

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

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JANUARY 28, 2005

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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, dietitians, 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.

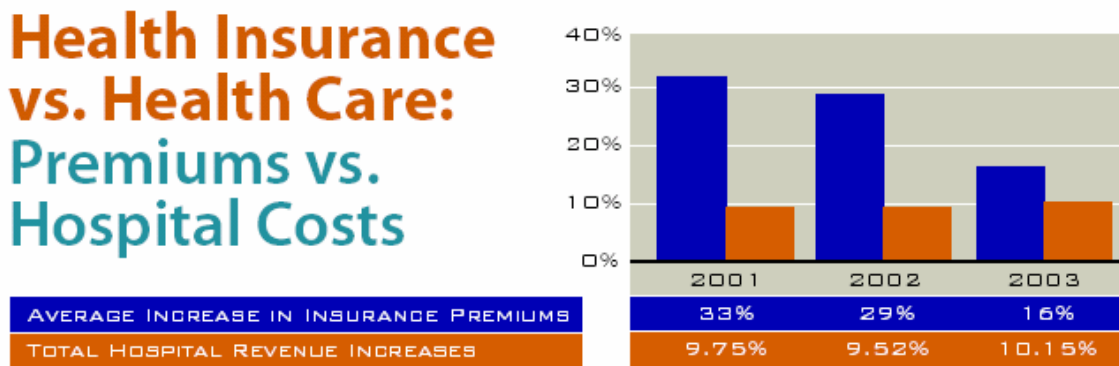
There is an unfortunate implication that Maine hospital trustees have been selfish in their governance role on Maine hospital boards and neglectful in fulfilling their fiduciary responsibilities. Although the report states: "The adequacy of Maine's community hospital network to provide high-quality, 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:

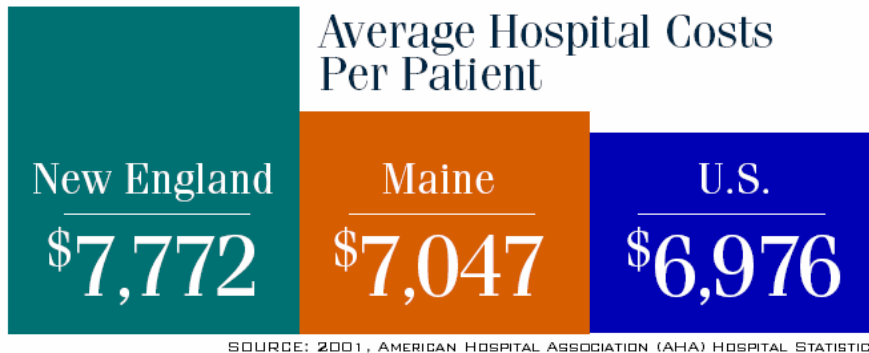


Source: Bureau of Insurance and Maine Hospital Association

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

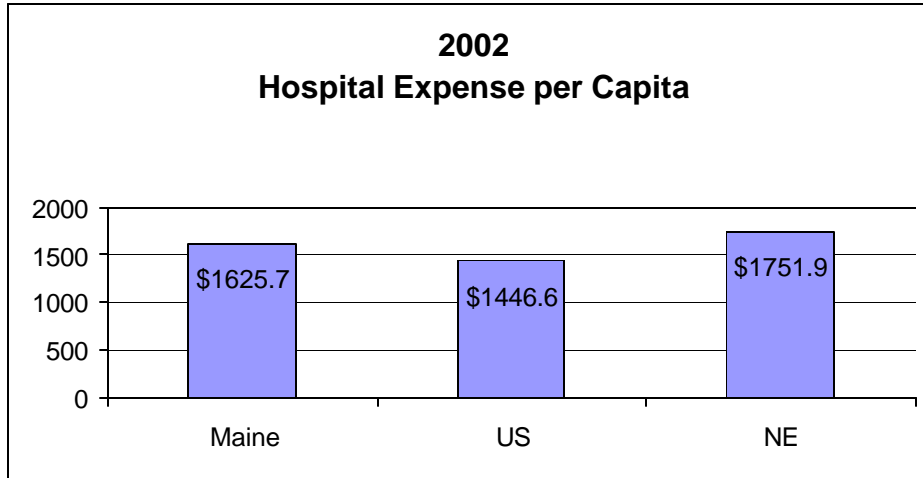
issues related to mental health services are not acknowledged in the majority report, nor are continuing care services or primary care services and their impact on hospital services and hospital budgets. Ms. Kane's labels are misleading and a disservice to a true analysis of Maine's hospital delivery 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.



