approval shall require the concurrence of all three reviewing agencies. The reviewing agencies shall issue a recommended decision at least 5 days prior to issuing a final decision. The recommended and final decisions must be in writing and set forth the basis for the decision.

4. Standards for certification. The department shall issue a certificate of public advantage for a cooperative agreement if the reviewing agencies determine that the applicants have demonstrated that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreement.

A. In evaluating the potential benefits of a cooperative agreement, the reviewing agencies shall consider whether one or more of the following benefits may result from the cooperative agreement:

(1) Enhancement of the quality of health care, mental health care, or related care provided to Maine citizens;

(2) Preservation of hospital or nonprofit mental health care provider and related facilities in geographical proximity to the communities traditionally served by those facilities;

(3) Lower costs and gains in the cost efficiency of services provided by the hospitals or health care providers involved;

(4) Improvements in the utilization of hospital or health care provider resources and equipment;

(5) Avoidance of duplication of hospital or health care provider resources; and

(6) Continuation or establishment of needed educational programs for health care professionals and providers.

In any certificate for a merger issued under this chapter, the reviewing agencies shall make specific findings as to the nature and extent of any likely benefit found under this paragraph.

B. The reviewing agencies' evaluation of any disadvantages attributable to any reduction in competition likely to result from the agreement may include, but need not be limited to, the following factors:

(1) The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents or other health care payors to negotiate optimal payment and service arrangements with hospitals, physicians, allied health care professionals or other health care providers;

(2) The extent of any reduction in competition among hospitals, physicians, allied health professionals, other health care providers or other persons furnishing goods or services to, or in competition with, hospitals or nonprofit mental health care providers that is likely to result directly or indirectly from the hospital cooperative agreement and its likely impact;

(3) The extent of any likely adverse impact on patients or clients in the quality, availability and price of health care services;

(4) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement; and

(5) The extent of any likely adverse impact on the access of persons in in-state educational programs for health professions to existing or future clinical training programs.

C. In evaluating the cooperative agreement under the standards in paragraphs A and B, the reviewing agencies shall consider the extent to which any likely disadvantages may be mitigated by any reasonably enforceable conditions and the extent to which the likely benefits or favorable balance of benefits over disadvantages may be enhanced by any reasonably enforceable conditions under subparagraph (2).

(1) In any certificate issued under this subsection, the reviewing agencies may include conditions reasonably necessary to mitigate any likely disadvantages of the type specified in paragraph B, subparagraphs (1) to (3).

(2) In any certificate issued under this subsection, the reviewing agencies may include additional conditions, if proposed by the applicants, designed to achieve public benefits, which may include but are not limited to the benefits listed in paragraph A.

D. The department shall maintain on file all cooperative agreements for which certificates of public advantage remain in effect. Any party to a cooperative agreement who terminates the agreement shall file a notice of termination with the department within 30 days after termination.

§ 1883-A Continuing supervision

1. Periodic reports. In any certificate issued under this subsection, the reviewing agencies shall require the applicants to report periodically on the extent of the benefits realized and, in the case of any certificate containing conditions, their compliance with any conditions issued under this chapter. The reviewing agencies shall evaluate the applicant's submission and compliance and within thirty days of receipt of the submission issue a report of their findings. Reviews are required as follows:

(a) For transactions not involving mergers, at least once in the first 12 months after issuance of the certificate; and

(b) For transactions involving mergers, between 12and 24 months after issuance of the certificate.

2. Supervisory proceedings. At any time, one or more of the reviewing agencies may initiate supervisory proceedings for the purpose of evaluating compliance with any conditions imposed in the certificate or for the purpose of determining whether, in their estimation, the likely benefits resulting from a certified agreement continue to outweigh the likely disadvantages attributable to any potential reduction in competition resulting from the agreement. Supervisory proceedings shall be governed by the procedures set forth in subsection 1883(3).

§ 1884. Judicial review of department action

Any applicant or intervenor aggrieved by a decision of the department in granting or denying an application, refusing to act on an application or terminating a certificate is entitled to judicial review of the decision in accordance with the Maine Administrative Procedure Act.

§1885. Effect of certification; applicability

1. Validity of certified cooperative agreements. Notwithstanding Title 5, chapter 10, Title 10, chapter 201 or any other provision of law, a cooperative agreement for which a certificate of public advantage has been issued is a lawful agreement. Notwithstanding Title 5, chapter 10, Title 10,

chapter 201 or any other provision of law, if the parties to a cooperative agreement file an application for a certificate of public advantage governing the agreement with the reviewing agencies, the conduct of the parties in negotiating and entering into a cooperative agreement is lawful conduct. Nothing in this subsection immunizes any person for conduct in negotiating and entering into a cooperative agreement for which an application for a certificate of public advantage is not filed.

2. Other laws specifically regulating hospitals. Nothing in this chapter exempts hospitals or other health care providers from compliance with laws governing certificates of need or hospital cost reimbursement.

3. Repealed. Laws 1995, c. 583, § 14, eff. April 1, 1996.

4. Contract disputes. Any dispute among the parties to a cooperative agreement concerning its meaning or terms is governed by normal principles of contract law.

§ 1886. Assessment

Except for state-operated mental health hospitals, all hospitals licensed by the department are subject to an annual assessment under this chapter. The department shall collect the assessment. The amount of the assessment must be based upon each hospital's gross patient service revenue. For any fiscal year, the aggregate amount raised by the assessment may not exceed $200,000. The department shall deposit funds collected under this section into a dedicated revenue account. Funds remaining in the account at the end of each fiscal year do not lapse but carry forward into subsequent years. Funds deposited into the account must be allocated to carry out the purposes of this chapter.

§ 1887. Application fee

Any application for a certificate of public advantage involving a merger must be accompanied by an application fee of $10,000, unless the hospitals seeking to merge each have less than 50 licensed beds, in which case the fee is $5,000. Any applications submitted that include as a party an entity not subject to the assessment described in § 1886 must be accompanied by an application fee of $5,000. The Attorney General shall place these funds into a nonlapsing dedicated revenue account and funds may be used only by the Attorney General for the payment of the cost of experts and consultants in connection with reviews conducted under this chapter.

ELECTRONIC MEDICAL RECORDS

Shifting from paper to electronic medical records (EMR) is an expensive, time consuming process, but the potential to improve quality and lower cost is great, and the Commission is urging Maine's hospitals to move in that direction. Consistent with that recommendation, the Commission also proposes that every Maine doctor and medical provider convert to EMRs using technology compatible with that employed by the hospitals.

Indeed, Dr. Dennis Shubert, the respected Director of the Maine Quality Forum testified before the Commission that implementing EMRs would have a more positive impact on quality than any other measure he could imagine. Likewise, in November 2004, Blue Cross & Blue Shield of Massachusetts announced its plan to spend about $50 million to electronically link doctors, hospitals and other health care providers in three Massachusetts communities covering about 2,000 physicians, plus hospitals, pharmacies and perhaps others. This is a large commitment, which demonstrates tangible support for the position espoused by Dr. Shubert.

Improving quality is important for the obvious reasons related to patient care and the long term ramifications on individuals directly affected, but also because the Commission has heard consistent testimony confirming the linkage between improved quality and reduced costs.

Witnesses have testified that EMRs are now ready for general use in Maine, even though there is still testing and developmental work underway at various locations around the country. The Commission believes the expertise and experience exists in Maine to make appropriate recommendations and selections. To make EMR decisions which best serve our state, a highly competent coalition fully aware of what exists today in Maine and staffed by recognized experts with technical, planning and financial knowledge should be utilized with strong representation from health care providers, government agencies, payors, consumers, and others, as proposed by the Maine Health Information Network Technology (MHINT) report of December 15, 2004. Every Maine hospital and other providers would be encouraged to participate to the maximum degree possible in this process.

The Commission believes it should be feasible to move forward at a rate which permits statewide hospital implementation of EMRs within a four to five year timeframe and keep Maine at the forefront in this process. Already, Eastern Maine Medical Center

reports working on EMR development for ten years and having invested over $33 million. Maine Medical Center has also made huge investments and impressive progress. Other hospitals are also heavily committed to EMR systems development, but many are only beginning the process and lack the resources to make major commitments without outside support. The Commission urges incremental moves forward as recommended in the MHINT report.

Overall, considerable progress has already been achieved within some Maine hospital systems, as is true in other parts of the U.S., and in certain developed countries around the world. That experience (particularly in Maine) builds confidence that a four to five year schedule should be achievable if adequate resources can be applied. Past experiences also demonstrate that potential benefits from a fully employed and effective EMR system will include:

- Provides maximum, accurate information, current and historic, at the point of care.
- Shares current information across sites.
- Facilitates better and more timely decision making by patients and physicians.
- Supports compliance with most appropriate clinical protocols.
- Provides immediate access to previous testing and imaging results.
- Minimizes transcribing errors.
- Minimizes dosing and drug interaction errors and ensures a complete order.
- Provides medication choice feedback at decision points.
- Improves security.
- Allows patient access to information, if desired.
- Provides the legal record.
- Processes all nursing documentation online.
- Automates quality tracking.
- Provides rapid and confidential data collection from many different patients, if desired and appropriately secured.
- Contains all patient safety data (allergies, organ diseases, drug sensitivities, etc.).
- May include admission/discharge standards.
- Accelerates administrative processing and minimizes clerical errors (i.e., billings, etc.).

There are other substantial quality and cost benefits which will accrue as EMR systems are implemented and their users (doctors, nurses and staff) become skilled utilizing the new technology. The MHINT report identifies an excellent financial return on an early phase investment. Among the most important long-term potential advantages of the EMR concept are the following:

- Eliminates repeated/duplicative paperwork.
- Medical records will be far more accurate and complete in one location.
- Forms an accessible historic record, including images, for each patient. Eliminates reliance on patient or family memories.
- Full and accurate information will be available anywhere, anytime.
- Permits the fastest medical intervention.
- Minimizes duplicative testing.
- Minimizes office and hospital visits.
- Reduces hospitalizations.
- Reduces medications and improves the appropriate use of medications.
- Standardizes treatments.
- Makes doctors, nurses and staff more efficient.
- Permits automatic quality tracking and reporting.
- Helps the process of developing standards across institutions. and
- Streamlines administrative functions, such as billings and coverage.

Under ideal circumstances, an individual's EMR would include all important data from birth to the present. However, most recognize it is not usually economically feasible to trace information back to birth when implementing a new EMR system for the first time. Therefore, the assumption is that only the most vital historic information on individuals will be incorporated into new EMR records, and the historic records search will only go back for a limited time duration. Such decisions should be left to the implementing committee.

The overall impact of EMRs along with other appropriate protocols should produce substantial improvements in the quality of care for all the reasons noted above and eventually contribute to lowering health care costs on a net basis.

The potential benefits of EMRs are important enough that Maine should act at the first opportunity to stimulate a phased system activation and assure the broadest possible

ultimate implementation. The long-range objective should be to have all Maine doctors and hospitals using EMR systems compatible with one another.

Major obstacles to implementing broad based EMR systems up to this point have included:

- Lack of agreement on which technology and software to utilize. The Commission believes thinking and experience has evolved in Maine to the point where knowledgeable people agree on how best to proceed and can identify which software to employ.
- Large, upfront expenditures for hospitals and doctors. The Commission recognizes that startup investments in Maine (beyond those already made) are likely to be significant and suggests a broad based approach to funding these costs. However, it seems clear that implementation and expenditures can be phased in over a period of years.
- Substantial ongoing system support, maintenance and upgrade costs in subsequent years after implementation. The Commission acknowledges that there will be such costs, but believes that savings resulting from the effective use of EMRs will more than offset annual operating costs once systems are fully implemented and operational. The MHINT report tends to support this assumption.
- Doctors will experience a meaningful productivity loss (i.e., loss of income) transitioning into the automated systems. The Commission believes this concern is valid and that many doctors will spend more time typing into computers or using voice activated systems for up to one year, and as a consequence will see fewer patients. Thereafter, physicians presently utilizing EMRs state that providers should be more productive and more effective for all the reasons stated elsewhere in this section. To help compensate physicians for the temporary efficiency loss during the brief transition period, the Commission recommends a modest increase in Medicaid rates for up to twelve months for those doctors who request such consideration.

To move the process forward at the most rapid rate consistent with achieving excellent results, the legislature should take the following action during its legislative session in 2005:

1. Support the recommendations of the MHINT report and encourage rapid progress.

2. Recommends state bonding to cover startup EMR costs, per the MHINT report, to help fund infrastructure related to statewide interconnectivity and developmental and implementation costs for hospitals. Significant additional funds should eventually be bonded by the state to support full EMR implementation. Hospitals, physicians , businesses and insurance companies will eventually be expected to contribute a fair share of total costs. Since the scope of Maine's efforts being recommended by the Commission are believed to be rare, if not unprecedented, it may also be appropriate to treat Maine as a statewide pilot project and request substantial startup financial support from the federal government and large private philanthropic organizations.

The amount of financial encouragement and support to be provided through state bonding should be of sufficient magnitude to stimulate action among all participants. The full extent of Maine's commitment should not be determined until projected costs have been fully estimated. However, the state should support phase #1 of the MHINT report, based on the current report. The Commission also recommends that state bonding for a portion of estimated costs be contingent upon substantial commitments from other participants.

The Commission recognizes that bonding millions of dollars for this project will represent a significant cost to Maine's taxpayers during a time when available resources will be inadequate to meet all demands. Large commitments are justified, however, because expected benefits to society in the form of improved health care quality and related cost savings will produce excellent returns on such investments. With federal and state sources paying over 40 percent of hospital costs in Maine, the anticipated payback to taxpayers is estimated to be very large., It has been virtually impossible for the Commission to produce a total cost estimate and specific ROI forecast because there is no American precedent for an overall undertaking of this scale (all hospitals and doctors in our state would be encouraged to participate and every citizen would have an EMR). With a population of only 1.3 million people, 39 hospitals and 3,600 doctors, Maine appears to provide a manageable, indeed excellent, implementation scope for the broad EMR process.

There are always risks associated with the implementation of concepts as broad and sweeping as the statewide EMR system envisioned in this recommendation. However, experts have testified, and the Commission believes that the risks are acceptable and manageable because implementation can be phased and the hardware, software and technology envisioned to make the ultimate EMR system design workable and

interconnected has been tested and proven in Maine applications. The Commission recognizes that EMR development and implementation will continue within Maine's three largest hospital systems independent of this recommendation, but without a master plan and substantial state financial support, statewide results could be disjointed and slow coming. Thus, the value of the MHINT report and it recommendations – followed by maximum possible collaboration.

For many doctors and small hospitals, the prospect of beginning the transition into EMRs without outside guidance and financial help appears to pose an overwhelming challenge. The risk of proceeding as outlined above, however, is reasonable, and the likelihood of success is good, if a coordinated statewide effort is undertaken and supported financially. Perhaps equally important, the ramifications of doing nothing to encourage this vital transformation to EMRs will be continuation of avoidable medical quality problems and excessive costs. Thus, the majority of Commission members view this recommendation as a high priority undertaking for hospitals and other health care providers.

Finally, the medical data automatically collected on a confidential basis (once all Maine hospitals and physicians are on-line) should be of huge value to those attempting to improve public health and health care practices in our state in the future. Some would argue that the ability to automatically collect reliable data from the state's entire population is one of the most powerful features of EMRs.

BUREAU OF INSURANCE RULE 850
PROPOSED REVISIONS

The Commission explored many possible ways to lower cost and improve the quality of health care in Maine. Among the areas examined was Rule 850. Several significant changes are recommended in this section of the report which a majority of Commission members believe will help achieve the objectives noted above.

An attachment to this section contains draft language believed appropriate to implement the Commission's recommendations if that is the desire of the Legislature.

Background. Rule 850 was originally promulgated in response to growth of managed care. A primary purpose was and is to ensure that people living in rural areas are not required to travel unreasonable distances to contracting providers when these providers are available locally. Rule 850 requires primary care services to be available within 30-minute travel time and specialty care and hospital services to be available within 60-minute travel time from an enrollee's residence.

The Dirigo statute amended Rule 850 to allow carriers to offer financial incentives to encourage enrollees to use designated providers up to twice the above travel times so long as:

- The carrier's entire network of providers meets the overall access standards elsewhere in Rule 850.
- The basis for identifying a provider beyond the established travel/distance limits is the provision of better quality services by these providers.
- The carrier demonstrates either: (a) that the superior care significantly outweighs any detrimental impact to covered persons encouraged to travel longer distances to access services; or (b) that the carrier has taken steps to mitigate any detrimental impact associated with the person's traveling longer distances to access services.
- The additional flexibility does not apply to primary, preventive, maternity, obstetrical, ancillary or emergency care services.
- The incentive is an additional benefit for use of a certain provider; i.e., there can be no diminution in benefits if the enrollee elects to use a provider within the existing travel/distance limits.
- The financial provisions apply to all of the enrollees covered under the carrier's health plan.

By providing incentives for consumers to use quality care, Rule 850 can serve to make consumers more aware of quality as they make decisions, and thus incent providers to improve quality. Improved quality can reduce complications and thus result in a reduction in preventable costs. Further, providers with well organized systems that support high quality health care typically are less expensive than other providers. Quality improvements can thus reduce costs across the health care delivery system.[22]

Employers have argued for the ability to provide incentives to travel to providers based on quality, but carriers have not offered any such plans to date. However, carriers say they might be willing to offer such plans if barriers to their doing so are addressed. Carriers have identified the following barriers:

- There has not been sufficient data available to identify quality providers.
- It was believed that costs associated with the following issues related to offering such plans have been prohibitive:
  - Identifying quality measures and demonstrating to BOI that a given providers has superior quality.
  - Rule 850's requirement that carriers demonstrate either: (a) that the superior care significantly outweighs any detrimental impact to covered persons traveling longer distances to access services; or (b) that the carrier has taken steps to mitigate any detrimental impact associated with covered persons traveling longer distances to access services.
- Even with the doubling of distance permitted by the Dirigo statute, allowed distances remain too small.

The Commission's recommendations to the Legislature are intended to address these and other issues.

First, the expectation is that quality differentiating measures for specialty services should become increasingly available over the next several years.

[22] Leatherman, Berwick, et al. (2003). The business case for quality: case studies and an analysis. Health Affairs v22(3); and Dimick, et al (2004). Hospital costs associated with surgical complications: a report from the private-sector national surgical quality improvement program. Journal of American College of Surgeons. v199(4)

In the meantime, one of the proposed changes to Rule 850 in the attachment would allow entire hospitals to be designated by the Maine Quality Forum[23] if they comply with all of the most current National Quality Forum voluntary consensus standards of safe practice for institutions. Dr. Shubert of the MQF has indicated that no hospitals currently comply with all of the standards, but that two to three may within 6 to 12 months. Using the NQF standards as the basis for an institution-wide designation is appropriate because they provide incentives for hospitals to strive to meet high standards, and all hospitals should eventually meet those standards. In the meantime, the MQF believes this is an appropriate way to designate some institutions as eligible for incentives under Rule 850. A majority of Commission members support this approach.

The Commission emphasizes that hospitals unable to meet these higher standards in the short run may still perform to excellent quality standards in virtually every respect. It is also worthy of emphasis that as specialty service quality measures become available, the MQF can and should proactively identify measures that will be deemed adequate for the purposes of providing quality incentive plans. No changes to rule or law are necessary for MQF to do this.

Another proposed change in the attachment removes any ambiguity regarding what a "benchmark" is by specifying that, "For a given measure or set of measures, the MQF will be the final arbiter regarding the level at which superior quality begins. The service of a designated provider must meet or exceed that level of quality." The word "final" is NOT meant to preclude parties from appealing any decisions made by the MQF.

The combined effect of these acts would be to remove the burden from carriers of having to identify quality measures and demonstrate to BOI that a given provider has superior quality.

A majority of the Commission also supports the concept of the following two part proposal. The Commission was not able to draft language in the time frame given, due to technical issues. Commission members supporting this recommendation would not support enactment of one part of this proposal without enactment of the other:

[23] The Commission notes that the MQF's authorizing statute states that the MQF is "governed by the [Dirigo Health] board [of Directors] with advice from the Maine Quality Forum Advisory Council," and that those two bodies would therefore have input regarding any MQF activity under these proposed changes to Rule 850.

- Expanding to a reasonable extent – but not eliminating – travel limits for quality incentives beyond the current 100 miles/2 hours. Current limits, for example, do not allow carriers to offer incentives for a patient to travel from Bangor to Portland or from Portland to Boston. Expanding the travel limits could allow incentives for such travel, and thus open new possibilities for carriers to offer quality incentives.
- Adding additional consumer protections to Rule 850 to ensure that consumers who are unable to travel greater distances for quality are not penalized; i.e., to protect consumers against disparities in plan payments that would remove the consumer's "choice" regarding travel.

In addition, the Commission unanimously recommends the legislative change shown in the attachment, from BOI "may" to BOI "must" consult with the Maine Quality Forum, while retaining "may" consult with other state agencies.

As a final recommendation, the Commission unanimously recommends extending the quality incentive program from July 1, 2007 to July 1, 2010.

There are no guarantees that the recommended changes will improve quality or lower cost, but they are intended to create an environment where prospects of accomplishing both goals are enhanced.

Attachment – Draft Language Pertaining Rule 850

1. **Proposed Changes to Rule 850**

6) The financial incentives must permit the provision of better quality services. The Superintendent will consider the following criteria in determining whether the carrier has met the quality requirements of this paragraph:

a) A designation for better quality services ~~must be at the specific service level and not the institutional level except that~~ may be at an institutional structural level, a service process and outcome level, or both.

(i) To be designated at the institutional structural level, an institution must comply with the all of the most current National Quality Forum voluntary consensus standards of safe practice for institutions. Compliance must be verified by the Maine Quality Forum, the Department of Health and Human Services, or another independent organization acceptable to the Bureau of Insurance

(ii) specialty physician services may be designated on a practice-wide level as long as the carrier can demonstrate that:

(~~i~~A) The designated specialty practice has either superior clinical outcomes or both superior processes of care and superior structures and systems of care. If documented consumer experience is available, the designated specialty practice is supported by positive consumer experience with care. Any standards, data or findings used to demonstrate superior quality must meet the criteria identified in sub-paragraphs (c), (d) and (e), respectively;

(~~ii~~B) To the extent data is available, the designated specialty practice exceeds performance standards or credentials of specialty practices providing comparable services;

(~~iii~~C) The designated specialty practice utilizes quality management activities that promote effective care, such as automated clinical information, computer-based clinical decision support systems or the application of performance and outcome measurement for quality improvement initiatives; and

(~~iv~~D) The designated specialty practice has a contractual arrangement with the carrier or its designee requiring external oversight of care quality as demonstrated by routine data submission and review to assess compliance with evidence-based protocols, performance and outcome measurement, and participation in quality improvement initiatives.

b) The demonstration of a better quality service by the designated provider must be based on a comparison with competing services available within the travel limits in subsection 7(C)(2) and must be based on either clinical outcomes or both processes of care and structures and systems of care. If documented consumer experience is available, the

service of the designated provider must be supported by positive consumer experience with care.

c) The standards used to demonstrate a better quality service must be documented in peer-reviewed literature and either nationally recognized or evidence-based.

d) The data used to compare providers of a service must be reliable and consistent across providers.

e) The findings of better quality must be verifiable as statistically significant using objective and independent analysis.

f) ~~The service of the designated provider must meet or exceed benchmarks of quality that are evidence-based. Relative performance should exceed other competing providers when evaluated against standards that have no evidence-based benchmark.~~ For a given measure or set of measures, the MQF will be the final arbiter regarding the level at which superior quality begins. The service of a designated provider must meet or exceed that level of quality.

g) If multiple quality measures exist for a given service that meet the requirements of this subsection, then quality differences should be substantiated by more than one quality measure.

2. **Proposed change to Title 24-A: Maine Insurance Code; Chapter 56-A: Health Plan Improvement Act (Heading: Pl 1997, C. 792, @2 (Rpr)); Subchapter 1: Health Plan Requirements (Heading: Pl 1997, C. 792, @2 (New)); Sec 4303 (1).**

"A. (TEXT EFFECTIVE UNTIL 7/1/07) Upon approval of the superintendent, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:

"…(5) The carrier establishes to the satisfaction of the superintendent that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The superintendent must consult with the Maine Quality Forum established in section 6951 and ~~the superintendent~~ may consult with other state entities, including the Department of Human Services, Bureau of Health ~~and the Maine Quality Forum established in section 6951~~, to determine whether the carrier has met the requirements of this subparagraph. The superintendent shall provisionally adopt rules by January 1, 2004 regarding the criteria used by the superintendent to determine whether the carrier meets the quality requirements of this subparagraph and present those rules for legislative review during the Second Regular Session of the 121st Legislature; and…

"…This paragraph takes effect January 1, 2004 and is repealed July 1, ~~2007~~ 2010."

THE HEALTH CARE PAYMENT SYSTEM

Cost Shifting

Reported cost shifting among the various payers of hospital services in Maine stimulated the Commission to examine this issue in-depth. For the uninformed, the extent of shift proved to be surprising – and one which has created significant problems for some payers of hospital services in Maine. Public payors – Medicare and MaineCare (Maine's Medicaid program) – pay for services at some factor less than charges, so providers shift that deficit into the charges submitted to private carriers. Public payors must balance program costs against the tax burden borne by citizens. As safety-net providers, public payors cover the medical costs of some of the most high risk patients and services not generally covered by private insurers, such as the lifetime costs of disabled children. Although the Commission is not recommending these, rates of reimbursement could be increased with one or more of the following tradeoffs: (a) increasing taxes; (b) reducing benefits to people in need, including benefits that support some individuals whose private coverage has been exhausted; (c) reducing the number of people served by public programs, thereby increasing the number of uninsured and increasing provider costs from bad debt and charity care. Additionally, in order to address rising health care costs, some employers must increase employee out-of-pocket costs or reduce or limit benefits.

It would be difficult to imagine a more complex payment system than that which exists today for hospitals. Last year, one Maine hospital reported that it billed approximately $139,000,000, collected approximately $79,000,000, and earned some $200,000. It stated that, as a percentage of the hospital's full costs, payments received equated to these percentages: Medicare 80%, Medicaid 75%, Self Pay Unreported and Insurance 143%. In other words, government payers paid less than full costs, while insured payers paid far more than full costs.

A Maine Hospital Association sponsored report recently stated that Medicare and Medicaid patients in Maine utilize 58% of hospital services, but pay only 43% of total revenues. That shift creates an obvious burden for commercial and self-pay users who utilize 42% of hospital services, but pay 57% of revenues. Clearly, those covered by private insurance, in one form or another, and individuals who pay on a direct basis are subsidizing government payers. The current payment structure poses problems for hospitals (and other health care providers) and is unfair to individuals and businesses in Maine who purchase

private insurance and pay an excessive share of the costs. The problem is more troublesome because, as Maine's population ages (as predicted), more will be covered by Medicare which does not pay full hospital costs. While Medicaid likewise pays below cost, that program covers low income citizens who would otherwise have incurred bad debt or charity care at Maine's hospitals. Still, the lack of adequate reimbursement from the uninsured, Medicaid and Medicare causes a cost shift to private payers which increases health insurance costs and affects Maine's economy and well being. [24]

The Commission recognizes that cost shifting (in its most undesirable form) has been a way of life in health care for many years. Moreover, the basic payment structure is almost certain to continue into the foreseeable future. Unfortunately, many Maine hospitals report cost shifting implications comparable to the hospital example cited above.

While the major focus of this Commission has been on recommendations intended to either improve quality or lower annual hospital costs, it has also taken into consideration expert testimony related to alleged Medicare payment shortfalls in Maine compared to other states. The Center for Medicare and Medicaid Services (CMS) told the Commission that in 2003, Medicare reimbursed Maine hospitals for only 92% of the inpatient expenses of providing services to Medicare patients. The source of this problem appears to be a combination of high Maine hospital costs and federal payments which are too low. Closing the gap between Maine's costs and costs for similar care in other states should reduce a portion of the Medicare shortfall.

The remainder of the shortfall is due to the federal formulas used to determine payments. For Maine, those formulas have not produced payment percentages comparable with the average state. CMS explained to the Commission, however, that the Medicare Modernization Act (MMA) will help hospitals in all states, particularly rural hospitals. CMS told the Commission that 57% of Maine's hospitals are classified as rural, and that the absolute effect of the MMA is that total payments to Maine's acute care non-CAH hospitals are projected to increase from $485 million in 2004, to $514 million in 2005, an increase of 6.0%. That value may change modestly because two additional hospitals have been

[24] The Commission also notes that Dr. Kane's presentations showed that the percentage of patients covered by Medicare and Medicaid does not explain differences between profitable and unprofitable hospitals. Rather hospitals that are struggling financially appear to be struggling because of (a) low patient volume and (b) a high proportion of patients suffering from ambulatory care sensitive conditions which could, in many cases, be best prevented and/or treated in an outpatient setting.

designated as CAHs this year, raising the total in Maine from eight to ten. The increases will help, but to the extent that the MMA fails to close the remaining gap to full payments of costs, the Commission recommends strong corrective efforts by Maine leaders.

The Commission urges Maine's legislators to clearly express their views to the federal government that our state must receive still higher Medicare payments and urge our Congressional delegation to continue to press for improved Medicare payments as well. Even though Maine's situation has improved, Maine deserves the same Medicare (100% of costs) payment treatment as other states.

Medicaid payments to hospitals are also well below full cost, but given the state's overall budgetary challenges, the Commission is unwilling to recommend any substantial across-the-board increase of hospital Medicaid payments as a percentage of hospital costs this year.

Medicaid payments to physicians (which reportedly have not been increased on an across-the-board basis since 1983) also pose a major problem. The ramifications affect hospitals which often are required to provide care to Medicaid patients because doctors cannot afford to service the individuals. The Commission believes every effort should be made to increase Medicaid payments to physicians as soon as possible, but recognizes Maine's budgeting constraints.

The Commission also urges Maine's Congressional delegation to work to maintain the Medicaid program's current funding mechanism, as changes to the current mechanism could jeopardize both the financial health of Maine's hospitals and Mainers' access to health services.

The Commission's long term objectives are to have its broad recommendations implemented so that hospital costs will drop, allowing the current levels of Medicaid payments to cover more individuals and a larger percentage of Medicaid patients hospital and physician costs in the future.

A reasonable expectation for Maine would be for Medicare and Medicaid compensation percentages to gradually increase until each government source is paying 100% of its fair share of costs by the end of this decade, which would allow private payers and private insurers to pay on a fair share basis as well. Cost related to bad debts and free care should be shared equally in the long run.

Cash Flow

The Commission also recognizes an issue with MaineCare payments to hospitals. MaineCare pays Maine's hospitals prospectively on a weekly basis through Periodic Interim Payments (PIP). When the fiscal year closes, hospital records are audited. At audit the hospitals' actual costs are reconciled against MaineCare PIP payments and settled. Since the early 1990's, the state's PIPs have been significantly lower than hospital experience with MaineCare utilization and have not been adjusted upward. This has resulted in large settlements and delays in hospital payment for services rendered.

Currently a number of hospitals are contesting settlements they believe are owed to them from 1993-2002. In addition more recent audits (2003-2004) are being completed, and it is anticipated that additional settlements will be due to hospitals. Hospitals have also requested that the State increase its PIP payment schedule in the future so hospitals receive more realistic interim payments; this would reduce the size of settlements at audit, allow more timely payment of MaineCare's hospital costs, and improve cash flow to hospitals, which should help mitigate the need for price increases.

The precise amount of settlements owed hospitals is pending court action and finalization of audits and/or negotiations. The PIP underpayment issue, which results in slow payment to hospitals from MaineCare, has developed over the last decade and has increased with the recent growth in MaineCare enrollment, volume, and utilization. The Commission urges continued vigilance on remedying these large and multifaceted issues**.**

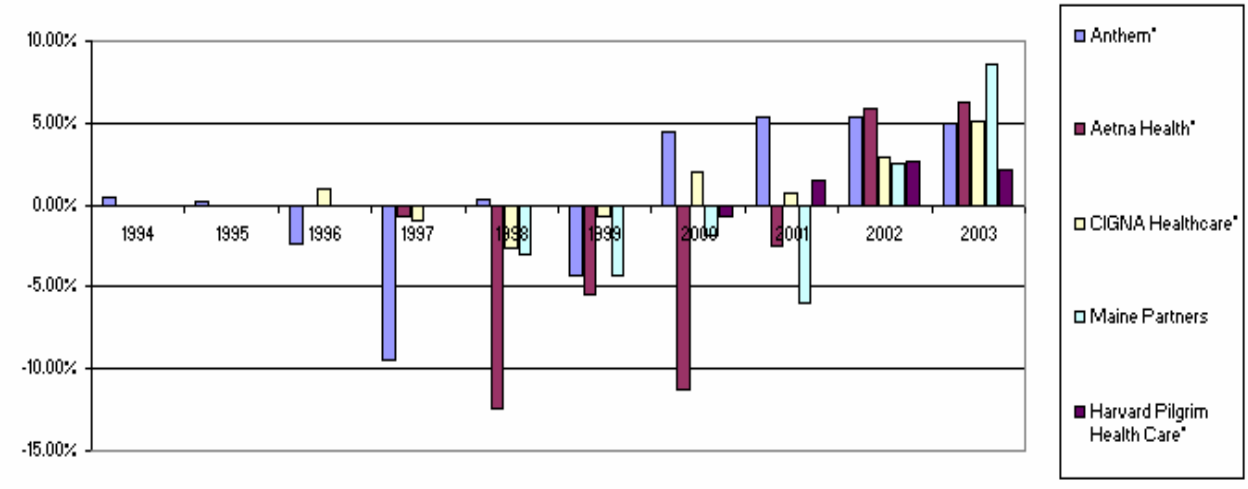
Putting hospital payment systems back into reasonable and fully equitable alignments, and hospital billing systems into a business-like condition, should be the goals of all parties involved. Federal and state governments will have to be fully engaged to achieve the objective outlined above. And, equally important, Maine’s hospital network must be fully cooperative, as we move forward placing greater emphasis on reducing operating costs through efficiency gains.

The potential exists to lower hospital costs and provide meaningful relief to private payers (insured and uninsured) as the federal government transitions into paying its full fair share of realistic costs and the State of Maine improves the timeliness of its payments. Maine leaders should encourage continued federal increases until full Medicare equity is achieved. Maine should pay its obligations on a current basis and Maine hospitals stay focused on becoming more efficient.

HEALTH INSURANCE

The Dirigo Health Reform Act that created this Commission recognized the health care spending could be brought under control only if all the major players in the health care system work together and bear some responsibility to restrain the growth in both their expenses and their revenues. For example, in addition to asking hospitals to voluntarily limit their cost increases and operating margins, the Act asked insurers to voluntarily limit the pricing of their products to a level that supports no more than 3% underwriting gain for the carrier's fiscal year beginning July 1, 2003 and ending June 30, 2004. The Act also implemented new insurance regulations to improve reporting and gain more insurance transparency and, importantly, establishes new rate regulation to require insurers in the small group market to spend at least 78 cents of every premium dollar on health care benefits. A primary purpose of these measures was to ensure that any savings to the system that accrue from the actions of hospitals and other providers would be passed on to Maine consumers. Recent rapid increases in profits reported by some insurance companies (see figure 5) and the huge compensation levels paid to some senior executives have raised concerns as to whether savings generated will be passed to consumers.

Figure 5. Maine Insurers, Net Profit Margins, 2000-2003*



Source: Annual financial statements

*Notes:

- Data not available for all insurers in earlier years.
- Anthem purchased Blue Cross Blue Shield of Maine (BCBSME) in 2000. Data for 2000 is a partial year. Data for 1994-99 is for BCBSME.
- Aetna Health (formerly Aetna U.S. Health Care) was previously NYLCare - purchased by Aetna in 1998.
- CIGNA was previously Healthsource - purchased by CIGNA in 2000.
- Harvard Pilgrim numbers include business in other New England states.

Recommendations

1. The Commission believes it is essential that all major players bear some responsibility in containing health care spending. Insurers have an obligation to use their purchasing power to obtain excellent quality care, to broker lower prices and return most savings resulting from reduced prices to their customers. The carriers should, of course, be expected to generate reasonable profit rates and hold adequate reserves. But, those must be in balance with margins proposed for hospitals and other providers.

   Since this Commission is recommending voluntary limits on hospital profits and on cost growth, those most affected should be confident that the vast majority of future savings generated by such limits – and by the efficiency-increasing recommendations implemented by hospitals – will be applied to the benefit of Maine people in the form of lower health insurance premiums and/or significantly improved benefit coverage.

   In focusing on hospitals, the Commission's work did not include an analysis of the role insurance companies have played in the rapid rise in healthcare spending and premiums, or of the scope of the Bureau of Insurance's (BOI) activities in regulating the industry. The Commission therefore recommends that the legislature charge the BOI and/or create a commission similar to the Commission to Study Maine's Hospitals to analyze insurance company finances, pricing, plan design, reserves, profits, and overall role in driving or mitigating health care spending, in order to ensure that savings are passed on to Maine consumers.

2. The Commission heard convincing testimony that hospitals incur sizable administrative expenses due to a billing and payment system that is fragmented and complex. For instance, hospitals reported extensive staff time required to verify differing eligibility status of publicly and privately insured patients. While vendors currently provide verification, hospitals reported that the available systems may not include all payers and that transaction costs are expensive. Simplifying the process that hospitals must go through to verify eligibility and secure payment from public and private insurers can therefore bring meaningful and immediate savings to Maine's hospitals, employers, and consumers.

   To achieve this end, the Commission recommends the creation of a single portal through which hospitals can access member eligibility, benefit, and claims information

from multiple insurers. A Commission subcommittee heard an impressive presentation from the New England Health Electronic Network (NEHEN), an organization established by several large payors and providers in Massachusetts, which provides a single point for connectivity between payors and providers to facilitate the transfer of data relating to eligibility, benefit coverage, and claims status. Participants have shared examples of the effectiveness and efficiency associated with this process. NEHEN representatives are open to a variety of possibilities in sharing their knowledge and experience with Maine, and there may be other vendors with comparable or even superior technology.

Pursuing such a concept for Maine should bring efficiency and effectiveness gains to this component of the health care system.

GOVERNANCE

Maine's 39 community hospitals are organized and governed in a number of different ways, each tailored to suit that hospital's special situation. Some are a part of large systems, others a part of small systems, and still others function as virtually stand alone entities.

Typical alignments have a Board of Directors and Chief Executive Officer in place for each hospital, irrespective of the structure in which the hospital operates. Although individual hospital governance issues deserve continuing attention at the local level, the Commission considered and rejected any attempt to standardize local hospital governance in our State. The Commission recognizes that excessive outside tampering with corporate structures can be unsettling locally where management organizations and hospital cultures have evolved over the years. Therefore, primary day-to-day decision making, pricing and fiduciary responsibilities should remain within the purview of existing organizational structures.

The move toward a significant degree of statewide cooperation within Maine's hospital network (i.e., the proposed Consortium in Section 2) will represent a change for many of Maine's community hospitals. But, the potential to generate essential improvements through more cooperation, affiliation and larger scale efforts is so significant that the Commission urges hospitals and their medical staffs to embrace such concepts and implement them with enthusiasm. Hospitals themselves will benefit, but the ultimate beneficiaries of better coordination and more cooperation within the community hospital network will be Maine citizens.

Beyond the voluntary guidelines recommended elsewhere in this report to stimulate more hospital affiliations, the Commission Chairman also suggests that each hospital or system Board of Directors reexamine its present management structure and management compensation packages.

Maine's hospitals and systems now vary in size and complexity from several large and relatively complicated organizations to many smaller, simpler management arrangements. In each case, the executive team should be sized to fit the unique requirements of its organization; and management compensation should be at levels sufficient to attract and retain individuals with the qualifications required to perform well in their respective assignments.

The Commission Chair has observed that many Maine hospitals appear to be effectively organized and tightly managed, but, the Chair also offers these observations and recommendations.

- Some current hospital management organizations appear to be top heavy with senior managers and could become more efficient and cost effective if reorganized. Each Board and Chief Executive Officer should reexamine its organization and, if appropriate, act to assure the most effective and efficient leadership possible, by eliminating unnecessary positions and consolidating functions. Many of Maine's hospitals are already lean and efficient at senior levels, but some would benefit from streamlining.
- Some hospitals/systems have senior level employees with staff assistants, performing sales/marketing functions. With the shift toward greater emphasis on affiliations and hospital cooperation, such functions and related costs should be substantially curtailed, with resulting savings.
- Management compensation levels appear to be higher than necessary (in some situations) to attract and retain excellent managerial leadership. It was difficult, if not impossible, to develop informed opinions in every case because compensation levels are sometimes obscured by complicated business structures. Hospital/System Boards should reexamine senior management compensation practices to assure that compensation rates are consistent with similar executive positions in Maine, as well as compensation paid in the health care industry in comparable states in the U.S.

A majority of Commission members believe every hospital or system in Maine should publish (i.e., report) for public dissemination, the total compensation received by its five most highly compensated executives each year. Such reports should include income from all sources related to hospital activities. Disclosures should begin in 2005.

The Chairman and Commission members recognize that changes related to senior management staffing levels and management compensation should be phased in, but where changes are deemed appropriate, the change process should be initiated as soon as possible.

Reducing the number of senior management positions and tightening senior management compensation levels in some cases will have relatively little direct impact on total hospital costs. Nevertheless, the indirect benefits of tightening managerial costs, where

appropriate, are important. Such steps are essential gestures at a time when hospital costs are increasing faster than the rate of inflation, most specifically, wage inflation; health care costs pose severe burdens to taxpayers; private insurance rates have become unaffordable for many individuals and organizations; and the number of uninsured is growing rapidly.

Hospital Boards make tremendous contributions to their institutions in many ways, but in the present environment they must become more sensitized to the importance of controlling costs throughout their organizations. Sending appropriate messages to employees are key Board and CEO functions, and tightening the organization and lowering costs should begin at the top. Likewise, payers will be more willing to accept price increases if they perceive hospitals to be making every effort to control costs from the top of the organization to the bottom.

In summary, it is the Chairman's view that many hospitals in Maine are managed efficiently today with adequate controls, but that some hospitals would benefit from tighter organizational structures. In making these recommendations, he is confident that Maine's hospital network overall can be managed with fewer executives and that total management compensation growth can be arrested for an extended period of time in some situations. Resulting cost savings should be achievable with no negative impact on hospital quality or access. Most important, the messages sent by streamlining management organizations and costs will have a beneficial impact on health care providers and throughout Maine's broad group of payers.

CONTROLLING COSTS AND PASSING SAVINGS TO CONSUMERS

Financial studies evaluating the overall economic health of Maine hospitals reflected encouraging trends. The majority of Maine hospitals are achieving profitable results and positive cash flows. Some, in fact, are reporting truly excellent financial accomplishments within a Maine hospital network comprised exclusively of nonprofit institutions.

During the eight years, 1996 through 2003, Maine hospitals generated aggregate operating margins between two and five percent each year. Between 1996 and 2002 (the most recent comparative data available), the profitability of Maine's median hospital out performed the median hospital in New England, and in six of the seven years, Maine hospitals out performed their counterparts in the United States as measured by the same standards.

Aggregate total margins during the same seven years varied between a low of two and a high of eight percent per year. Thus, Maine hospitals overall have enjoyed a profitable decade in real and relative terms, confirming that many are in very good financial health. During the period of relative prosperity, however, nearly one-third of Maine hospitals have been incurring losses each year.

Hospital boards and administrations have obviously been committed to operating in the black. Since most hospitals have been successful, they deserve credit for achieving that important objective.

During this recent period of strong financial performance within Maine's hospital network, their costs have continued to increase much faster than most inflation rates or the average growth in personal income. For example, during the years 2000-2003, total hospital operating expenses increased at an average rate of approximately 10% per year, and the upward pressure of health care insurance rates, in excess of non-health care inflation rates has been continuous.

In Maine, the problem has been exacerbated based on information released in the most recent Census Bureau data which compared the 1998-2000 period with the years 2001-2003 and showed the following:

- Maine's median annual household income dropped from $39,815 to $37,619.
- And the percentage of Mainers living in poverty jumped from 9.8% to 11.8%.

On both accounts, Maine's performance trends ran counter to those reported for Vermont, New Hampshire and the United States as a whole. In part, the reversals have reflected the impacts of losing some 18,000 manufacturing jobs in our state over the past three years. Business representatives cite high health care costs as a prime source of economic problems in Maine.