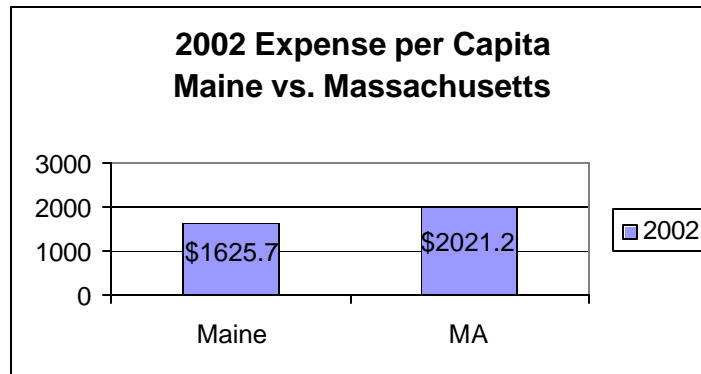
SOURCE: 2001, AMERICAN HOSPITAL ASSOCIATION (AHA) HOSPITAL STATISTICS

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

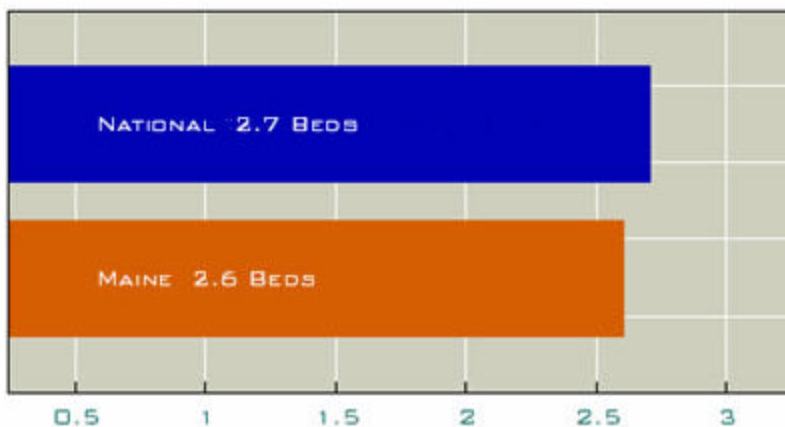
And Maine's hospital cost per capita is significantly lower than costs in Massachusetts.



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.

Inpatient Beds Per 1000 Residents



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.

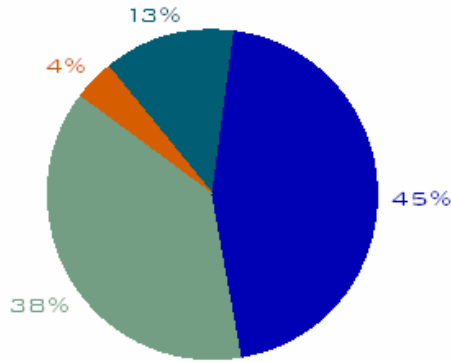
Key Health Care Cost and Spending Drivers:

- 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

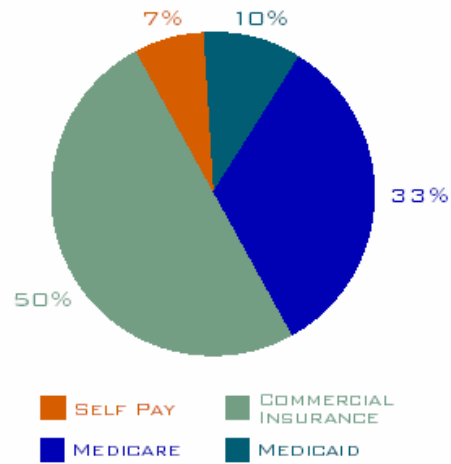
A lot has changed for hospitals in the past 10 years. Managed care, which so aggressively managed costs rather than care, significantly constrained hospital margins elsewhere in areas of the country where managed care companies dominated the insurance market. While managed care had an impact in reducing 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.