The voluntary 3.5% target on hospital expenses and 3% target on profits imposed last year are reported by some hospital CEOs to have helped control certain expenditures. At least one large hospital implemented a temporary price reduction because profit trends during the year were exceeding the guidelines. Those are encouraging reactions.

However, Jim Parker, former Anthem Vice President and General Manager, who provided testimony on behalf of the Maine Association of Health Plans, reported seeing no significant hospital cost reductions yet as a result of savings related to the targets, and opinions differ as to whether voluntary targets should be continued. At least some hospital administrators support continuation, but with a higher target level of 4.5% for cost increases, while Mr. Parker would discontinue the targets all together. Mr. Parker argued that while the voluntary targets were seen as goals to limit hospital administrative expenses and profits, there have been instances where hospital prices still increased at twice the target limits and/or hospital discounts to insurers have been reduced.

Given the overall state of Maine's economy (reflected in the two Census statistics noted earlier) our state can not afford continuation of recent health insurance rate increases or those predicted for the near future. A July 2004 national survey by Marsh, Inc. for employers with 2,000 or fewer employees showed a 9.8% health insurance premium rise in 2003, following an 18.4% increase in 2002. That same survey reported that 1,900 employers nationwide predicted a 14% jump this year. Other reports have reflected average premium increases of 11.2% for most recent timeframes. Still other consumer groups report that insurance premiums paid by Maine workers have increased over 40% since 2000, far outpacing the growth in wages. Experts are quick to point out that deductibles and co-pays are increasing rapidly and must be given full consideration in evaluating premium trends, since cash payments are as real to the payer as the insurance premiums.

While exact numerical expectations may vary from one source to another, most recent forecasts are predicting that double-digit annual health insurance increases lie ahead.

Continued health care cost growth of such magnitude slows Maine's economy and disrupts the lives of many of our fellow citizens. An August 2004 *New York Times* feature article highlights included the following:

- "Government data, industry surveys and interviews with employers big and small indicate that many businesses remain reluctant to hire full time employees because of health insurance…"
- "Health care is a major reason why employment growth has been so sluggish." Chief Economist at Wells Fargo.
- Because of the cost of health insurance "we are making decisions not to hire people" said Steve Hayes, owner of Custom Electronics in Falmouth, Maine. Mr. Hayes said his health insurance premiums had risen by 22% a year in the last four years.

The Commission believes there is an indisputable link between the cost of health care in Maine and the state's economy – particularly as related to job growth. Both private and public sectors of the economy are affected.

Thus, the primary thrusts of this report are significant recommendations intended to change the business environment within Maine's overall hospital network so that efficiency improves, resulting in cost savings, with no degradation in quality or patient care. Another key objective is to encourage state efforts to bring federal Medicare payments in Maine up to the national average, *i.e.*, 100% of costs which should also help mitigate insurance premium increases.

Lowering hospital cost growth over time and increasing Medicare revenues as a percentage of costs are absolutely essential. Equally important, is the need to pass along savings to payers. Maine hospital prices and health insurance premiums must gradually fall in line with New England and national averages if Maine's citizens are to experience the full benefits of a competitive statewide economy.

Since it has been reported to the Commission that most Maine hospitals are already profitable, with good cash flows, adequate reserves and with plant ages comparable to national averages, the stage should be set to pass along most benefits of future savings to

citizens, employers and private payers. Indeed, it is imperative that such happen and insurance companies have vital roles in that process as noted elsewhere in this report.

To assure compliance with the requirements to control costs and pass along the benefits of cost improvements, the Commission suggests the following:

1. Hospital boards and administrators not already doing so should develop and implement strategic plans targeting annual implementation of efficiency improvements. Those plans should include phased cost goals each year, with the long term objective being to slow or reverse cost growth until Maine hospitals become fully competitive at the national level.

2. Legislation should be enacted which sets targets for hospitals (and hospital systems') operating margins and total margins at 3% and 5% respectively (see the chapter "Standardized Reporting and Voluntary Targets"). If earnings are trending in excess of those targets, then hospital pricing should be adjusted (i.e., reduced) to assure that the goals are not exceeded in the next fiscal year. The objective of this legislation will be to permit the most successful hospitals to generate excellent results (in 2003, the average operating margin of the top-performing one-third of Maine's hospitals was 3.7%, and the average operating margin of the middle-third was 2.7%) by non-profit standards, but still be motivated to reduce prices whenever the opportunity presents itself. State monitors should be cautious, however, because regulations which limit profitability often run the risk of diminishing motivation to improve efficiency – and improving hospital efficiency is the highest priority. Therefore, the Commission recommends that the suggested legislation carry a five year sunset provision giving all parties an opportunity to review the initial results of this policy before legislation is implemented for an indefinite period.

3. The Commission also proposes that Maine hospitals and systems implement voluntary spending targets to help control total annual cost increases (see the chapter "Standardized Reporting and Voluntary Targets"). These voluntary targets would be retained for three years. The targets are intended to set expenditure guidelines and help control short term cost growth. The primary objective would be to implement efficiency improvements and cost controls so that final results remain within the guidelines.

Hopefully, these targets will stimulate implementation of more cost controls which slow hospital cost and pricing growth while other economic sectors in Maine improve, thus helping make health care more affordable to Maine citizens.

Even though profit and spending targets appear necessary and are an acceptable way in the short term to stimulate improvements, the Commission is reluctant to recommend targets on spending, revenues or capital investments as part of a long term strategy. In the long run, Maine will be best served if every hospital board, manager and employee recognizes the importance of operating at maximum efficiency levels (consistent with high quality) and that fully effective cost controls become self imposed as part of every hospital's normal routine.

The best case scenario will be for hospital boards and administrators to develop and implement effective annual plans which achieve continuing pricing reductions and quality improvements for extended periods with minimal government involvement. Equally important, each hospital is strongly encouraged to participate as an affiliate within the consortium of Maine hospitals (see section 2 of this report) which together will strive to achieve meaningful quality improvements and cost reductions in areas where combined efforts should improve results.

Although reluctant to support long term spending targets, the Commission believes it is essential that Maine hospitals' costs and prices be reduced (in relative terms) and that insurance rates must become competitive and affordable. If cost trends begin moving in a favorable direction, the approaches recommended here should be continued, with results monitored annually. Hopefully, spending targets can be eliminated in the future. On the other hand, if few of this report's recommendations have been implemented or if hospital pricing growth continues unabated after three years, other actions may be necessary.

SPECIAL SITUATIONS

The adequacy of Maine's community hospital network to provide high quality, cost effective care to all Maine citizens was evaluated in depth. Recommendations found in this report reflect the Commission's broad findings and are intended to impact to varying degrees on all Maine hospitals.

The Commission also developed opinions relative to localized situations in our state. Applicable observations and related recommendations are addressed in this section of the report. The issues identified can most appropriately be resolved by affected hospital board decisions if responsible boards concur that this Commission's observations are applicable in their situation. Local concerns should receive appropriate emphasis, along with reasonable consideration of statewide ramifications in each situation.

For purposes of clarity, the Commission emphasizes its position that what follows are its observations and recommendations, but that any decisions to act are left up to responsible boards.

Issue No. 1

The Commission considered and rejected making specific recommendations which could have resulted in the closing of two Maine hospitals and the merger of two others. We ultimately concluded that consideration of such an important act be left to responsible hospital boards. It was always intended that responsible boards have final decision making authority relative to any merger or action which would trigger a significant structural change for the organization.

Thus, this report contains no specific recommendations relative to hospital closings or mergers. Nor was there ever any consideration of recommending closure of any rural hospitals in Maine.

However, a central theme of this report is the Commission's conclusions that there are significant benefits to be gained in Maine through more hospital cooperation, collaboration, consolidations and/or affiliations. That view applies to working together as an entire 39 hospital network, but also is germane as related to the potential for improvement when two hospitals decide to get together on a fully cooperative basis within a small geographic area.

There are several hospital situations in Maine where rethinking, and perhaps reorganizing, business relations between two hospitals holds great promise of improving

quality and lowering costs. In those cases, two hospitals together appear to represent too much hospital infrastructure and costly duplication. The Commission's conclusion is that every hospital board should be proactive in evaluating possible opportunities to minimize excessive duplication of services, equipment, facilities and staffing in its area and increasing utilization to a cost effective level by working more closely with one or two other hospitals. The form of more cooperative relationships adopted can vary from case to case and should fit local circumstances. Such decisions are best left to local boards.

Issue No. 2

Maine has eleven Critical Access hospitals, and others are giving serious consideration to becoming Critical Access. In many cases, the Critical Access (C.A.) designation appears to be producing excellent results – particularly when the C.A. hospital is tied into an effective working relationship with a larger hospital within a system.

The Commission heard powerful testimony regarding the many benefits the Rumford Hospital has received as a C.A. hospital through its relationship with CMMC in Lewiston. Rumford's leadership is absolutely convinced that people in the Rumford service area, as well as the hospital itself, have gained in virtually every respect by being a C.A. hospital tied to CMMC. Other C.A. hospitals have reported revenue increases between one and two million dollars during the first year operating under that status.

We believe more Maine hospitals (perhaps as many as five) would benefit by transitioning into a Critical Access status. The shift to more C.A. hospitals will increase government costs in some situations, but will result in more Medicare payments into Maine. The C.A. concept appears ideally suited for hospitals in most of Maine's more remote areas. The impact of increasing the number of C.A. hospitals should improve overall quality and lower costs within Maine's total hospital network.

Presently C.A. Hospitals:

- CA Dean Memorial
- St. Andrews
- Rumford Community
- Calais Regional
- Mount Desert Island
- Blue Hill Memorial
- Millinocket Regional

- Penobscot Valley
- Mayo Regional
- Houlton Regional
- Bridgton Hospital

The Commission concluded that it lacked sufficient specific information to identify by name hospitals which should consider changing to C.A. status. That decision is best left to local boards. Potential implementation of this general recommendation, however, could increase the number of C.A. hospitals in Maine by up to 60%. Within the cooperative and affiliated approaches encouraged elsewhere in this report, the Commission believes a move toward more C.A. hospitals is a logical outcome of that transition.

Issue No. 3

Maine's hospitals have evolved over the years from being primarily independent acute care providers into multi-faceted corporate structures – often organized within systems. As social needs and health care patterns have changed, hospitals have stepped up and filled vacuums within their communities. Providing housing and care for the elderly is just one obvious example of the path followed by many Maine hospitals.

Another quantum leap occurred as hospitals, perceiving the need to retain physicians within their communities or to serve their hospitals, began hiring physicians as full-time hospital employees or created hospital-owned physician practices. In a relatively short time, roughly one-third of Maine's physicians have become hospital employees in one form or another. They cover the skills gamut from primary care physicians to emergency room physicians to surgeons.

Although these are very expensive hospital employees, the Commission believes most hiring decisions were justified.

However, studies performed for the Commission concluded that physician practice subsidies can run as high as 50% of practice expenses – and that related costs are real burdens for many hospitals. To be cost effective, the objective should be to utilize each employed physician at optimum levels of efficiency.

Therefore, hospitals are encouraged to share physicians, including specialists, to the maximum extent feasible, with other hospitals. The cooperative groups of affiliated

hospitals approach recommended in this report is intended to encourage such relationships, but physician sharing should also occur wherever such proves cost effective.

The potential exists to reduce costs throughout Maine's hospital network, with no degradation to the quality of care, by increasing cooperation between and among hospitals related to the most effective utilization of employed physicians. Such sharing is not intended to place excessive workload or travel burdens on any one physician, but simply to facilitate a move to more effective utilization of those highly skilled and expensive resources.

The Commission notes that many Maine hospitals already share services and physicians. The thrust of these comments is to motivate other hospitals into such cooperative relationships.

MALPRACTICE ISSUES

Initially, some Commission members expressed great concern for the impacts malpractice insurance costs and defensive medical practices were having on overall hospital costs and operations in Maine. In response to questions, several witnesses responded that malpractice related issues (in relative terms) did not pose major problems for Maine hospitals. Based on that early testimony and the personal knowledge of experienced Commission members, the Commission chose to pursue other issues which it believed at the time deserved higher priority attention.

With the passage of time, and the benefit of new information during its study process, the Commission became more concerned relative to the impact malpractice decisions have had, and are likely to have, on hospital costs and health care in Maine. Those growing concerns came late in the deliberations process and the Commission lacked sufficient time to conduct a full investigation of the ramifications of malpractice decisions on Maine hospitals and develop appropriate recommendations.

However, based on personal interviews and emerging evidence over the last year, the troubling direct and indirect consequences of malpractice fears appears to be growing in Maine. It now appears to the Commission that:

- Several very large malpractice decisions have shaken the confidence of some Maine hospitals and health care providers.
- Hospitals and physicians report having been driven to practice more costly defensive medicine to minimize their exposure to malpractice allegations. Improving quality and patient care are always worthwhile objectives, but the defensive practices many believe required today are reported by some hospitals to have passed the point of diminishing returns in terms of high quality medical care or cost effectiveness.
- Maine hospital administrators and physicians are expressing growing concerns over potential problems which lie ahead. They fear that the next waive of pressure to increase health care costs and insurance rates will be driven by the consequences of malpractice decisions.

The Committee recognizes the legitimate entitlement of patients who have received improper or inadequate medical treatment to be fully compensated. However, when

compensation levels become excessive, then large burdens are placed on health care providers and those who pay for health care.

The Commission notes that the Dirigo Act contained language instructing the Bureau of Insurance (BOI) to submit a report to the Legislature on medical malpractice issues, stating that the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters may report out legislation to the First Regular Session of the 122nd Legislature in response to the report. BOI's report is expected in January 2005 and may prove sufficient to satisfy this recommendation.

STANDARDIZED REPORTING AND VOLUNTARY TARGETS

The people of Maine depend on Maine's hospitals to provide them and their families safe, effective, quality health care. To assist hospitals in their missions to serve the public good, non-profits are granted tax-exempt status, and thus are funded in part by taxpayers. While non-profits are not in business for the purpose of generating profits, they must nevertheless maintain operating margins (i.e., profits) that are sufficient to generate adequate financial resources to meet operational obligations, and to permit reasonable capital expenditures and debt repayment.

In order to balance the need to reduce consumers' costs with the need to ensure that Maine's hospitals generate adequate margins, the Dirigo Act asked hospitals to voluntarily hold their operating margins to no more than 3% for the hospital fiscal year beginning July 1, 2003 and ending June 30, 2004. The Act also asked hospitals to limit their cost-growth to 3.5% for the same period.

The presumption behind that policy was that if hospitals met the targets, savings from decreased costs and lower profits would be passed on to consumers in the form of lower premiums, since over 33 cents of every health care dollar pays for hospital care.

The Commission recommends the continuation of voluntary profit margin targets and voluntary targets limiting cost growth, with several essential refinements to bring additional precision to the way hospitals report their performance against the targets, and to bring greater transparency to the public regarding hospital performance.

Standardized Financial Reporting and Operating Margin Targets

The Importance Of Standardized Financial Reporting

As mentioned above, Maine's non-profits hospitals are granted tax-exempt status to assist them in their missions to serve the public good. While non-profits are not in business for the primary purpose of generating profits, they should generate reasonable profits on a recurring basis for the reasons expressed earlier.

In order to evaluate whether a fair balance of hospital profit and consumer affordability is achieved, it is essential to understand the financial health and profitability of Maine's hospitals and to be able to make valid comparisons between and among hospitals and over time. The process of assessing the financial health of Maine's hospitals, however, has been complicated by several factors:

- Many of Maine's hospitals belong to larger hospital systems and have a wide range of related entities, which complicates evaluation of their reports. For example, MaineGeneral Health has six corporations, including one hospital. The Maine Health system appears to have over forty different entities.

- In some cases, over one-third of hospital profits are transferred to subsidiaries, system affiliates, and/or physician practices. Some of the related entities are for-profit organizations, whose financial statements are not publicly available. Complex organizational structures and financial transactions are sometimes required by the complexity of the health care industry, but they can obscure a complete understanding of a hospital entity's financial performance.

- Even when complying with generally accepted accounting practices, the method of presenting financial data in audited financial statements can vary from one hospital to the next and, sometimes, from one year to the next for the same hospital. It has been impossible to make apples to apples comparisons between hospitals over time when such has been the case.

Because of those complications, GOHPF retained the services of Nancy Kane, D.B.A., Professor of Health Policy and Management, Harvard School of Public Health, an independent nationally recognized expert in hospital financial analysis. Dr. Kane conducted a 10-year analysis of Maine's hospitals financial health.

As noted, the method of presenting financial data in audited financial statements can vary from one hospital to the next and, sometimes, from one year to the next for the same hospital. To conduct her analysis, Dr. Kane therefore first *standardized* the contents of hospitals audited financial statements. That is to say, she reorganized the data contained in audited financial statements (a major undertaking) so that information was reported the same way for all hospitals in all years, so that it became possible to make apples to apples comparisons.

To permit Maine people to clearly understand the financial health of its hospitals in the future, the Commission believes it necessary to require Maine hospitals to submit to the Maine Health Data Organization (MHDO's) standardized financial information annually, in the electronic format developed by Dr. Kane and agreed to by the Maine Hospital Association (see attachment to this chapter). The information should be reported for

individual hospitals, as opposed to hospital systems. This requirement can be implemented through MHDO rule-making.

Further, the MHDO should be required to post a summary of the data on its public website, and GOHPF should be required to publish an annual report to the public on the financial health of Maine's hospitals, informed by the standardized financial information reported. This report will inform policy-making and allow for comparability within Maine's hospital network.

Profitability Targets and the Financial Health of Maine's Hospitals

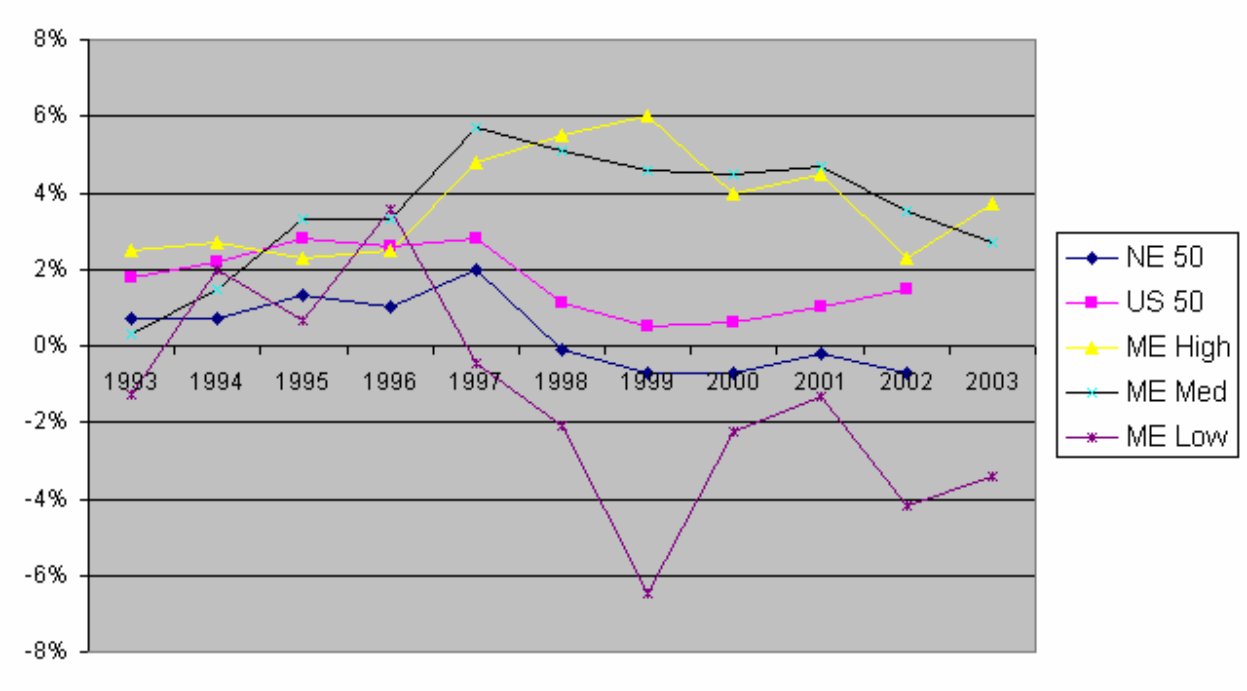
Dr. Kane compared the financial performance of Maine's hospitals to the nation's hospitals and those in the Northeast. She also compared the financial performance of hospitals within Maine and found that, in general, the profitability of Maine's hospitals has consistently exceeded Northeast region and national benchmarks. Her future findings could also be used to show the performance of Maine's hospitals against targeted levels.

Dr. Kane divided Maine's hospitals into three groups: one with the highest profitability from 1999-2003, one with the lowest profitability, and one with medium profitability. She then analyzed a range of characteristics of those hospitals to examine what factors might explain differences in profitability (see discussion elsewhere in this report).

Figure 6 shows the operating margins (i.e., margins from *operations*, which exclude revenue from investments, donations, and other non-operating sources)) of the three Maine financial performance groupings, along with the national and northeast medians. The operating margins of two-thirds of Maine's hospitals (the two top lines on the chart) were significantly higher than both the national and northeast region medians (the two middle lines on the chart) in five out the six years from 1997 to 2002.[25] It is some hospitals in those groupings which could be affected in the future by the continuation of profit margin targets. The one-third of Maine's hospitals (the bottom line on the chart) which have performed below benchmarks would not be affected by profit margin targets unless and until their margins increase substantially. The reasons for the struggles of lower performing hospitals are discussed elsewhere in this report.

[25] The dip in Maine's margins in 2002 was attributable to an extremely high increase in operating costs (11%), which exceeded hospitals 10% increase in revenues. Benchmark data for 2003 is not yet available.

Figure 6. Average Operating Margins by Financial Performance Group in Maine Versus Northeast and National Medians



Most hospitals report that they met the Dirigo Act's initial voluntary profit margin target. In recommending continuation of profit margin targets, it is important to note that the Dirigo Act's target was on "consolidated operating margins," which means that it applied to *hospital systems*, but not to *individual hospitals.* As noted earlier, variation both in hospital accounting practices and in the composition of hospitals systems have made it difficult to assess what impact the Dirigo targets had on the profitability of *individual* hospitals. Hospital CEOs in some instances report that the targets contributed to spending discipline during the year.

The Commission recommends acceptance of voluntary targets of 3% on operating margins for individual hospitals *and* hospital systems, as measured using the standardized financial data submitted to the MHDO.

If such a target had been in place in 2003, 13 hospitals would have exceeded that target. If those 13 hospitals had limited their operating margins to 3% instead of their actual 2003 margins, the Commission believes they would have remained financially healthy, and consumers would have saved an additional $16 million.[26] If all hospitals had limited their

[26] Nancy Kane, September 2004 update to the Commission.

operating margins to 3% over the period 1997-2003, consumers would have saved an additional $205 million.

The Commission also recommends the institution of a voluntary three-year rolling average target of 5% on the total margins of both individual hospitals and hospital systems. Total profit margins includes revenue from sources such as investments and donations. The purpose of such targets is not in any way to reduce philanthropy or to suggest that hospitals should not strive to make healthy returns on their investment portfolios, and the Commission does not believe such targets would have that effect. Rather, the Commission believes that if philanthropy and investments generate total margins in excess of the target, it might be possible for hospitals to offer better prices to insurers and consumers, which would have the effect of lowering the operating margin and bringing total margins closer to the target. The purpose of using a three-year rolling average is to allow for the fact that there can be year to year variation both in philanthropy in the performance of investment portfolios.

The Commission also notes that a value of both targets is (a) to provide benchmarks against which hospital performance can be assessed, and (b) to provide an understanding of how we finance care (e.g., a hospital with a 1% operating margin may be able to maintain its financial viability by virtue of investments and philanthropy that yield a much higher total margin; it would be useful for the public to have this information and to understand the effect that such a financing structure has on the cost of care).

Cost Increase Targets

A target limiting operating margins is most valuable if combined with a target limiting cost increases. Targets for operating margins ask hospitals to ensure that profits are no more than 3% of costs. If costs are allowed to increase without limits, total profits could also grow beyond acceptable levels, and Mainers would not realize savings. Thus, the Commission recommends targets on operating margins *and* cost increases.

The Dirigo Act asked hospitals "to voluntarily restrain costs increases, measured as expenses per case mix adjusted discharge." "Expenses per case mix adjusted discharge" refers to the cost of one unit of service; i.e., of treating one patient. Hospitals were asked to ensure that the cost of providing one unit of service be no more than 3.5% greater than the previous year. The Act focused on the cost of a *unit* of service rather than on *total* costs,

because hospitals cannot necessarily control utilization (i.e., number of units consumed) to the same extent that they control the cost of each unit.

In order to budget to meet that goal – and to observe after the fact whether the goal was met – hospitals defined the meaning of one unit of service. The unit hospitals chose is different than the units recommended to the Commission by Dr. Kane. The difference is due largely to the fact that, while there are well-established and precise ways to measure the cost of a unit of inpatient service (i.e., the cost of treating a patient who spends at least one night in the hospital), there are no such well-established measures for patients treated in an outpatient setting. That point is significant because outpatient services account roughly for one-half of hospital revenue.

Hospitals used a single mixed inpatient/outpatient measure to budget the Dirigo Act's target and suggest using that same measure for future targets. Hospitals acknowledge a weakness of their measure is that the measurement of outpatient activity is imprecise and can be affected by applying different charge increases to inpatient and outpatient services. Two hospitals with identical underlying total costs and patient-loads could appear to have different costs per unit depending on how each hospital sets charges for inpatient and outpatient services.[27]

Dr. Kane recommended use of separate measures for inpatient and outpatient costs, using "cost per casemix adjusted inpatient discharge" (the universally accepted measure of inpatient costs), and the Ambulatory Payment Classification (APC) system used by Medicare since August 2000, as the tool to measure cost per outpatient unit of service.

The Commission and the MHA agree that the inpatient measure is a useful and precise measure. The Commission and the MHA also agree that the APC methodology may be meaningful in the near future both for public policy and hospital management purposes. The Commission therefore recommends that the MHA begin working immediately with GOHPF to further develop the APC methodology as a tool to measure the cost per outpatient unit of service.

The Legislature may wish to recognize this commitment and set a target date to have the APC system in place for measurement for the fiscal year beginning July 2006. Future decisions regarding whether to set separate inpatient and outpatient cost-increase targets can be made only after the measurement system is in place. The MHA has indicated that

[27] For greater explanation and detail see minutes of the September 27, 2004 meeting of the Commission.

hospitals will attempt to complete such a system by that date, but cannot guarantee that necessary work can be accomplished in that time frame.

In the interim (i.e., while the outpatient measurement methodology is being developed), the Commission's recommendation proposes a compromise. Namely, it suggests two separate targets, one using the MHA measure used to budget for the Dirigo Act's voluntary targets, and one using the inpatient measure suggested by Dr. Kane. Hospitals should be asked to budget to meet *both* targets.

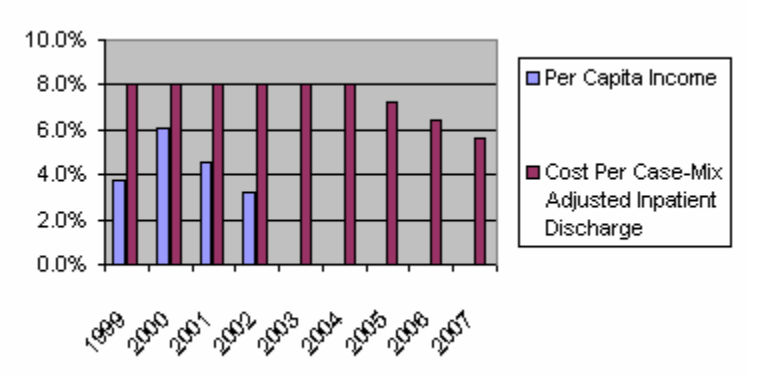
Target 1. The Commission recommends a 3.5% increase on total cost per unit using cost per adjusted inpatient/outpatient discharge.

Target 2. For the "cost per casemix adjusted inpatient discharge" measure, the Commission recommends a separate target, designed to make hospital services more affordable by reducing the gap between past increases in hospital unit costs and increases in Mainers' income. The exact percentage for cost increase targets should be derived by evaluating historic cost increases using this measure, looking at historic income growth and setting the target to lessen the gap between increases in hospital unit costs and increases in income. The Commission has asked the Governor's Office of Health Policy and Finance (GOHPF) to obtain the necessary hospital historical data so that the Legislature has that data when it is considering the Commission's recommendations; at the time of publication, GOHPF is working to obtain that data.

Specifically, the target should be set by looking at the average rate of growth in unit costs over the three most recent years for which data are available, and then setting the target for the following year to be ten percent less than the average rate of growth over that three-year period. The target for subsequent years would reduced by the same amount (i.e., ten percent less than the average rate of growth over the baseline three-year period), until cost growth reaches a level that the Legislature believes is in line with growth in Mainers' income.

Figure 7 provides an example of how this target would work. The figure shows growth in income for each year 1999-2002, along with 8% growth per year in casemix adjusted inpatient discharge used as a placeholder pending receipt of actual data. If the average annual increase in cost per unit over the three most recent years for which data are available is 8%, the target for the first year that the targets are in place will be 7.2% (8.0% minus 0.8%), 6.4% (7.2% minus 0.8%) for the second year the targets are in place, etc.

Figure 7. Change in Maine Per Capita Income and Cost Per Case-Mix Adjusted Inpatient Discharge, (8% growth per year in casemix adjusted inpatient discharge used as a placeholder pending receipt of actual data**), with example of how target would work**



The Commission is unanimous in its recommendation that spending- and profit-limiting voluntary targets be adopted, and that performance against these targets be measured for the next several years. However, some Commission members do not believe that voluntary spending targets will be effective long-range management controls and that they should be studied during the five-year sunset review proposed earlier in this report.

Standardized Administrative Cost Reporting

Finally, the Commission was interested in learning the extent of hospital spending comprised by administrative costs. The Commission was told that, because there is no standardized way to record hospital administrative activities, there is tremendous variation in how hospitals measure such costs, and that administrative cost comparisons would be meaningless.

The Commission therefore recommends that the MHA develop an "administrative cost code book," which hospitals could use when establishing budgets and reporting spending on such non-patient care categories as billing, payroll, advertising, consultants, and other administrative categories. Standardized reporting would provide a basis for apples to apples comparisons of hospital administrative costs to inform future discussions regarding the appropriateness of administrative spending levels.

Attachment – Electronic Standardized Accounting Template[28]

1	**Hospital Name**		
2	**Location**		
3	**YEAR**	**2002**	**2001**
4	**BALANCE SHEET, UNRESTRICTED FUND ($000s)**		
5	CURRENT ASSETS		
6	Cash and cash equivalents		
7	Current Assets Whose Use Is Limited		
8	Receivables:		
9	Net Patient Accounts Rec		
10	Due from Affiliates		
11	Third Party Settlemt Rec		
12	Other Accounts Rec		
13	Inventory		
14	Other Current Assets		
15	Total Current Assets		
16	NONCURRENT ASSETS		
17	Assets Whose Use Is Limited:		
18	Trustee-held Investments		
19	Board-Designated & Undesignated Investments		
20	Due From Affiliates		
21	Investment in Affiliates		
22	Other Noncurrent Assets		
23	Gross PP&E		
24	Accum. Depreciation		
25	Net PP&E		
26	Total Noncurrent Assets		
27	TOTAL UNRESTRICTED ASSETS		
28	LIABILITIES AND EQUITY		
29	CURRENT LIABILITIES		
30	Current Long Term Debt		
31	Accounts Payable + Accrued Expenses		
32	Estimated Third-Party Settlements		
33	Due to Affiliate		
34	Other Current Liabilities		
35	Total Current Liabilities		
36	NONCURRENT LIABILITIES		
37	Long term debt		
38	Estimated Third Party Settlements		
39	Due to Affiliate		
40	Self-Insurance Fund		
41	Accrued Pension & Post-Retiree Health Bens		
42	Other noncurrent liabilities		
43	Total Noncurrent Liabilities		
44	Fund Balance-Unrestricted		
45	TOTAL LIABILITIES AND EQUITY		
46	**RESTRICTED FUNDS ($000s)**		
47	Cash and Investments		
48	Receivables		
49	Other Assets		

[28] See Appendix 4 for a glossary explaining the contents of line.

50	Total Restricted Assets		
51	LIABILITIES AND EQUITY		
52	Total liabilities		
54	Temporarily restricted		
55	Permanently Restricted		
56	Total Restricted Fund Bal		
57	Total Restr Liab and Equit		
58	**INCOME STATEMENT ($000s)**		
59	Gross Inpatient Service Revenue		
60	Gross Outpatient Service Revenue		
61	Total Gross Patient Service Revenue		
62	Deductions from Revenue:		
63	Free Care		
64	Bad Debt		
65	Contractual adjustments - current year		
66	Changes in prior year estimated/final settlements		
67	Net Patient Serv Revenue		
68	Other Operating Revenue		
69	Total Operating Revenue		
70	OPERATING EXPENSES		
71	Depreciation		
72	Interest		
73	Other operating expenses		
74	Total operating expenses		
75	Operating Income		
76	NONOPERATING REVENUE		
77	Interest and Dividend		
78	Realized Gains on sales of securities		
79	Permanently impaired security writedowns		
80	Total investment income		
81	Gains/losses on joint ventures/equity investments		
82	Permanently impaired writedowns of nonsecurity assets		
83	Other no operating revenues (gifts, bequests		
84	Total no operating revenue		
85	Excess of revenue over expenses		
86	Extraordinary Gains (Losses)		
88	Total Surplus/Deficit		
89			
90	**Other Changes in Unrestricted Net Assets:**		
91	Net assets released for restrictions - capital		
92	Unrealized gains (losses) on investments		
93	Minimum pension liability adjustment		
94	Transfers from (to) affiliates		
95	Mergers		
96	Consolidations with support organizations		
97	Other Changes		
98	Total Change in Unrestricted Net Assets		
99			
100	**STATEMENT OF CASH FLOWS ($000s)**		
101	CASH GENERATED FROM OPERATING ACTIVITIES		
102	Total Surplus/Deficit		
103	Noncash expenses (revenues)		

104	Funds from Operations		
105	Decr (incr) Current Assets Limited Use		
106	Decr (incr) Accounts Rec		
107	Decr(incr) Affil Rec		
108	Decr (incr) 3rd Party Rec		
109	Decr (incr) inventory		
110	Decr (incr) other current assets		
111	Incr (decr) accts pay/accd exp		
112	Incr (decr) 3rd Party Settlement		
113	Incr (decr) Due to Afffiliates		
114	Incr (decr) Other Curr Liab except LTD		
115	CASH FROM WORKING CAPITAL		
116	Cash from operating activities		
117	CASH FROM INVESTING ACTIVITIES		
118	Decr (incr) Bd Designted Invstmt		
119	Decr (incr) TrusteeHeld Invstmt		
120	Decr (incr) Due From Affiliates		
121	Decr (Incr) Affiliate Investments		
122	Decr (incr) Other Noncurrent Assets		
123	Decr (incr) PP&E gross		
124	Sale of Fixed Assets		
125	Cash provided (used) in investing activities		
126	Cash Position before Outside Financing Activities		
127	CASH FROM FINANCING ACTIVITIES		
128	Issue Long Term Debt		
129	Repay Long Term Debt (incl Current LTD)		
130	Incr (decr) Third Party Settlmt		
131	Incr(decr) Due to Affiliates		
132	Incr(decr) Pension, Self Insur		
133	Incr(decr) other Noncurrent Liabl		
134	Transfers from (to) restricted funds		
135	Transfers from (to) other entities		
136	Cash Provided (Used) Financing Activities		
137	Net Change in Cash		
138	rec		
139	dif		
140	% total assets		

THE CERITIFICATE OF NEED PROGRAM

In 1978, the Maine Legislature enacted the state's Certificate of Need law, finding it in the public's interest to minimize unnecessary construction and/or modification of health care facilities and the duplication of services, the objective being to exercise control over capital expenditures affecting cost and access to health care. Over time, as funding for state health planning and the Certificate of Need CON review was reduced by the Federal government and state budgetary constraints, the effectiveness of Maine's program appears to have eroded.

The Dirigo Act made several important changes to strengthen the CON program to ensure wise and coordinated health care investments. One change was to require the Governor's Office to establish an annual limit, called the Capital Investment Fund (CIF), on the dollar amount of capital expenditures and new technology investments approved under the CON program, and to require the State Health Plan to prioritize the capital investment needs of the health care system within the CIF. The Act also expanded CON review to include physician's offices and Ambulatory Surgical Units. This was in response to more and more services migrating from the inpatient to outpatient settings and off the hospital campus entirely – a phenomenon which was leaving a significant gap in the state's ability to fully consider and oversee the rational development of Maine's health care system, as well as its ability to assess the impact on system costs those investments represent.

The Commission believes that in order for Maine citizens to reap the benefits of the Act's improvements in the CON law, it is essential that the Department of Health and Human Services (DHHS) – the agency in which the CON program resides – develop and implement a plan to significantly strengthen the CON unit (CONU) staff.

The State Health Plan and the CIF are designed to bring rationality and coordination to capital investment in order to ensure an efficient and effective health care system. To fulfill those objectives, the CONU needs a staff capable of conducting robust research and analysis to evaluate the extent to which proposed projects meet Mainers' health needs and its citizens' ability to pay. It is also necessary to ensure that the CONU has adequate funding to hire consultants if and when needed. Current staff capacity is clearly insufficient to run a CON program providing Mainers the high quality and efficient health system that they need and deserve, so the staff must be strengthened. Strengthening means hiring a few more capable people and adding to the skills and experience levels within the organization.

The program may also be strengthened by moving it from status as a division within the Bureau of Medical Services closer to the policymakers in DHHS.

To finance the expansion and improvement of CON review capabilities, the Commission recommends an increase in CON application fees if more funds are needed after the Department has determined its budgetary needs, with revenues to be used specifically for CON staffing and consulting support. Currently the CON program includes a fee schedule under which an applicant pays $1000 per $1 million, or part thereof, in proposed capital expenditures. The Commission believes that DHHS can revise its fee structure in such a way as to increase revenues and fairly distribute the cost of CON reviews among applicants, without having fees serve as a deterrent to providers' submission of applications. Revenues received should be directed exclusively to the CON process.

The Commission also recommends that DHHS ensure that CON staff has the capacity to conduct meaningful follow up to assure that the goals articulated in CON applications are met. DHHS should also review the current range of sanctions provided by law for failure to meet stated goals, and – if it determines that the current range of sanctions are insufficient – propose changes to the law to establish a more reasonable range of sanctions. Currently, little meaningful follow-up appears to be conducted, so the state has no formal way of assessing whether approved projects succeed in achieving the goals they were meant to achieve. For instance, how does actual utilization compare to projected utilization? What additional costs are ultimately borne by consumers? How does the project affect other providers in the area, and what are the bottom line effect on costs throughout the system? Did the project bring expected improvements in health? The CON process will improve with more effective reviews prior to approval and more effective follow-up after the fact.

The Commission also heard evidence that the CON hearing process can be unwieldy, with no firm rules governing the submission and review of evidence and the creation of a public record that ensures that the Commissioner has all the information needed to make a fair and accurate determination regarding which projects best meet the needs of our citizens. The Commission therefore recommends that DHHS examine and strengthen the hearing process.

Finally, the Commission notes that the majority of Capital Investments (i.e., about 80%) fall below CON review thresholds and is thus not subject to the planning and

coordination that the CON program, the State Health Plan, and the CIF are designed to ensure. The Commission also notes that the vast majority of the 37 states (and the District of Columbia) that have CON programs have lower thresholds than Maine.[29]

The Commission considered a recommendation to lower CON review thresholds to encourage better investment decisions, but ultimately decided that such a recommendation would be premature without a data-driven evaluation of the impact of such action. The Commission is, however, recommending that hospitals and non-hospital providers be required to report to CONU those projects whose costs are above ½ of the current review thresholds. Accumulated data should be used in the future to evaluate the impact of recommendations to lower CON thresholds, including the impact of those projects on Maine's health care system, estimating the number of projects that would be subject to CON review if thresholds are lowered, and assessing the costs and benefits of lowering the thresholds. The data could also be used to inform discussions regarding the size of the CIF and development of the State Health Plan.

Finally, the Commission supports continuation of capital expenditure spending limits at least for the near term. However, it is preferable that such caps not remain in place for extended durations, with the industry moving itself toward a more sustainable and systemically efficient allocation of investment and resources. If hospital boards and managers engage in meaningful collaboration within the Consortium framework (discussed elsewhere in this report) and if the state's CON program receives the resources needed to sufficiently strengthen its capacity to effectively oversee capital investment in Maine, caps will no longer be needed.

[29]CON review is required if any one of the following is true for a project:

1. Capital Costs: (a) any capital expenditure of $2,400,000 or more; (b) any major medical equipment that costs $1,200,000 or more; OR (c) any capital expenditures of $110,000 or more that is associated with the addition of a new health service (i.e., "that was not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered").
2. Incremental 3rd Year operating costs of $400,000 or more for a new health service (i.e., "that was not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered").

WELLNESS PROGRAM SUPPORT - ESSENTIAL

Individual living habits and lifestyles have profound impacts on health and the quality of life. It is equally true that the entire health care system has become burdened with high cost of care ramifications, because a large percentage of our citizens fail to practice widely recognized dietary controls or adopt even minimally acceptable fitness programs.

While some progress has been made reducing cigarette smoking nationally and in Maine, the problem still persists to an unacceptable degree. Smoking cessation programs need continuing attention and emphasis in our state. Fortunately, there are many formal programs underway to address this major health issue and the Commission is not proposing any shift in emphasis within Maine's hospital network – just continued cooperation and collaboration with those whose primary focus is to eliminate smoking.

Other wellness issues need far more attention in Maine than they are receiving.

The Commission believes there are important educational roles for all Maine hospitals as even stronger advocates of good wellness practices, with special emphasis on high priority concerns in each hospital's local area. While some significant problems, such as the growing epidemic of obesity among Americans, have spread throughout our state, in many instances the magnitude of a problem varies considerably from one county to another depending on economic and social circumstances.

Some Maine hospitals have been proactive in identifying wellness issues of greatest concern within their geographic area and initiating appropriate action. Clearly, there have been many instances where impressive progress has been achieved. The Commission applauds those hospitals and urges others to follow their lead.

Maine's community hospitals are highly respected institutions in the areas they serve. For many individuals, the most credible interfaces with health care are represented by their family physician and local hospital. What people hear and learn from those two sources should have the most tangible positive impact on wellness. Thus, the Commission encourages all hospitals to become local leaders consistently promoting healthy behavior.

Examples of health problems brought on by personal decisions and behavior abound, but are too numerous to address on a case-by-case basis in this report. However, the Commission believes primary wellness emphasis should be placed on initiatives emphasizing the need for proper diets and the vital importance of adequate daily exercise routines. Obesity is the most common predecessor of heart and kidney disease, as well as

diabetes. Those diseases, so prevalent and costly in both personal and financial terms, can be delayed or prevented by effective wellness efforts.

While anti-smoking campaigns already receive significant support, diet controls and exercise needs are two wellness areas demanding more attention and better results. Although these issues should receive high priorities, in some parts of Maine other wellness issues are equally critical. Each hospital should tailor its wellness program to the needs of the geographic area and those needs are known to vary from one area in Maine to another.

The Commission recognizes that most wellness programs, by their very nature, are designed and expected to produce long range favorable results as a consequence of improving the general health of society. No one disputes the fact that many chronic health problems can be minimized or eliminated by changing personal habits, controlling weight and/or becoming more physically fit. But, changing wellness related behavior within a culture is hard work and takes considerable time. The long range payoffs, however, in lifestyle improvements and reduced health related problems can be massive. So our hospitals, which have historically emphasized acute care, should shift an appropriate level of emphasis into programs with longer term benefits to society. To do this job effectively, some hospitals may be required to add specialized staff personnel, new programs and perhaps some new facilities. There will be increased costs related to some of the anticipated wellness efforts. Hospitals alone, however, cannot bear the substantial cost of these programs. Employers and payers should also recognize the long term return on such investments and support meaningful wellness programs.

Hospitals, therefore, should be only one of many institutions focusing more attention on wellness. It will require a significant statewide action program (indeed a national effort) not unlike the coordinated efforts to reduce smoking, to move our society in a more healthy direction. Hospitals, while expected to remain primarily focused on their acute care responsibilities, should be meaningful players, indeed leaders, in efforts to promote wellness. The Commission believes this can be achieved without a large net commitment of new staffing or substantial cost increases. However, more resources should be committed to this important task. Much can be gained if hospital managers use the influence of their positions to aggressively pursue wellness matters in public forums and within their own organizations. Likewise, hospitals should become local catalysts for wellness programs within the community by promoting the need for pro-active involvement and providing

accommodations and leadership for volunteer organizations. Most hospitals have an effective public relations program which in part can be effectively employed toward support of wellness activities.

While every hospital is encouraged to expand and formalize its efforts to promote wellness within its region, the Commission recognizes that each hospital should continue to place its primary focus on the day-to-day and month-to-month job of providing the finest quality acute care, for the most people, as efficiently as possible. Wellness programs are essential because they possess the potential to make life much better for individuals, doctors and hospitals in the future, but those long-term benefits must be balanced against more urgent hospital needs to provide excellent care 24 hours per day, every day. Thus, in advocating more active hospital roles in wellness activities, the Commission cautions that it is not encouraging any diminution of the more pressing near term hospital objectives to improve quality, increase access and lower costs addressed elsewhere in this report. Dealing with acute health problems should remain the highest priority for Maine hospitals into the foreseeable future, but hospital efforts to expand and improve wellness programs should continue year after year at accelerating rates.

Many long term health concerns are related to dietary problems. The increased consumption of soft drinks, fast foods, snacks, etc., is clearly linked to the growing incidence of obesity – and obesity is known to trigger and exacerbate numerous health problems. Such health problems increase the state's share of costs throughout Maine's health care network – including hospitals. Several recommendations in this report require upfront capital investments to generate long term savings. To help finance such new investments, wellness programs and other continuing health related costs in Maine, such as Medicaid, the Commission recommends that the legislature apply a modest tax or fee to each processed food item or beverage item sold. Revenues generated would be dedicated to address wellness and other health care issues in Maine. Hopefully, the new tax and related price increases would discourage some consumption of unhealthy food products by our citizens, just as cigarette taxes have discouraged consumption.

If this concept is acceptable to the legislature, a committee comprised of hospital representatives, Maine public health officials and wellness experts should develop a definitive operational and financial plan and oversee implementation of an effective wellness program.

The Commission re-emphasizes that wellness touches all of us and all stakeholders in Maine's health care must take on enlarged roles related to the maintenance of good health. Hospital-based efforts proposed in this section must be matched by those of all providers, educators, employers and insurance companies doing business in Maine.

CONTINUING OVERSIGHT

This report recommends action to be taken by the legislature, government agencies, hospital systems and individual hospitals.

The Commission envisions the need for 100% hospital cooperation and participation in most cases. Voluntary hospital involvement is most desirable and the Commission is only recommending mandatory participation or action in those few situations where having all Maine community hospitals included appears absolutely essential.

Some recommendations were considered during deliberations which related to only one or two hospitals, but few such specific recommendations are included in this final report. Some of those suggestions would have required decisions troublesome to many active hospital supporters at the local level. The Commission ultimately decided it best to leave decision making responsibilities relating to specific hospitals in the hands of local hospital boards – expecting that they will appreciate the importance and potentially broad ramifications of their actions and make decisions which, while difficult at the local level, are in the best interest of Maine people as a whole.

There should be some independent, objective follow-up on all the Commission's recommendations after an appropriate amount of time has elapsed. The Office of Health Policy and Finance should establish a plan wherein each recommendation of this report be reviewed in the future to assure that the implementation process has produced optimum results. Where action has been inappropriate or inadequate, steps should be taken at that time to change the recommendations or assure reasonable follow through on an issue-by-issue basis.

Voluntary compliance will always produce the best results, but in those instances where voluntary action is not forthcoming, there should be a thorough follow-up to determine if delays or failures to act are appropriate responses. Most hospitals in Maine are local institutions operated for the benefit of area citizens. But, 58% of the patients utilizing Maine hospitals are covered by federal or state insurance and the vast majority of other patients are covered by private insurance payers who reside throughout our state. A strong case can be made that every local hospital should be expected to act in the best interests of all Maine people or, at a minimum, balance statewide priorities with local interests.

In the final analysis, state guidance and direction may be justified and appropriate, but only if other approaches fail, voluntary action is still the preferred approach.

Appendix 1. Data Issues

Why is there an Issue?

- Until recently, hospitals treated the vast majority of patients on an inpatient basis. That is, patients are admitted to the hospital, treated, and discharged when their care is done. The method to come up with the cost for each patient has been used by CMS for 20 years.
- In the past few years, there has been a trend to much more outpatient care, and there is a newly-established way to measure the cost of each outpatient visit. Inpatient and outpatient care each account for about half of hospital spending.

What Do I Need to Know About Inpatient Care?

- There is a longstanding measure of the cost of an inpatient admission.
- The data is from Medicare Cost Reports (MCRs) that all hospitals submit annually to CMS (the federal agency that administers the Medicare and Medicaid programs).
- To allow comparisons between hospitals and states, it is necessary to recognize that hospital costs are affected both by how sick the patients are and by the wage rate where the hospital is located.
- "Adjusting" for these two factors allows comparisons ***after*** taking into account the effect that those factors have on a hospital's costs.
- For the wage adjustment part, the Medicare program puts hospitals in different regional buckets based on actual paid wage data hospitals submit on their MCRs.
- Using that data, the 2002 median cost per inpatient admission in Maine's hospitals ($6,917) is 19% higher than the US median ($5,819) and 45% higher than the Northeast region's median ($4,759).
- The MHA has long disputed the Medicare wage adjustment for Maine, saying that it has put Maine hospitals in a regional bucket where the wages are too low. The MHA says that Maine's wages are closer to Boston's, and that if the wage difference were fixed, our costs would appear lower.
- Therefore, the MHA does not want to use this measure for inter-state comparisons.

What Do I Need to Know About Outpatient Care?

- In the past few years, there has been a trend from inpatient to more outpatient care. Inpatient and outpatient now each account for about half of hospital spending.
- Outpatient and inpatient services are very different. Whereas the average cost of an inpatient stay nationally is approximately $6000, the cost of an outpatient visit is often less than $100.
- Also, unlike inpatient hospital services, it is difficult to define what a unit of hospital outpatient service really is. For example, one patient may come to the outpatient department for a simple blood test, being seen only in the laboratory. Another may be served in the emergency department, attended to by hospital doctors and nurses, given an IV, having x-rays and blood work and an EKG. These are obviously two very different types of visits and the costs associated with them are not fairly compared.

- As a result of the trend towards more outpatient care, CMS recently developed a method of measuring outpatient activity called Ambulatory Patient Classifications (APCs). The new APC system is currently only available for Medicare patients and for a subset of services, so it currently does not cover all outpatient activity.
- Using that data, Maine's 2002 median cost per outpatient Medicare visit was 12% higher than the national median, 28%, 16%, and 10% higher than Massachusetts, New Hampshire, and Vermont, respectively.
- The MHA has agreed to work on an APC system to track all outpatient efficiency in Maine in the future, but believes the Medicare-only data should not be used for comparisons because it does not cover all outpatient activity.

What Does the MHA suggest for Inter-State Comparisons?

- For the reasons above, the MHA prefers using a single efficiency measure that blends inpatient and outpatient services and that does not include a wage index adjustment for inter-state comparisons. The American Hospital Association produces these numbers, and they are not verified by an outside source.
- The MHA stated in its testimony on the first draft of the State Health Plan that using this measure, in 2002 Maine's cost per blended inpatient/outpatient unit was $7,641, compared to a national figure of $7,355 and a New England figure of $8,127.
- Here is how the MHA's measure works:
    - It starts with the total amount the hospitals spend on both inpatient and outpatient care.
    - It then divides that by the number by the total number of inpatient admissions plus an estimate of "outpatient activity." It uses an estimate because – as mentioned earlier – unlike inpatient hospital services where an admission is the unit, it is difficult to define what a unit of hospital outpatient service really is.

In the MHA's Blended Measure, How is the Outpatient Estimate Made, and How Does That Effect the Costs Reported?

- The estimate of "outpatient activity" is made based on the hospital's total outpatient charges; i.e., how much they billed insurance companies for outpatient services. It divides the total outpatient charges by how much the hospital charged for each inpatient admission, and says that that is the amount of "outpatient activity."
- An issue with this is that charges and costs are not the same thing. Different hospitals have different practices for how they bill insurance companies. For instance, one hospital might charge one insurance company at 20% above cost, while it charges another insurance company 30% above cost. Another hospital might do things differently. Also, hospitals might change the way they bill insurance companies from one year to the next.
- The effect of all this variation is that two hospitals that have the exact same costs, number of patients, types of patients, etc. can appear to have very different "cost per blended inpatient/outpatient unit," just because they have different billing practices.
- This – and the fact that the measure mixes inpatient ***costs*** and outpatient ***charges*** – leads some to question whether the measure allows for meaningful comparisons.

Appendix 2. Commission to Study Maine's Community Hospitals, Summary of Meetings

1. **November 20, 2003. Inaugural Meeting**
   - The Commission discussed the approach it would take over the coming months; there were no presenters.

2. **December 4, 2003. Hospital Financing**
   - Nancy Kane, Professor of Health Policy and Management at the Harvard School of Public Health, the Governor's Office consultant conducting an analysis of Maine's hospital system, including performing a financial analysis and assisting in building a baseline against which compliance with voluntary price constraints may be measured.

3. **January 5, 2004. Overview by the Maine Hospital Association**
   - Mary Mayhew, Vice President for Government Affairs and Communications
   - David Winslow, Vice President for Financial Policy

4. **January 20, 2004. Payor Perspectives**
   - Cathy Gavin, Executive Director, Maine Healthcare Purchasing Collaborative
   - Kevin Gildart, Vice President of Human Resources, Bath Iron Works (BIW)

5. **February 2, 2004. Provider Perspectives**
   - Maine Medical Association president Dr. Maroulla Gleaton
   - Maine Osteopathic Association president, Dr. Bruce Bates
   - Maine State Nurses Association Executive Director Pat Philbrook
   - Ambulatory Surgery Centers Coalition representative John Wipfler
   - Organization of Maine Nurse Executives representative Barbara Whitehead

6. **February 17, 2004. Insurance Perspectives**
   - Maine Association of Health Plans Director Katherine Pelletreau
   - Mr. Brent Churchill, Employee Benefits Design, Inc.

7. **March 1, 2004. Anti-Trust and Other Legal Issues**
   - Assistant Attorney General Tina Moylan
   - Assistant Attorney General Linda Conti

8. **March 15, 2004. Hospital Variation**
   - Dr. David Wennberg -- who has performed research on national health care efficiency and quality issues and currently works with (1) the Maine Medical Center's "Center for Outcomes Research and Evaluation" on measuring efficiency and quality on a national scale, and (2) the Health Dialog Data Service, where he consults with large employers and health plans on using efficiency and quality measures to reduce healthcare expenditures without negatively impacting quality -- presented on measures of hospital quality and efficiency and how some large

employers and health plans can use them to reduce healthcare expenditures without negatively impacting quality.

9. **April 5, 2004. Joint Meeting of the Commission and the Advisory Council on Health Systems Development: Health Status in Maine/Maine's Public Health/State Health Planning**
   - Dora Mills, Director of the Maine Bureau of Health
   - Ron Deprez, President of the Public Health Resource Group

10. **April 20, 2004. Critical Access Hospitals**
    - Andy Coburn, a Professor of Health Policy at USM's Muskie School of Public Service, provided a general overview of Critical Access Hospital (CAH) program.
    - John Welsh, President and CEO of Rumford Hospital, presented about Rumford Hospital's experience since its designation as a Critical Access Hospital in July 2002.

11. **May 3, 2004. Hospitals and Maine's Economy**
    - Dana Evans, State Labor Economist, Department of Labor
    - Charlie Colgan, Professor, Muskie School of Public Service

12. **May 17, 2004. Patient Safety and Medical Errors**
    - Rebecca Martins, a consumer advocate with "Voices 4 Patients"
    - Jill Rosenthal of the National Academy for State Health Policy
    - Lou Dorogi, Director, Division of Licensing and Certification, Department of Human Services

13. **June 7, 2004. The Commission held an all-day retreat.**

14. **June 21, 2004. Nancy Kane presented findings on Hospital Financial performance.**

15. **July 6, 2004. Hospital Systems**
    - Norman Ledwin, President & CEO, Eastern Maine Healthcare Systems (EMH)
    - Charles "Guy" Orne, Executive Vice-President, Finance, Treasurer and Chief Financial Officer, Central Maine Healthcare
    - Frank McGinty, Executive Vice President & Treasurer, MaineHealth

16. **July 12, 2004. Electronic Medical Record Systems**
    - Dr. Eric Hartz, Oncologist and Chief Medical Information Officer at Eastern Maine Medical Center (EMMC)
    - Larry Blevins, EMMC Chief Information Officer.
    - Dr. Dennis Shubert, Director of the Maine Quality Forum (MQF)

17. **July 19, 2004. Anti-Trust Issues**
    - Robert Frank, Harvey & Frank, Portland
    - Charles Dingman, Preti Flaherty Beliveau Pachios & Haley, Augusta
    - Joe Kozak, Kozak & Geyer, Augusta

- Linda Pistner, Chief Deputy Attorney General
- Linda Conti, Asst. Attorney General, Division Chief, Consumer Protection, Maine
- Christina Moylan, Asst. Attorney General

18. July 26, 2004. Administrative Streamlining

- Beth Kilbreth, Senior Research Associate & Asst. Professor, Institute for Health Policy, Muskie School, USM;
- Will Kilbreth, Program Coordinator, Dirigo Health Agency

19. August 2, 2004. Workforce Issues, Update on the State health plan and the Capital Investment Fund

- Beth Kilbreth, Associate Professor, Muskie School of Public Policy
- Ellen Schneiter, Governor's Office of Health Policy and Finance
- Peter Kraut, Governor's Office of Health Policy and Finance

20. August 9, 2004. Rule 850

- Peter Kraut, Governor's Office of Health Policy and Finance, presented the findings of a workgroup that included:
- Scott Bullock, Commission member, MaineGeneral Hospital
- Joe Ditre, Commission member, Consumers for Affordable Healthcare
- Cathy Gavin, Maine Healthcare Purchasing Collaborative
- Katherine Pelletreau, Maine Association of Health Plans
- Gino Nalli, Muskie School of Public Service
- Joanne Rawlings-Sekunda, Bureau of Insurance

21. August 16, 2004. Hospital Collaboration and Budgeting Under the Hospital Experimental Payment Program in greater Rochester, New York

- Al Charbonneau, C.H.E., Health System Consultant

22. August 23, 2004. Hospitals that Have Chosen Not to Affiliate

- Ron Victory, Penn Valley Hospital
- Rick Batt, Franklin Memorial Hospital
- Jud Knox, York Hospital
- Sister Mary Norberta, St. Joseph's Hospital

23. September 7, 2004. The Commission Looked at Several of the Chair's Draft Chapters

24. September 13, 2004. The Commission Looked at Several of the Chair's Draft Chapters

25. September 20, 2004. The Commission Looked at Several of the Chair's Draft Chapters

26. September 27, 2004. Status of Voluntary Targets for Maine's Hospitals

- David Winslow, Vice President of Financial Policy, Maine Hospital Association

- Jim Parker, Vice President and General Manager, Anthem (Representing Maine Association of Health Plans)
- Nancy Kane, DBA, Harvard University

27. October 4, 2004. Update from Anti-Trust Workgroup, Creation of Additional Workgroups

- James T. Kilbreth, Partner, Verrill & Dana, presented an update from the Anti-Trust Workgroup

28. October 2004. The following workgroups -- created as a result of discussions at the previous meeting -- held multiple meetings throughout the month of October, with each ultimately submitting a report to the Full Commission.

- Administrative Streamlining
- Standardized Reporting
- Rule 850/Certificate of Need/Rule 120

29. November 8, 2004. Medicare

- Dr. Charlotte Yeh, CMS, Regional Director
- Jim Bryant, CMS, Associate Regional Administrator, Region 1

30. November 22, 2004.

- Jack Burke, Consulting Actuary, Milliman -- "Health Plans' comparative paid information for selected medical services in Maine, Massachusetts and New Hampshire"
- Nancy Kane, D.B.A., Harvard School of Public Health – "Hospital Financial Performance: Differences within Maine"

31. November 29, 2004. The Commission voted on recommendations.

32. December 1, 2004. The Commission voted on recommendations.

33. December 13, 2004. The Commission reviewed the Chair's draft report.

34. January 6th and 7th. The Commission held public hearings in Portland, Augusta, and Bangor.

35. January 10, 2005. The Commission met to discuss public comments.

36. January 24, 2005. The Commission finalized the report.

Appendix 3. Members of the Commission to Study Maine's Community Hospitals

Chair
William E. Haggett
Chairman of the Board and CEO
Naturally Potatoes

Scott Bullock
CEO
Maine General Health

John Welsh, Jr., FACHE
President and CEO
Rumford Hospital

D. Joshua Cutler, MD
Maine Cardiology Associates

Patricia S. Philbrook, RNC NP
Executive Director
Maine State Nurses Association

Louis A. Hanson, DO
Private Solo Family Practice
Cumberland, Maine

Joseph Ditre
Executive Director
Consumers for Affordable Health Care Foundation

Robert K. Downs
Harvard Pilgrim Health Care

Christopher St. John
Executive Director
Maine Center for Economic Policy

Appendix 4. Glossary for Electronic Standardized Accounting Template

	Hospital Name	
	Location	
	Year	
Cell		**Definition**
4	Balance Sheet, Unrestricted Funds ($000s)	Heading. All dollar amounts rounded to the nearest thousand.
5	CURRENT ASSETS	Heading. Short-term resources (i.e., those expected to be converted to cash or used within one year).
6	Cash and Investment	Cash, cash equivalents (money market funds) and short-term investments (marketable securities) listed under current assets and not restricted by external (donor or grantor) or internal (board or trustee) designations.
7	Current Assets Whose Use Is Limited	Cash, cash equivalents (money market funds) and short-term investments (marketable securities) limited internally without clear distinction between being board-designated or trustee-held, listed under current assets.
9	Net Patient Accounts Receivable	Patient accounts receivable, reported net of provisions for bad debt/uncollectible accounts and contractual allowances.
10	Due from Affiliates	Current portion of receivables due from affiliated entities. Includes also notes receivable from/loans or advances to affiliated entities. Check footnotes if affiliate status is unclear and for loans to affiliates included under heading "other current assets."
11	Third Party Settlements Receivable	Current portion of final settlements from third-party payers due to the hospital.
12	Other Accounts Receivable	Includes other receivables not related to patient services, third party receivables or amounts due from affiliates. Includes amounts due from restricted funds. Does not include grants or pledges receivable if their purpose is restricted by external stipulations (by donors or grantors).
13	Inventory	If missing, may be combined with other current assets.
14	Other Current Assets	All other current assets not listed above, including prepaid expenses and deposits.
15	Total Current Assets	Excel sums all short-term resources (rows 6 through 14).
16	NONCURRENT ASSETS	Heading. Long-term resources (i.e., those not expected to be converted to cash or used within one year).
17	Assets Whose Use Is Limited	Heading. Investments and assets internally designated by the board or held by trustee for a contractual purpose. Does not include investments or assets whose purpose is externally restricted by donor or grantor stipulations.
18	Trustee-held Investments	Noncurrent portion of assets whose use is limited designated as trustee held. Includes investments or assets held under a contractual arrangement with an outside party other than a donor/grantor; these include funds held by a trustee, debt service reserve funds, bond and mortgage sinking funds. Trustee-held investments are contractually obligated for the purpose specified and are not available to fulfill other obligations of the hospital.

19	Board-Designated and Undesignated Investments	Noncurrent portion of assets whose use is limited by Board of Trustees (i.e., internally designated) and any undesignated long-term investments. Includes assets set aside for capital improvements/acquisitions, funded depreciation and assets functioning as endowments. These fund designations can be revoked by Board decree and used to meet other obligations of the hospital if necessary (hence these funds are discretionary). Check footnotes for affiliate loans included here and move these amounts to "due from affiliate" (line 20). Include in here "beneficial interest in net assets of parent" unless the amounts are clearly donor restricted (e.g. are needed to make the restricted fund balance sheet balance)
20	Due From Affiliates	Noncurrent portion of receivables due from affiliated entities, reported as notes receivable from/loans or advances to affiliated entities. Check footnotes if affiliate status is unclear and to find affiliate loans included under "assets whose use is limited" or "other noncurrent assets."
21	Investment in Affiliates	Amounts recorded as equity investments (i.e., less than 50% share). Includes amount listed as goodwill/intangible assets for the purchase of another entity (e.g., a physician practice). (Although goodwill technically should be kept separate because it occurs with the purchase (i.e., 100% ownership) of another entity, it is not common on hospital balance sheets and therefore is listed here.)
22	Other Noncurrent Assets	All other noncurrent assets not listed above, including amounts due from restricted funds; deposits; other noncurrent unrestricted receivables; deferred financing costs (e.g., bond issuance costs) and deferred charges; pension and insurance obligations or retirement programs; cash surrender value of life insurance; organization costs, etc.
23	Gross Property, Plant & Equipment	Gross value of land, buildings, equipment, construction in progress and capitalized leases.
24	Accumulated Depreciation	Includes depreciation of PP&E and amortization of capitalized leases.
25	Net Property, Plant & Equipment	Excel calculates gross PP&E minus accumulated depreciation (line 23 minus line 24).
26	Total Noncurrent Assets	Excel sums all long-term assets (lines 17 through 22, plus line 25).
27	Total Unrestricted Assets	Excel sums all current and noncurrent assets not restricted externally by donors or grantors (line 15 plus 26). Check that unrestricted balance sheet balances (line 27 = line 45).
29	CURRENT LIABILITIES	Heading. Short-term obligations (i.e., those expected to be due within one year).
30	Current Long Term Debt	Current portion of long-term debt/bonds payable and capital leases; does not include notes payable, lines of credit or other short-term obligations (which are put in other current liabilities, line 34). Refer to footnotes if current LTD is not specified on balance sheet.
31	Accounts Payable + Accrued Expenses	Includes accounts payable, accrued salaries, wages, payroll taxes, interest, vacation (earned time) and other accrued liabilities.
32	Estimated Third-Party Settlements	Current portion of amounts received from third party payers which the hospital expects to be due back to third parties in the current year (i.e., amounts received from third parties in the past may be in excess of allowable amounts and may therefore be paid back to third parties or else resolved favorably and recognized as revenue in the future).
33	Due to Affiliate	Current amounts owed to related entities. Check footnotes if affiliate status is unclear.

34	Other Current Liabilities	All other current liabilities, including amounts due to restricted funds; notes payable (unless owed to affiliated entity); lines of credit; deferred gift annuities; construction & retainage payable; current portion of self insurance funds, pension costs and postretirement health benefits; current portion of deferred revenue, etc.
35	Total Current Liabilities	Excel sums all short-term obligations (lines 30 through 34).
36	NONCURRENT LIABILITIES	Heading. Long-term obligations (i.e., those not due within one year).
37	Long-term debt	Noncurrent portion of long-term debt, capital leases and mortgage notes payable. Check footnotes if not specified on the balance sheet.
38	Estimated Third Party Settlements	Noncurrent portion of amounts received from third party payers which the hospital expects to be due back to third parties (i.e., amounts received from third parties in the past may be in excess of allowable amounts and may therefore be paid back to third parties or else resolved favorably and recognized as revenue in the future).
39	Due to Affiliate	Noncurrent amounts owed to related entities. Check footnotes if affiliate status is unclear.
40	Self-Insurance Fund	Includes self insurance, reserve for professional liability or workers' compensation.
41	Accrued Pension & Post-Retiree Health Benefits	Noncurrent amounts of accrued pension and postretirement health benefits.
42	Other Noncurrent Liabilities	All other noncurrent liabilities including amounts due to restricted funds, notes payable (unless owed to affiliated entity), deferred gift annuities, construction & retainage payable, deferred revenue, etc.
43	Total Noncurrent Liabilities	Excel sums all long-term obligations (lines 37 through 42).
44	Fund Balance-Unrestricted	Includes all net assets that are not temporarily or permanently restricted by donor or grantor stipulations. Includes funded depreciation.
45	Total Liabilities and Equity	Excel sums all liabilities and net assets (fund balance) not restricted externally by donors or grantors (lines 35 plus 43 plus 44). Check that unrestricted balance sheet balances (line 30 = line 48).
46	RESTRICTED FUNDS	Heading. Includes accounts with external (donor or grantor) stipulations. After implementation of FASB 117 (differs by hospital but generally around FY 95), restricted and unrestricted assets, liabilities and net assets are on a single balance sheet. Remove restricted accounts from unrestricted fund balance sheet and insert them in this balance sheet.
47	Cash and Investments	Includes cash and investments restricted by donor or grantor. If restricted assets are not clearly reported on the balance sheet or if they are less than restricted liabilities and net assets, remove an amount from funds whose use is limited (line 19) to balance restricted liabilities and equity and enter here.
48	Receivables	Includes pledges and grants receivable restricted by donor or grantor and amounts due from general (unrestricted) fund.
49	Other Assets	Assets other than cash, investments and receivables restricted by donor or grantor.
50	Total Restricted Assets	Excel sums all restricted assets (lines 47 through 49). Check that restricted assets equal restricted liabilities and net assets (line 50= line 57).
51	LIABILITIES AND EQUITY	Heading.

52	Total liabilities	Amounts due to the general fund and any liabilities whose purpose is restricted. If temporarily and permanently restricted liabilities and net assets are less than restricted assets, remove the amount necessary to balance restricted assets from unrestricted current liabilities (from other current liabilities if enough, otherwise from accrued expenses) and put here.
54	Temporarily restricted	Temporarily restricted net assets. Includes funds temporarily restricted by donor or grantor stipulations. Includes funds called specific purpose; property, plant and replacement; or term endowment funds.
55	Permanently Restricted	Permanently restricted net assets. Includes funds permanently restricted by donor or grantor stipulations, also called permanent endowment funds.
56	Total Restricted Fund Balance	Excel sums temporarily and permanently restricted net assets (lines 54 through 55).
57	Total Restricted Liabilities and Equity	Excel sums restricted liabilities and temporarily and permanently restricted net assets (Line 52 plus 56). Check that restricted assets equal restricted liabilities and net assets (line 50 = line 56).
58	INCOME STATEMENT ($000s)	Heading. All dollar amounts are rounded to the nearest thousand.
59	Gross Inpatient Service Revenue no	if available (footnotes or supplemental data)
60	Gross Outpatient Service Revenue	if available (footnotes or supplemental data)
61	Gross Patient Service Revenue (GPSR) **(In Maine, put inpatient and outpatient gross revenues in above this line if available**)	Total inpatient and outpatient revenues before deductions. Reported in footnotes (if missing, may be obtained from Medicare Cost Report). Add in amount reported as free care charges forgone (also in footnotes) unless it is already included in the GPSR amount.
62	DEDUCTIONS	Heading
63	Free Care	Amount of charges forgone for providing charity care, generally reported in the footnotes. (Be careful to enter free care charges not costs.) Since free care is included in the excel formula as a revenue deduction, it must be added to gross patient service revenue unless the GPSR footnote indicates that this amount is already included.
64	Bad Debt	Provision for bad debt is generally reported as an operating expense. In our format, we are maintaining it as a revenue deduction (affects the markup ratio). Subtract bad debt amount from operating expenses and insert it here instead.
65	Contractuals	Contractual allowances reported in footnotes, usually with gross patient service revenue. Includes discounts to third parties (Medicare, Medicaid, Blue Cross, commercial insurers, etc.) and employees, etc. If provision for charity is included, remove this amount from contractuals and enter amount as free care. Record this net of changes in estimated settlements from prior years , which goes on the next line...The total of 65+66 should equal total contractual adjustments presented in the footnotes.
66	Changes in prior year estimated/final settlements	From Footnotes, often in the section on accounting policies describing Net Patient Service Revenue, Estimated Third Party Settlements, or Use of Estimates. If impact on Net Patient Service Revenue is favorable, record this as a negative number (reduction in revenue deduction); if unfavorable, record a positive number.

67	Net Patient Service Revenue	Excel calculates gross patient service revenue minus deductions for free care, bad debt and contractuals (line 61-63-64-65-66). If gross patient service revenue is not available in the footnotes, record the net of net patient service revenue minus bad debt expense here.
68	Other Operating Revenue	Include any other operating revenue from non-patient sources (e.g., garage revenue, cafeteria revenue, rental income), usually reported as other operating revenue and assets released from restriction for operations.
69	Total Operating Revenue	Excel sums net patient service revenue and other operating revenue (line 67 plus 68).
70	OPERATING EXPENSES	Heading.
71	Depreciation and Amortization	Includes amounts listed as depreciation and amortization. If this is not broken out on the income statement, use amount reported on the cash flow statement.
72	Interest	Includes all interest expense. If not broken out on income statement, check footnotes. If the hospital has no long-term debt, enter zero.
73	Other operating expenses	Includes all operating expenses other than depreciation/amortization, interest and bad debt.
74	Total operating expenses	Includes depreciation, interest and all other operating expenses. (Note: Amount will be less that reported on income statement by amount of bad debt.)
75	Net Operating Income	Excel calculates total operating revenue minus total operating expense (line 69 minus 74).
76	NONOPERATING REVENUE	Heading. Includes all gains/losses due to activities peripheral to the mission of the hospital.
77	Interest and Dividends	Includes dividend income; interest income from and realized gains/losses on sale of unrestricted investments; and unrestricted income on restricted assets.
78	Realized Gains/losses on sales of securities	Include realized gains and losses on investments which accrue to the unrestricted fund; omit realized gains and losses accruing to restricted funds (see changes in net assets)
79	Permanently impaired security writedowns	Includes unrealized losses deemed other than temporary by management, and taken out of income
80	Total investment income	sum of lines 77 through 79
81	Gains/losses on joint ventures/equity investments	Includes gains or losses on sale of fixed assets and gains/losses from equity investments and joint ventures
82	Permanently impaired writedowns of other asset	Includes writedowns of assets deemed not worth their historical cost value, other than marketable securities
83	Other nonoperating revenues (gifts, bequests	Mostly contributions, gifts, bequest, although may include the "other" category
84	Total nonoperating revenue	Sum of lines 80 through 83
85	Excess of revenue over expenses	Excel calculates net operating income plus nonoperating revenue (line 75+84). This is the element used for total margin, ROA, ROE as it represents recurring performance, excluding nonrecurring items and non-income related changes in net assets (such as equity transfers, unrealized gains/losses, capital donations, changes in accounting policies)
86	Extraordinary Gains (Losses)	Generally related to extraordinary gains/losses from advance extinguishment of debt..
88	Total Surplus/Deficit	Line 85 + line 86
90	**Other Changes in Unrestricted Net Assets:**	

91	Net assets released for restrictions - capital	include transfers from restricted funds for capital, as well as direct capital donations
92	Unrealized gains (losses) on investments	Use the number in the statement of changes in unrestricted net assets; avoid using a total unrealized gain/loss that would include those accruing to restricted funds
93	Minimum pension liability adjustment	Occurs when market value of pension assets drops below a minimum level relative to the value of benefits
94	Transfers from (to) affiliates	Generally disclosed in statement of changes in net assets; some hospitals may report them as nonoperating expenses; read footnote on Affiliate transactions very carefully, and go back and see how these transactions were handled in prior years for guidance
95	Mergers	Cash impact of mergers; should be disclosed in cash flow statement
96	Consolidations with support organizations	Generally occurs around 2000 and later; due to accounting pronouncement requiring that hospitals show the value of assets held on their behalf by other organizations in their balance sheets. Disclosure wording varies considerably.C125
97	Other Changes	May include accounting policy changes and other nonincome transactions not specifically identified above, that affect unrestricted net assets
98	Total Change in Unrestricted Net Assets	sum lines 88 through 97
100	**STATEMENT OF CASH FLOWS ($000s)**	
101	CASH GENERATED FROM OPERATING ACTIVITIES	Heading.
102	Total Surplus/Deficit	Line 88
103	Noncash expenses (revenues)	Includes noncash items affecting the total surplus number , such as depreciation and amortization expenses, gains/losses on equity investments, gain/loss on sale of assets, realized gain on sale of investments, and gains/losses associated with extraordinary items. Do not include any adjustments for restricted accounts or for items not included in the total surplus number (e.g., unrealized gains, accounting policy changes, etc.).
104	Funds from Operations	Lines 102+103
105	Decr (incr) Current Assets Limited Use	Formula: Prior year minus current year current portion of AWUIL (Change in line 7)
106	Decr (incr) Accounts Receivable	Formula: Prior year minus current year current portion of patient accounts and other receivables excluding 3rd party and affiliate receivables (Change in lines 9 and 12)
107	Decr(incr) Affil Receivable	Formula: Prior year minus current year current portion of affiliate receivable (Change in line 10).
108	Decr (incr) 3rd Party Receivable	Formula: Prior year minus current year current portion of 3rd party receivables (Change in line 11).
109	Decr (incr) inventory	Formula: Prior year minus current year current portion of inventories (Change in line 13).
110	Decr (incr) other current assets	Formula: Prior year minus current year of other current assets (Change in line 14).
111	Incr (decr) accounts payable/accrued expenses	Formula: Current year minus prior year current portion of AP and AE (Change in line 31).
112	Incr (decr) 3rd Party Settlement	Formula: Current year minus prior year current portion of 3rd party receivables (Change in line 32).
113	Incr (decr) Due to Afffiliates	Formula: Current year minus prior year current portion of due to affiliates (Change in line 33).

114	Incr (decr) Other Curr Liab except LTD	Formula: Current year minus prior year of other current liabilities (Change in line 34).
115	CASH FROM WORKING CAPITAL	Formula: Sum lines 105 through 114
116	CASH FROM OPERATING ACTIVITIES	Sum of funds from operations and cash from working capital (l104+115)
117	CASH FROM INVESTING ACTIVITIES	Heading. Investing activities include changes in noncurrent assets.
118	Decr (incr) Bd Designted Invstmt	Formula: Prior year minus current year balance of board designated and undesignated investments. (Change in line 19). After 1995, most hospitals changed the valuation of marketable securities to market value, so balance sheet changes will include unrealized gains (losses). These must be added (subtracted), respectively, from the change in line 19. Check the actual difference provided in the SCF if difficult to reconcile cash flow statement,
119	Decr (incr) TrusteeHeld Invstmt	Formula: Prior year minus current year balance in trustee-held investments (Change in line 18). We assume all unrealized gains and losses go into line 117 above, for simplicity.
120	Decr (incr) Due From Affiliates	Formula: Prior year minus current year noncurrent portion of due from affiliates (Change in line 20). However, this must be adjusted for write-offs, which are frequent. Check footnotes regarding transactions with affiliates.
121	Decr (Incr) Affiliate Investments	Formula: Prior year minus current year noncurrent portion of investment in affiliates (Change in line 21). Gains/losses in equity of affiliate should be added/subtracted from formula here. Also, if amortization amount is available for any goodwill/intangible assets included in "affiliate investments," subtract amortization amount from the formula here.
122	Decr (incr) Other Noncurrent Assets	Formula: Prior year minus current year of other noncurrent assets (Change in line 22). If amortization amounts available for assets included in "other noncurrent assets," subtract amortization amounts from the formula here.
123	Decr (incr) PP&E gross (see note below about noncash lease transactions; be sure to include PP&E added this way to this row)	Insert amount reported on cash flow statement, reported as purchase of /additions to PP&E or capital expenditures; if you need to allocate it to the hospital subsidiary from a consolidated cash flow statement, try to do it based on the hospital's share of gross pp&e change that year: hospital change in GPPE /total change in GPPE consolidated = Hospital share of cash flow reported investment in PP&E
124	Sale of Fixed Assets	Insert amount reported on cash flow statement, reported as proceeds from the sale of fixed assets/PP&E.
125	Cash provided (used) in investing activities	Sum of lines 118 through 124
126	Cash Position before Outside Financing Activities	Sum of lines 116 and 125
127	CASH FROM FINANCING ACTIVITIES	Heading. Includes changes in long-term debt (incl current portion) and noncurrent liabilities and amounts transferred to/from restricted funds and other entities..
128	Issue Long Term Debt (include leases for equipment even if reported as noncash; be sure to add the amount added to PP&E as well)	Insert amount reported on cash flow statement, reported as proceeds from/issue of long-term debt/bonds payable and capital lease obligations. Do not insert reported proceeds from short-term obligations/notes payable/lines of credit, which should be captured in line 101 (change in other current liabilities).

129	Repay Long Term Debt (incl Current LTD)	Insert amount reported on cash flow statement, reported as payment of long-term debt/bonds payable and capital lease obligations. (Amount reported should include change in current portion of long-term debt). Do not insert amounts reported for payment of financing costs/bond issuance costs, which are captured in line 122 (change in other noncurrent assets), or any payment of short-term obligations/notes payable/line of credit, which are captured in line 114 (change in other current liabilities).
130	Incr (decr) Third Party Settlmt	Formula: Current year minus prior year noncurrent portion of 3rd party settlements (Change in line 38).
131	Incr(decr) Due to Affiliates	Formula: Current year minus prior year noncurrent portion of due to affiliates (Change in line 39).
132	Incr(decr) Pension, Self Insur	Formula: Current year minus prior year noncurrent portion of accrued pension, self insurance reserves (Change in lines 40 and 41).
133	Incr(decr) other Noncurrent Liabl	Formula: Current year minus prior year of other noncurrent liabilities (Change in line 42).
134	Transfers from (to) restricted funds	Transfers to/from restricted funds from/to general (unrestricted) fund for capital, as reported on line 91
135	Transfers from (to) other entities	Equity transfers from/to other entities, line 94. Reported on the statement of changes in net assets as well as on the cash flow statement under investing or financing activities. Sometimes disclosed in footnotes. (Note: if it is reported in the footnotes that part of transfer is loan forgiveness, be sure not to double count this amount with the formula in line 107 or line 120 (changes in current and noncurrrent affiliate receivables)
136	Cash Provided (Used) Financing Activities	Sum of Lines 128 through 135
137	Net Change in Cash	Sumd of line 126 and line 136
138	rec	Line 6, current year minus prior year
139	dif	Difference between change in cash per balance sheet and standardized cash flow statement. The difference should not be greater than 1% of total assets. (Note: difference is generally due to rounding or amortization or other noncash amounts captured in the formulas; however, in years in which the hospital adopted FASB 117 and FASB 124, larger differences may occur.). Mergers, consolidations, and other accounting policy changes will make it harder to reconcile
140	% total assets	line 139 /line 27 (see explanation, line 139); if over 1%, try to figure out why and fix it.

A MINORITY REPORT OF THE COMMISSION TO STUDY MAINE'S HOSPITALS

SCOTT BULLOCK
PRESIDENT, MAINEGENERAL MEDICAL CENTER
JOHN WELSH
CEO, RUMFORD HOSPITAL
JANUARY 28, 2005

A MINORITY REPORT
OF THE COMMISSION TO STUDY MAINE'S HOSPITALS

Scott Bullock
John Welsh
January 28, 2005

Introduction

The Hospital Study Commission was one of the various commissions created in the Dirigo Health law. The Commission was charged to:

- Study the comprehensive role of Maine's hospitals and evaluate them in the context of the state health plan priorities;
- Collect and evaluate data on overall hospital expenditures, cost efficiencies, the availability of health care services; and
- Determine opportunities/public policies to advance changes in hospital roles, to encourage collaboration and to improve affordability.

While we are supportive of 14 of the 20 recommendations included within the majority report, it is the opinion of the minority members that, overall, the majority report fails to accurately portray the current role and status of hospitals in Maine's health care delivery system, and the key drivers affecting health care spending, cost increases, and health insurance premiums. As a result, several of the key recommendations are not only inappropriate because they fail to address the primary drivers, but they have the potential to jeopardize access and quality. As a result of this inaccurate portrayal of the current system and associated challenges, the Commission reached erroneous and often redundant solutions.

Maine's 39 community hospitals have supported—and continue to support—efforts to ensure vital access to high-quality health care services throughout Maine and efforts to improve the affordability of health care and health insurance. We have the highest regard for our fellow commission members and the time they have dedicated to working on this project. However, we have been frustrated by preconceived notions of what needs to be done. There have been solutions offered to problems that don't exist and a general sense that Maine's hospitals are responsible for all that is expensive and wrong with the health care system.

We do agree with certain portions of the majority report, namely:

- Voluntary cost and margin targets
- Increasing public transparency of health care cost and quality data
- Standardized reporting of hospital financial data
- Implementation of evidence-based clinical protocols
- The importance of electronic medical records and other health information systems
- Efforts to increase administrative efficiencies
- Appropriate staffing of the Certificate of Need office.

The remainder of this report is focused on addressing our concerns with the characterizations of the key challenges in the health care system, recommendations that

we oppose, and data and factual statements that are inaccurate or misleading. These views and recommendations are focused on ensuring that our overall goal of improving health care affordability without sacrificing access or quality is met.

Overview

In addition to the emergency departments, intensive care units and operating rooms and other core services, Maine hospitals support doctors' offices, nursing homes, visiting nurse organizations, community wellness programs, disease prevention, rehabilitation, mental health and other services that reach beyond the hospital walls and do as much to prevent disease and injury as treat them. Maine hospitals also serve as the public health infrastructure–a role and cost typically borne by local and state governments in other parts of the country. These services not only provide care in the most appropriate setting at the right time, but also improve health care affordability by enhancing the health of individuals and reducing costly hospitalizations. In many parts of Maine, critical access to pediatricians, obstetricians, and family physicians would not exist if not for the financial support of the community hospital. Maine hospitals play a vital role in ensuring access to a broad range of health care services. In addition to acute care hospital facilities, hospitals are affiliated with 15 home health agencies, 17 skilled nursing facilities, 18 nursing facilities, 9 residential care facilities, and about 200 physician practices.

With more than 25,000 full and part-time employees, hospitals are vital to Maine's economy. Hospitals are most often the largest employer in their communities. Health care is one of the largest employment sectors in the state. An estimated 13,000 new jobs will be created in health care in Maine from 1998 to 2008.

Each day, Maine's hospitals experience the reality of our fragmented health care system. Each day hospitals, nurses, physicians, nursing homes, mental health providers, dieticians, physical therapists, home health agencies, social workers, pharmacists, lab employees, imaging technicians, housecleaning staff, medical records staff, community health directors, and so many more come to work to meet the health care needs of their communities. Every day hospitals are on the front lines with a mission to fulfill: To improve the health and welfare of the people in our communities.

Hospitals share the Commission's goals of improving the affordability of health care, strengthening access, and ensuring that investments in quality health care remain a top priority. It is crucial that initiatives to control costs do not jeopardize appropriate access to high quality health care services and efforts to improve the health status of Maine citizens.

Maine's hospitals provide quality health care 24 hours a day, seven days a week to all patients regardless of their ability to pay. Hospitals exist first and foremost to care for patients in times of need. Hospitals provide life-saving emergency and trauma care, offer many specialized technologies and services and perform miracles every day. In addition to their core services, hospitals provide substantial support to ensure the availability of primary care, continuing care, hospice and home health services, community wellness programs, rehabilitation, disease prevention, behavioral health, and many more services.

These services not only exist to provide care in the most appropriate setting and to improve community health status, but also to improve health care affordability by making individuals healthier and reducing costly hospitalizations. More than one-third of Maine's actively practicing physicians are employed by Maine hospitals.

Through free care, thousands of hospital patients without coverage receive needed medical services at no cost. In 2003, for instance, Maine hospitals provided more than $170 million in uncompensated care. Maine's acute care hospitals are nonprofit, community-governed organizations with more than 800 volunteer community leaders serving on the boards of Maine's hospitals. Maine is one of only a handful of states in which all of its acute care hospitals are non-profit.

We believe it is those volunteer board members, in consultation with hospital administrators, who can best decide the health care priorities for a given community. Who better can decide than the residents of a community if they need a pediatrician or a low-cost dental clinic or a facility to care for the elderly? Such needs in the face of limited resources drive hospitals to cooperate with each other to bring necessary services to an area. Every community hospital in Maine participates in organizations and/or partnerships to provide various peer collaborations.

In order to run efficiently and provide high quality care to their patients, hospitals engage in a variety of affiliations and collaborations. Hospitals are to be commended for their *voluntary* efforts to reduce duplicative services, and share staff, equipment and knowledge. Such collaborations have been made, without mandated centralization, to the benefit of patients.

We must strongly object to many of the characterizations of Maine's community hospitals, and several of the major recommendations developed as a result, that demean the day-to-day work of hospitals, their boards of trustees, and their staffs.

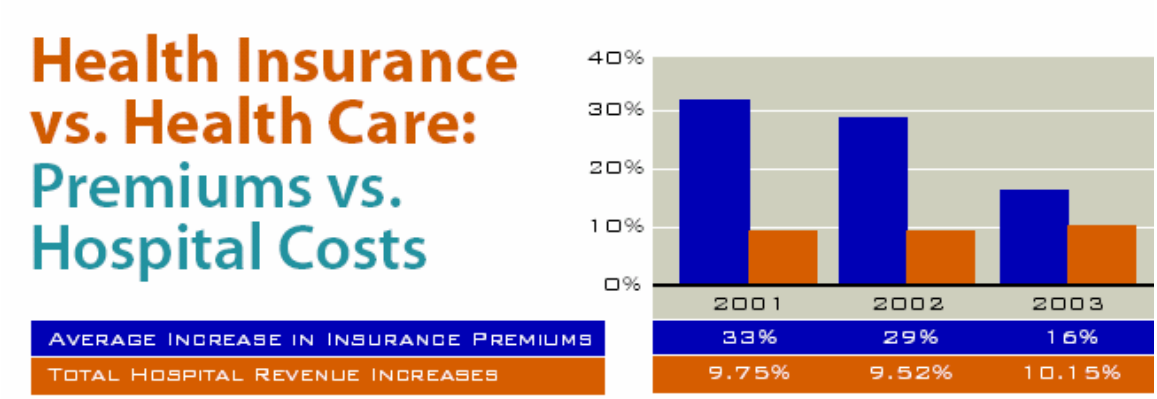
There is an unfortunate implication that Maine hospital trustees have been selfish in their governance role on Maine hospital boards and neglectful in fulfilling their fiduciary responsibilities. Although the report states: "The adequacy of Maine's community hospital network to provide high-quality, cost-effective care to all Maine citizens was evaluated in depth," with all due respect, this statement is simply not true. There was not an objective in depth evaluation of hospital costs, access demands, or clinical quality data. Nor was the financial impact of the current and future expansion of the MaineCare program in a state already in fiscal crisis measured and assessed. Had there been such an evaluation, this would be a very different report.

Maine's hospitals are not broken and in need of great repair by state government. Nor are Maine hospitals locked in a time warp. As we attempt to constrain costs in our health care system, we must not inappropriately reduce access to health care or jeopardize the quality of that care. In fact, Maine hospitals today are ranked third best in the country in the quality of care provided according to two recent studies conducted by Medicare. Additionally, Maine hospitals voluntarily undertook projects to evaluate themselves in terms of clinical quality and patient satisfaction. In the areas of heart attack and heart

failure treatments, Maine hospitals collectively scored better than **97 percent** of the hospitals in a national database.

Clearly, many of the reforms adopted in Maine's Dirigo Health law included initiatives and strategies to address the multitude of challenges we face in improving access to quality affordable health care in Maine. The creation of a new insurance program, the establishment of the Maine Quality Forum, greater transparency of cost and quality data, strengthening Maine's Certificate of Need process and the implementation of a state biennial health plan are all part of a comprehensive approach to improving access, increasing affordability, and improving quality–efforts we strongly support.

The key drivers of health care costs, health care spending, and health insurance premium increases are complex and many. And the problems created are real and frightening. In emergency rooms, clinics, and physician practices, hospitals experience the harsh reality of the gaping holes in our system and the impact of delayed care or the fear of losing coverage. While we agree that health insurance has become unaffordable for many individuals and businesses, this Commission did not conduct an analysis of health insurance premiums in Maine. However the majority report consistently refers to increasing health insurance premiums as justification for key recommendations—a justification that is without merit given the absence of any review of the multitude of drivers affecting health insurance premiums. Furthermore, premiums have risen at a far greater rate than hospital costs as the chart below illustrates:

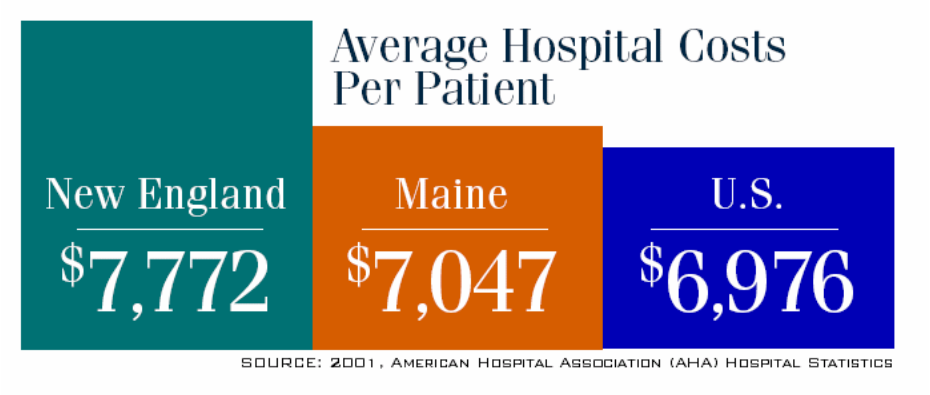


Source: Bureau of Insurance and Maine Hospital Association

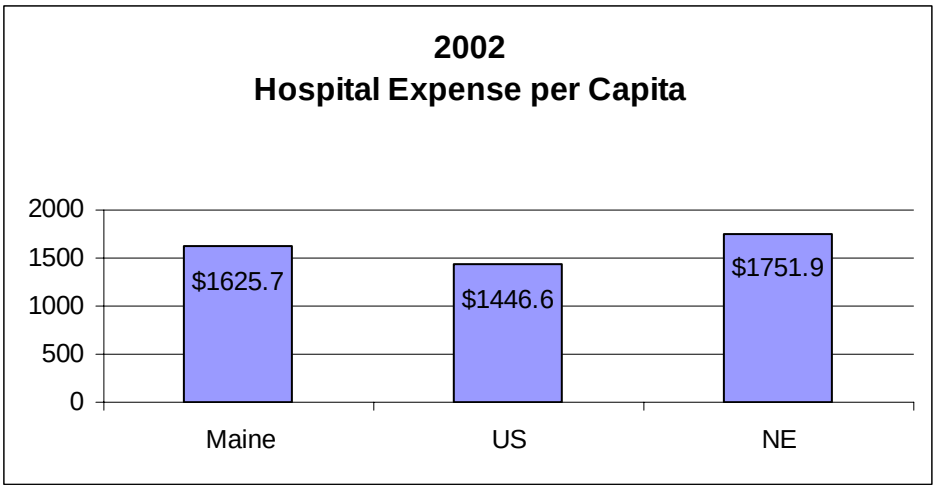
The high premiums cannot be because Maine hospitals cost more than in other areas. Maine hospital costs are below the New England average and only slightly above the national average. We have several concerns with Ms. Kane's financial analysis of hospitals. Specifically, the labeling of hospitals as high, medium and low performers would suggest that much of their financial health is within their control. The reality is that hospital budgets are greatly affected by the broken payment systems created by state and federal government insurance programs that fail to cover the costs of their beneficiaries and the socio-economic status of the communities served by these hospitals, which dictates the types of health care services needed in a region. Moreover, the need for critical services, such as community–based mental health services, is yet another example of the various gaps in the system that Maine hospitals seek to fill. Ironically, the

issues related to mental health services are not acknowledged in the majority report, nor are continuing care services or primary care services and their impact on hospital services and hospital budgets. Ms. Kane's labels are misleading and a disservice to a true analysis of Maine's hospital delivery system. With no margin there is no mission. Without margins, hospitals would be unable to financially support physician practices, nursing homes, home health agencies, public health initiatives and numerous other health care services that routinely lose money because of chronic below-cost reimbursement by Medicare and MaineCare.

In 2002, the most recent year for which we have comparative data, the median operating margin in Maine hospitals was 1.1 percent, which is actually below the national average. That margin is below the Dirigo target of 3 percent and below what most experts would define as a credit-worthy nonprofit. Ms. Kane's cost data uses a methodology that fails to comprehensively look at Maine's hospitals and the totality of services they provide. It makes inappropriate adjustments that fail to truly capture hospital costs. The following data is based on a nationally accepted methodology of evaluating hospitals costs that uses the same data source as is used by Nancy Kane but with a very different conclusion.

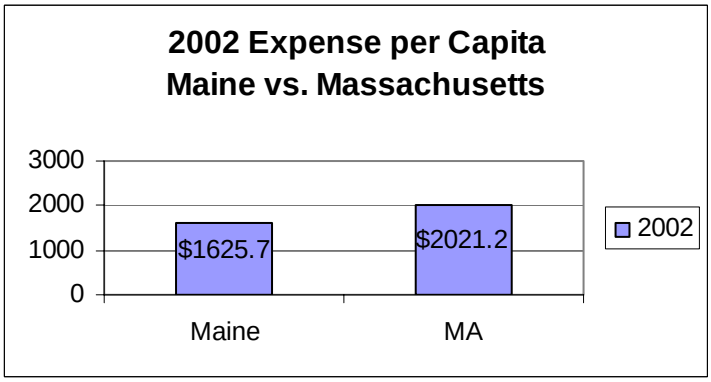


A straight forward, simple way to look at hospital costs, is to look at those costs per person. As the chart below shows, Maine's hospital costs per capita are lower than New England's costs.



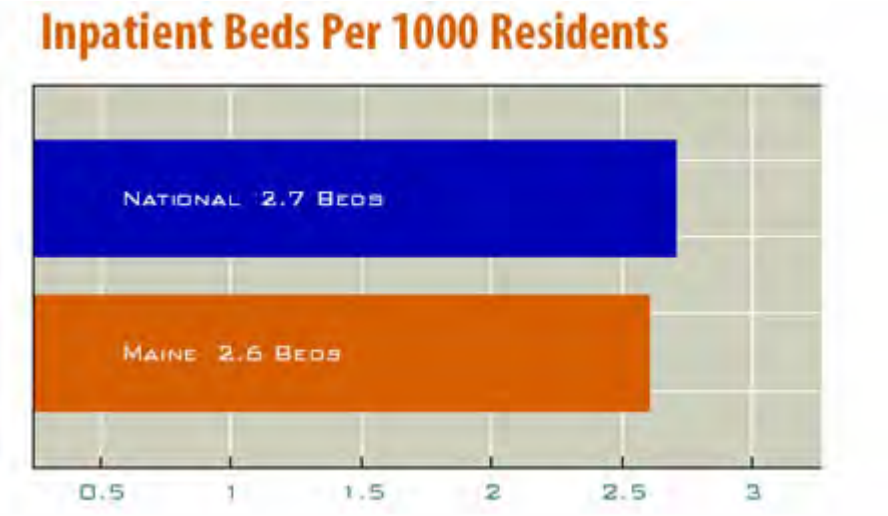
Source: American Hospital Association Statistics

And Maine's hospital cost per capita is significantly lower than costs in Massachusetts.



Source: American Hospital Association Statistics

Nor can the high premiums be because Maine has "too many" hospital beds because the number of hospital beds per 1,000 residents is less than the national average.



Source: Milliman USA

One of the fundamental disagreements we have with the majority report is that our fellow commissioners chose to use data to support their contentions that we believe is flawed and does not accurately portray the true cost of hospital care in Maine.

Many of the majority report's recommendations are unnecessary, not only because they are already part of hospital efforts throughout the state, but many of them are duplicative of existing law and initiatives currently underway in Dirigo:

- Clinical Protocols/Best Practices: Maine Quality Forum
- Electronic Medical Records: Maine Quality Forum
- Health Planning: Governor's Office of Health Policy & Finance - State Health Plan
- Rationing Development of New Medical Technology and Health Care Services: Certificate of Need and Capital Investment Fund.

The establishment of the biennial state health plan, the creation of the Maine Quality Forum and the strengthening of the Certificate of Need program are substantial initiatives that significantly address many of the key drivers of health care spending and health care cost increases.

The Drivers of Health Care Spending

Today, like never before, there are enormous economic pressures on our hospitals. Total health care spending, hospitals, physicians, drugs, etc. is increasing–in Maine and nationally. We also recognize that one of the largest drivers of health care spending is all of us. Patients increasingly demand unfettered access to sophisticated medical technology and medical services. New medical technologies—from CT scans and drug-coated stents to targeted chemotherapies—may be responsible for as much as half of the U.S. medical cost growth, according to some health economists. These drivers of health care spending are further compounded by an increasingly unhealthy population that suffers from a sedentary lifestyle and poor eating habits. Maine has the fourth highest rate of chronic disease in the country. Chronic diseases cause a third of all disabilities and often require long hospital stays. Future insurance premium growth will have more to do with increases in health care spending as a result of higher utilization rates, increasing costs of medicines and new medical technologies, consumerism and a rapidly aging population. We all want, and many need and use, a lot of health care—far more than was consumed generations ago. Advancements in medicine, the pace of technology, the incidence of chronic disease and unhealthy lifestyles, and a rapidly aging population are driving much of the consumption of services. Utilization—patient volume—is the primary driver of the increase. More people are using hospitals, not surprising given our aging population:

Hospital Utilization:

	1997	**2003**
Admissions	143,351	148,517
Outpatient visits	2,661,645	3,925,464

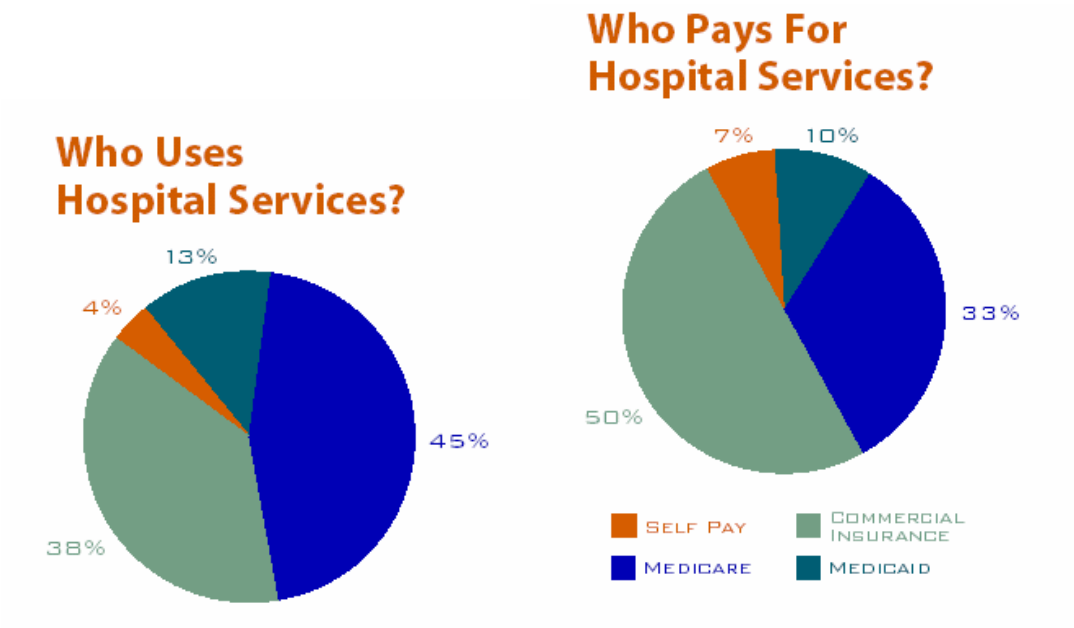
The following are the key drivers of health care costs, health care spending and health insurance premiums and the key strategies to address health care affordability and quality.

Key Health Care Cost and Spending Drivers:

- Increasing consumer demand
- High incidence of chronic diseases in Maine: 20 percent of the population responsible for 80 percent of health care expenditures
- Rapidly aging and increasingly overweight population in need of more health care services
- Expensive medical technology and information systems
- Cost of drugs
- Health care professionals recruitment and retention; wages and benefits
- Defensive medicine/liability insurance
- Cost increases of blood and other medical supplies
- Enrollment increases in MaineCare
- Cost of regulatory compliance

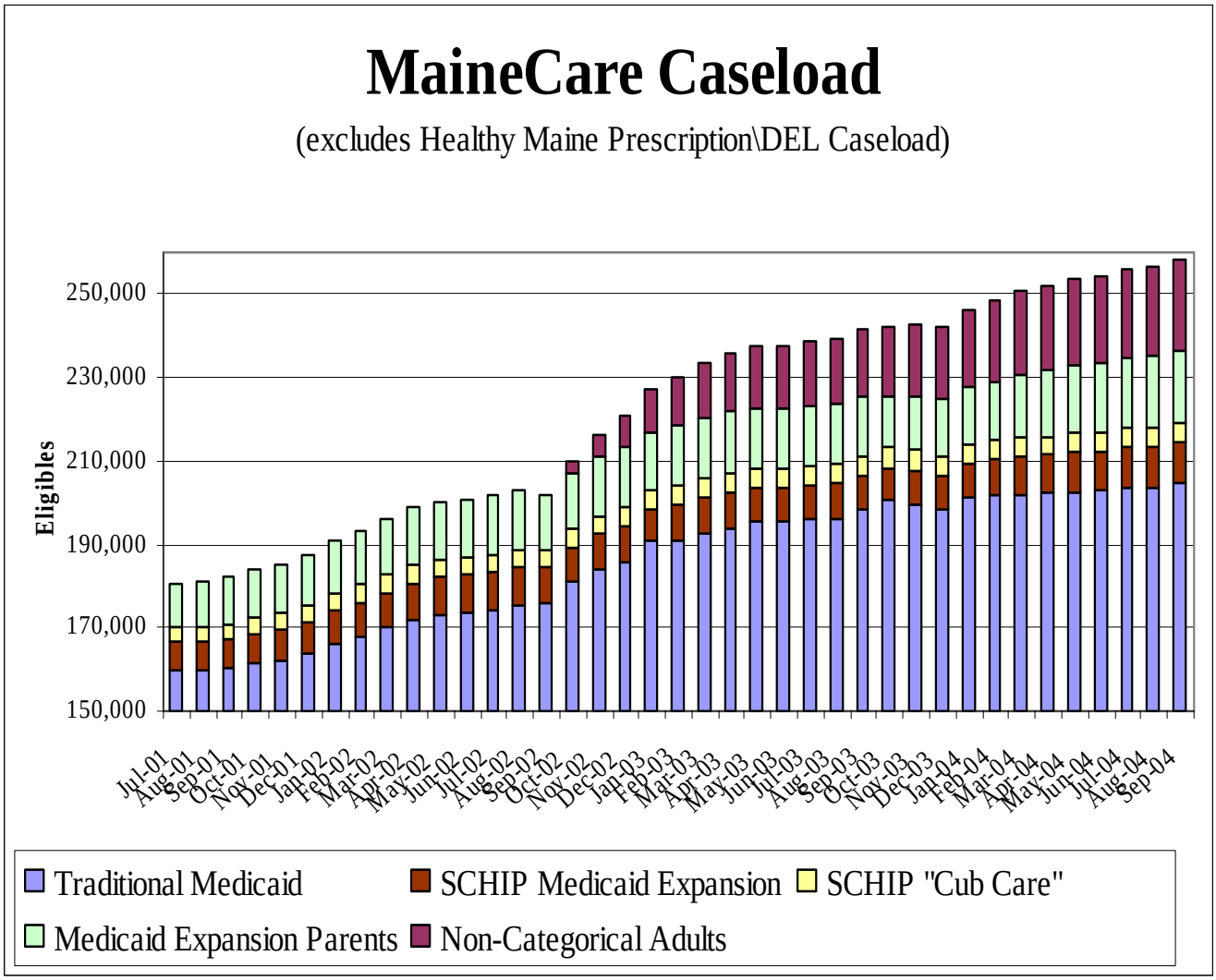
A lot has changed for hospitals in the past 10 years. Managed care, which so aggressively managed costs rather than care, significantly constrained hospital margins elsewhere in areas of the country where managed care companies dominated the insurance market. While managed care had an impact in reducing costs in Maine, hospitals here were not subjected to the destructive cost-cutting wrath experienced elsewhere that sacrificed quality and access for the sake of financial savings. These differences can be seen in Ms. Kane's chart on operating margins—while managed care was forcing hospital closures in other parts of the country, Maine hospitals survived.

In Maine, 58 percent of hospital services are provided to Medicare and MaineCare patients—public payers that fail to fully reimburse hospitals for the costs of caring for these individuals. Fully 14.4 percent of Maine's population is 65 or older (the national average is 12.1 percent), with our state having the seventh highest population of elderly. That 14 percent of Mainers aged 65 plus account for 45 percent of all hospital services provided. Medicare, which covers those 65 and older, pays only 88 cents for every $1 of care provided.



MaineCare, the insurance program for the poor and disabled, pays hospitals only 75 cents for every $1 of care provided to its patients. In addition to that shortfall, the Maine state government owes hospitals more than $120 million in payments for individuals that Maine hospitals treated and cared for during the past three years and have not been paid for *at all.* Additionally, for state fiscal year 2005, projections are that the state will owe hospitals more than $75 million as the result of growing utilization that has not been budgeted for by the state in their reimbursement for hospital services. It is simply irresponsible to evaluate the financial "performance" of Maine hospitals and ignore the significant debt owed to Maine hospitals by the State's MaineCare program.

MaineCare Enrollment from July 2001 – September 2004

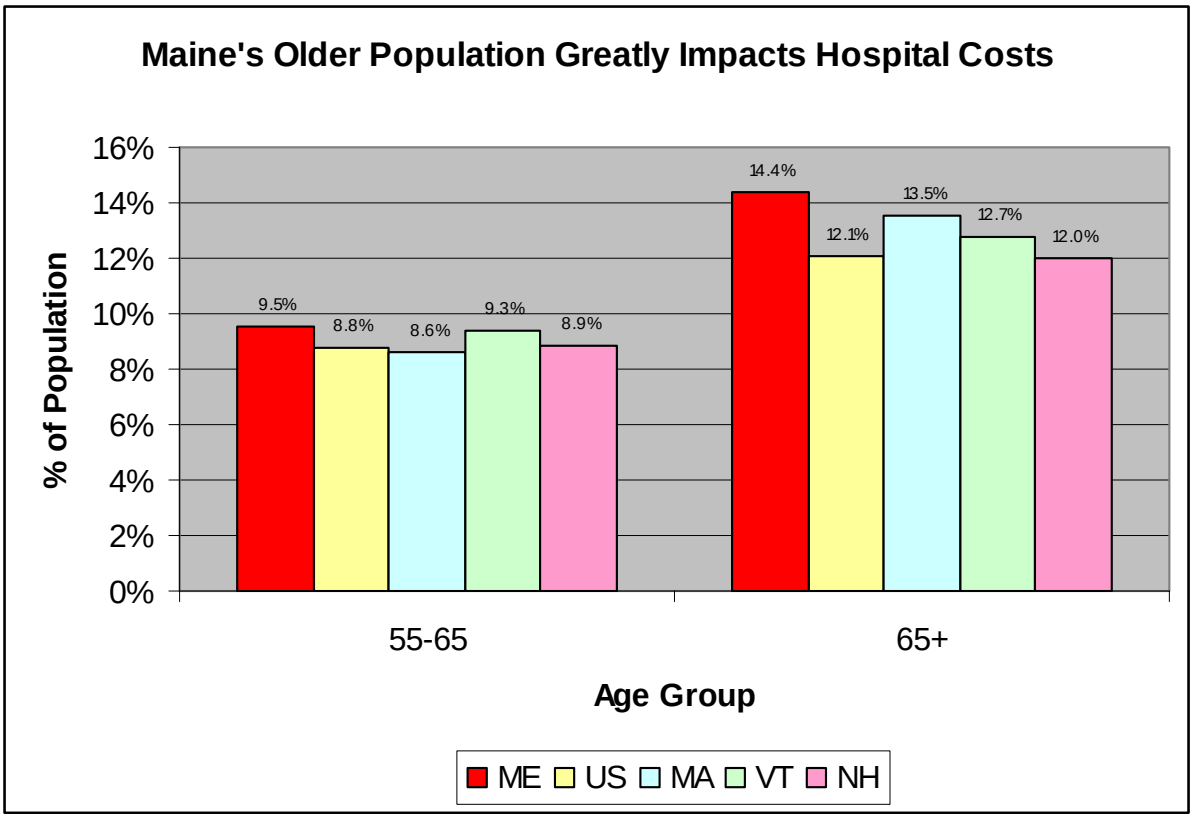


- Medicaid (MaineCare) pays only 75 percent of what it costs to care for Medicaid beneficiaries.
- Maine hospitals are not immediately reimbursed for the services they provide Medicaid patients. Instead, hospitals are paid a weekly Prospective Interim Payment (PIP) that is based on the estimated number of Medicaid patients the hospital will treat. However, the state has not updated the estimated number of patients each hospital serves, despite the fact that hospitals are serving an increasing number of Medicaid recipients because of increasing enrollment. As a result, hospitals are providing services that go unpaid for two or more years.
- Maine hospitals are owed more than $120 million for services provided to MaineCare beneficiaries over the past three years that were not reimbursed through the hospitals' Prospective Interim Payments (PIP).
- The projected underpayment of hospital PIPs for FY '05 as a result of increasing Medicaid patient utilization is $75 million.

There is no doubt that the failure of these two large government payers to fairly reimburse for the costs of caring for their beneficiaries is a significant contributor to the affordability problem in Maine. These losses cannot be sustained by hospitals and other health care providers. These shortfalls created by government payers are exacerbating the affordability crisis in commercial health insurance because these losses must be recovered through higher charges borne by the commercial and self-paying patients. Poor reimbursement by government is forcing hospitals to hire more physicians in order to ensure critical access to primary care and other needed physician specialists who cannot financially support their practices independently because of government's significant under-funding. The state and federal government, through their reimbursement policies, are eroding critical access to health care services. These policies are not only compounding the challenges of managing hospital budgets in Maine but further jeopardizing the ability to maintain an adequate health care delivery system that will advance the State Health Plan's goals of improving the overall health of Mainers.

The State Health Plan's goal is to make Maine the healthiest state in the nation. Maine hospitals support that goal every day with their preventive and acute care services. But hospitals can offer these services and fulfill their mission of improving community health only if they are financially healthy too. Their budgets must balance their mission with critical accounting and banking standards that govern their financial decision-making to ensure the viability of these community assets.

Health care financing is stunningly complicated. One simply cannot compare the management of for-profit enterprises with the management of nonprofit charitable organizations. In few for-profit industries is a service provided, only to be paid for years later as happens with MaineCare patients. And few for-profit companies would continue to subsidize money-losing services the way that hospitals, as part of their charitable and benevolent missions, support emergency rooms, pediatric practices, nursing homes, home health agencies, public health initiatives, etc. But hospitals are different. Their mission isn't to make money—it's to save lives and improve health.



- Maine has the 4th-highest rate of chronic disease in the U.S.
- Chronic diseases cause over a third of all disabilities, and often require long hospital stays.
- Fully 14.4 percent of Maine's population is 65 and older (7th highest in U.S.), vs. 12.1 percent nationally.
- The 14.4 percent of Mainers aged 65-plus account for 45 percent of all hospital services provided.
- Even though just 14 percent of Maine's residents are insured by Medicare, these beneficiaries use the health care system more than any major sector of the payer community, *including all commercially insured individuals*.
- Medicare pays only 88 percent of what it costs to care for an individual.
- Maine ranks 46th nationally in the percentage of costs that are reimbursed to its hospitals by the federal Medicare program.
- When federal and state governments fail to make payments that cover the costs of caring for their beneficiaries, it puts a strain on the State's entire health care delivery system.

Key Health Insurance Premium Drivers:

- Lack of competition
- Health care utilization and cost increases
- Regulation of the commercial insurance market
- Cost-shifting to commercial payers as a result of Medicaid & Medicare's failure to reimburse for the full costs of caring for their beneficiaries
- Mandated benefits

- Small risk pool in Maine
- Healthier people dropping coverage preferring to take the risk rather than pay the premiums.

Strategies to Improve Health Care Quality & Affordability

- Improve health status of Maine people to reduce, over the long term, preventable hospitalizations and the use of expensive drugs.
    - Ensure vital access to appropriate health care services through affordable health insurance coverage and implementation of the state's biennial health plan;
    - Strengthen public health programs; and
    - Implement evidence-based clinical protocols to achieve quality outcomes.
- Improve the affordability of health care through:
    - Increased transparency and public accountability of health care costs and quality;
    - Rational development of expensive services and technology through the Certificate of Need process;
    - Increasing reimbursement by Medicaid and Medicare;
    - Agreements to voluntarily limit cost increases and margins;
    - Implementation of evidence based clinical protocols and disease-management protocols;
    - Implementation of electronic health information systems, with appropriate financial and technical support; and
    - Evaluate opportunity for state-wide health information network.

Cooperation, Collaboration, Affiliation and/or Consolidation

Maine hospitals are committed to operating efficiently. Hospitals have joined together to recruit physicians, to bring needed medical technology into an area, to share information on best practices, to facilitate cost-efficient bulk purchases, to implement important health information systems—all cost savings measures that also help hospitals meet their mission. Furthermore, hospitals are working closely with the state to comply with voluntary cost targets to continue to hold cost increases down. Moreover, 11 Maine hospitals have converted to critical access hospital status. The Critical Access Hospital program was established by the federal Medicare program in the late 1990's and adopted by Maine to recognize the importance of rural hospitals and the need to provide additional financial security to these hospitals and the vital services they provide to their communities. These hospitals have agreed to limit their number of beds to 25 and the average length of stay for patients in exchange for cost-based reimbursement of allowable costs by Medicare and MaineCare. This improved reimbursement creates added financial stability for these hospitals to allow them to maintain vital access to critical acute care hospital services and to support primary care and other health programs in their communities.

There *is* a strong theme of centralization and greater state oversight of hospitals that permeates the majority report. Although community hospitals shared hundreds of examples of the types of affiliations and collaborative partnerships that exist to meet health care needs and increase cost efficiencies, those are not included in the majority

report and are largely ignored in the context of that report's recommendations. The notion that Maine hospitals work in a vacuum and in isolation or that more services need to be delivered on a regional basis and less on a local basis again underscores how little is understood of the workings of the existing hospital system. As a small state, the interdependency and collaborative relationships among health care providers are critical and evident throughout Maine.

Hospitals work in a variety of collaborative relationships including the Maine Hospital Association (MHA), the Maine Health Alliance, Quorum, the three hospital systems, Synernet, the Maine Quality Forum, and between individual hospitals and within hospital systems. These relationships include efforts to capitalize on group purchasing, clinical collaboration, development of shared information systems and quality improvement initiatives among peers.

Hospitals in Maine participate in quality improvement initiatives through the MHA that evaluate clinical care and patient satisfaction and identify tools through shared best practices to improve care and patient experience. Hospital data collected through this initiative was publicly reported in May 2004 and will be updated in 2005. The majority report makes no mention of this initiative. In fact, one of the examples cited in the majority report is the Biomedical Waste facility, which is a venture developed and owned by the Maine Hospital Association and facilitated by a close working relationship with the Department of Environmental Protection.

We support the proposed amendments to the Hospital Cooperation Act that are intended to provide greater opportunities for hospitals to voluntarily collaborate and voluntary collaboration between physician practices.

We oppose the creation of any kind of state-overseen consortium as unnecessary because it would be an additional unneeded costly bureaucracy given the existing and growing collaborative efforts. State involvement is duplicative and could prove to be an inhibitor to continued creative collaboration among hospitals. The majority report's recommendation in this regard is dominated by the view that there is a need for greater centralization of hospital care arguing that "Family doctors and local hospitals **were** primary sources of health care." Family doctors and local hospitals **are** primary sources of health care and must remain so. Specialized and complex services are already largely limited to Maine's larger hospitals.

The proposal to create a voluntary state-level consortium of various stakeholders and state government is unnecessary. The proposed list of potential benefits from such an organization are duplicative of efforts already underway by hospitals through the organizations mentioned above.

Recommendation: We recommend that the Legislature amend the Hospital Cooperation Act to provide greater opportunities for hospitals and physician practices to voluntarily collaborate.

Electronic Medical Records

Consumers, employers, payers and regulators continue to seek more detailed information regarding the quality of care and patients' satisfaction with their hospital experience. There is a push to embrace computerized pharmacy technology and electronic medical records—both of which will require enormous financial investments. Pressure to collect and report clinical quality data and to invest in expensive health information systems has a significant financial price tag that must be acknowledged in the overall debate in balancing cost, quality and access.

We support the implementation of electronic medical records as long as there is consideration of the costs, timeframe and available software, etc. The Maine Quality Forum has made implementation of electronic medical records one of its top priorities. We urge the state to issue bonds to finance the purchase of these expensive information systems for both hospitals and physicians.

Recommendation: We recommend that the state issue bonds to finance the purchase of electronic medical records systems by both hospitals and physician practices.

Rule 850

Bureau of Insurance Rule 850 was recently amended in the Dirigo statute to permit an insurance carrier to provide financial incentives encouraging members to use designated providers for a limited set of services insofar as these providers meet specified quality standards. Therefore any changes to Rule 850 are not only unnecessary but will detrimentally affect critical access to services.

Suggestions that institutions be designated higher quality only if they comply with all 30 National Quality Forum (NQF) recommended safe practices are inappropriate because:

- We question whether these 30 practices should be the complete and sole measure of whether a provider is of "higher quality."
- All 30 practices are not uniformly applicable to all Maine hospitals, ambulatory surgery centers and other health care institutions. For example, the NQF report clearly identifies which practices are inappropriate for small rural hospitals as well as which ones might be incrementally implemented.
- Currently, there are no nationally accepted objective methods for measuring compliance or validating compliance. The NQF report recommends that performance measures should be developed to assess the implementation and use of the safe practices and that those measures should be endorsed by the NQF.

We do not support expanding the authority of the Maine Quality Forum to serve as final arbiter of quality designations within the Bureau of Insurance Rule 850.

Recommendation: Bureau of Insurance Rule 850 should remain unchanged.

The Health Care Payment System

Medicare/MaineCare: The chronic under-payments by the two public payers has created significant shortfalls–Medicare reimburses hospitals only 88 percent of costs; MaineCare reimburses Maine hospitals on 75 percent of costs. These shortfalls have contributed to the increasing commercial health insurance premiums as a result of the cost-shifting of those losses.

Moreover, attention should be given to the difference between costs and allowable costs. MaineCare and Medicare only reimburse hospitals for defined allowable costs, other costs are excluded from reimbursement. One notable example of an excluded cost is physician recruitment.

The state and federal government have failed to pay their fair share of the costs of caring for their beneficiaries. Rural Maine hospitals are reimbursed about 50 percent less per DRG by Medicare than their urban counterparts in other states. However, Maine hospitals' costs for supplies, wages, medical technology, etc. are not 50 percent less than the costs paid by larger urban hospitals.

MaineCare must increase its reimbursement to physicians and to hospitals. The answer to Maine's budget problems, and specifically the MaineCare budget, has been to cut reimbursement to hospitals, physicians, nursing homes, and other health care providers–jeopardizing access to providers and eroding necessary financial support to maintain quality care for MaineCare beneficiaries. Maine hospitals are owed more than $120 million in payments for services provided over the past three years to MaineCare beneficiaries. For the current year, it is estimated that hospitals are being under-reimbursed by more than $75 million.

Recommendations: The state should pay hospitals for the accumulating debt for services provided to MaineCare beneficiaries that have not been reimbursed and increase its PIP payments to more accurately reflect current utilization rates. The state budget should not be balanced on the backs of physicians and hospitals. Medicare and MaineCare should pay for the total cost of caring for their patients.

Governance

Hospital Boards of Trustees take their jobs seriously and have responsibly overseen the governance of their respective hospitals. The IRS and the State Attorney General have significant authority and oversight of tax-exempt charitable and benevolent organizations. The IRS requires that all nonprofits report the salaries of their highest paid employees on their form 990s and make that information available to the public. It is unnecessarily duplicative to have additional reporting requirements.

Recommendations:
We oppose additional compensation reporting requirements as redundant and unnecessary.

Controlling Costs and Passing Savings to Consumers

Maine hospital costs are substantially below the New England average and slightly above the national average. For the most recent reporting year, Maine hospital margins are below the national average.

Maine's low personal income is not a justification for reducing hospital and health care spending. People who live in a poorer state should not be cheated out of an adequately funded and quality health care system, just because they aren't wealthy.

Financial Transparency/Benchmarking/Targets

Standardization: Because hospitals report their financial status in different ways, it can be difficult to compare hospitals. Therefore we recommend, concurring with the majority report, that additional data be submitted and discussions begin to identify other areas that lack standardization in order to achieve greater comparability.

Reporting: Efforts to provide greater information on hospital costs, charges, and margins should be continued. The Administration has the authority to use hospital audited financial statements to issue reports. Therefore, there is no need for additional statutory authority.

Targets: Hospitals should continue efforts to comply with negotiated voluntary margin and cost increase targets. These targets should be set in a collaborative manner, rather than dictated by state statute.

Administrative Compliance: Increasing the oversight of the Governor's office to verify compliance with targets will result in unnecessary costs to the system. It is unnecessary given the improvements to the reporting system.

Recommendations:

- We support greater public reporting of hospital finances.
- Hospital financial reporting should be standardized.
- Hospitals should continue efforts to comply with negotiated voluntary margin and cost increase targets.

Special Situations

The fact that during the past six years, 11 hospitals (three in the past four months) have taken advantage of the Critical Access Hospital Program means that Maine's health care system is vastly different from what it was a decade ago. The program's limits on bed numbers and length of stay forces the CAHs to forge relationships with larger hospitals, increasing opportunities for cooperation while still maintaining a local presence in their communities.

Furthermore, federal reporting requirements and changes in accreditation requirements mean that hospitals have embraced evidence-based protocols and more clinical

collaboration. All this has occurred and continues to occur without further state intervention.

Malpractice

Malpractice insurance rates are not the only portion of litigation that raises the cost of health care. While premium increases are a part of the problem, they are only one factor of the equation affecting increasing health care costs.

The threat of lawsuits is ever-present in the practice of medicine. The practice of defensive medicine is a significant contributor to increasing health care costs. Doctors, fearful that they will be sued, order tests that would ordinarily be unnecessary, just to ensure they haven't missed an unusual diagnosis.

While we agree that health care quality and affordability will be enhanced through greater implementation of evidence-based clinical guidelines, we must consider additional legal protections for health care providers to reduce the amount of defensive medicine, to reduce the frequency of litigation, and to improve health care affordability. Implementation of clinical guidelines should be strongly linked to tort reform to reduce the extent of defensive medicine in Maine.

We also recommend that we reduce malpractice rates and ensure its availability by establishing a cap on non-economic damages and preserving/strengthening Maine's pre-litigation screening panels.

Recommendations:

- Implementation of clinical guidelines should be strongly linked to tort reform to reduce the extent of defensive medicine.
- The Legislature should set a cap on non-economic damages.
- Maine's pre-litigation screening panels should be strengthened.

Certificate of Need

The state CON office is woefully understaffed. We support strengthening the CON office. Any increase in the budget should be based upon clear review of the existing budget and the needed resources to ensure that the CON unit and the Department will greatly improve the administrative efficiency in the review of CON applications. Fees were recently and substantially increased last month and should not be increased again at this time.

Capital projects that fall below the current thresholds should not be reported to the CON division. Such a requirement adds unnecessary costs to the system.

Maine's CON statute was recently amended and provides substantial authority to the Department. We do not support additional statutory language regarding CON criteria or look-back provisions given the Department's current broad authority. The Department has very broad authority to request data and to add conditions to applications.

Recommendation:
- The state CON office should be fully staffed.
- The Certificate of need process should be used to fulfill the goals of the state health plan.
- The Capital investment fund cap should be raised.

Wellness

We support efforts to strengthen public health, prevention, and wellness programs. We support preservation of the use of the tobacco settlement monies that currently fund many of these programs.

Recommendation: The state health plan should define health care needs throughout the state and, using the CON process, ensure that those needs are appropriately met.

Quality

Maine hospitals today are ranked third best in the country in the quality of care provided according to two recent studies conducted by the Centers for Medicare & Medicaid Services. Additionally, Maine hospitals voluntarily undertook projects to evaluate themselves in terms of clinical quality and patient satisfaction. In the areas of heart attack and heart failure treatments, Maine hospitals collectively scored better than 97 percent of the hospitals in a national database. In patient satisfaction, Maine hospitals collectively scored above the norm 175 times in 16 categories. Not only are these studies indicators of the high quality in Maine hospitals but are also directly linked to effective staffing of our hospitals. The report can be found at http://www.themha.org/pubs/Caring for our Communities.pdf.

Consumers and purchasers must have access to a reasonable amount of meaningful quality data that lead to informed decisions. Quality initiatives must be coordinated on a national and state level to avoid duplication and to minimize costs associated with participation in data collection and reporting. Quality initiatives should be prioritized to reflect key health concerns, both to improve the quality of outcomes and to reduce overall health care costs.

Quality data is not claims data. Claims data reflect where people get care, how often they get care and why they get care but they are limited in measuring the quality of care received. Claims data is not clinical data based on medical records.

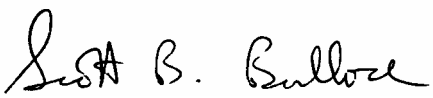
We must recognize and reduce variation in practice by using clinical, evidence-based protocols to improve the quality of care available in the hospital and in the community to reduce health care through reduced utilization.

Recommendations:

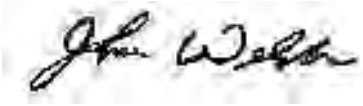
- Identify a single uniform statewide approach for measuring, improving and reporting on the quality of health care at Maine hospitals.
- Focus quality initiatives on prevalent chronic diseases that are major causes of illness and disability in Maine.
- Facilitate the development and implementation of properly structured pay-for-performance programs.
- Using the Maine Health Data Organization's claims database, analyze the way care is accessed in Maine to improve standardization of clinical care and better clinical coordination. Seek agreement by the state and federal governments to release Medicare and MaineCare claims data to this database.
- Use quality data to encourage the reduction of practice variation around clinical, evidence-based protocols.

Maine's community hospitals have worked with the governor's office to voluntarily comply with the margin and cost limits set by the Dirigo legislation. Hospitals have also worked to keep down costs while maintaining superior quality. Medical care and medical needs in Maine are ever-changing. Our challenges are great. We have great opportunities to meet these challenges. Maine hospitals and their team of community leaders and health professionals are and will be responsive to the changes needed to provide high quality affordable care close to home. We have great opportunities to meet these challenges if we take the recommendations we have presented in this report.

Respectfully submitted,



President, MaineGeneral Medical Center



CEO, Rumford Hospital

List of Maine Hospitals

The Acadia Hospital Bangor

The Aroostook Medical Center Presque Isle

Blue Hill Memorial Hospital Blue Hill

Bridgton Hospital Bridgton

Calais Regional Hospital Calais

Cary Medical Center Caribou

Central Maine Medical Center Lewiston

Charles A. Dean Memorial Hospital Greenville

Down East Community Hospital Machias

Eastern Maine Medical Center Bangor

Franklin Memorial Hospital Farmington

Goodall Hospital Sanford

Houlton Regional Hospital Houlton

Inland Hospital Waterville

MaineGeneral Medical Center Augusta/Waterville

Maine Coast Memorial Hospital Ellsworth

Maine Medical Center Portland

Mayo Regional Hospital Dover-Foxcroft

Mercy Hospital Portland

Mid Coast Hospital Brunswick

Miles Memorial Hospital Damariscotta

Millinocket Regional Hospital Millinocket

Mount Desert Island Hospital Bar Harbor

New England Rehabilitation Hospital Portland

Northern Maine Medical Center Fort Kent

Parkview Adventist Medical Center Brunswick

Penobscot Bay Medical Center Rockport

Penobscot Valley Hospital Lincoln

Redington-Fairview General Hospital Skowhegan

Rumford Hospital Rumford

St.Andrews Hospital Boothbay Harbor

St. Joseph Hospital Bangor

St.Mary's Regional Medical Center Lewiston

Sebasticook Valley Hospital Pittsfield

Southern Maine Medical Center Biddeford

Spring Harbor Hospital Westbrook

Stephens Memorial Hospital Norway

Waldo County General Hospital Belfast

York Hospital York