Who Uses Hospital Services?

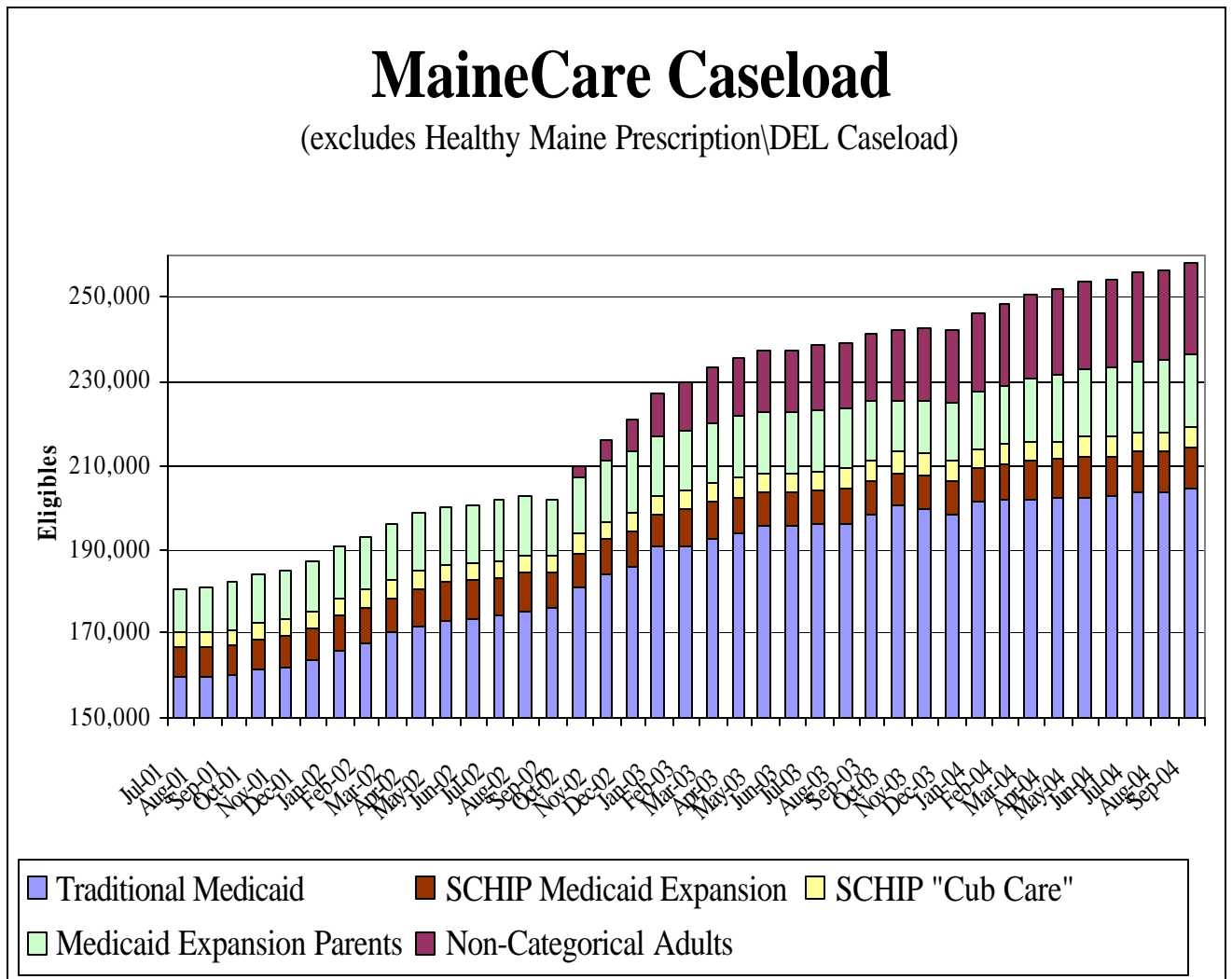


Who Pays For Hospital Services?



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

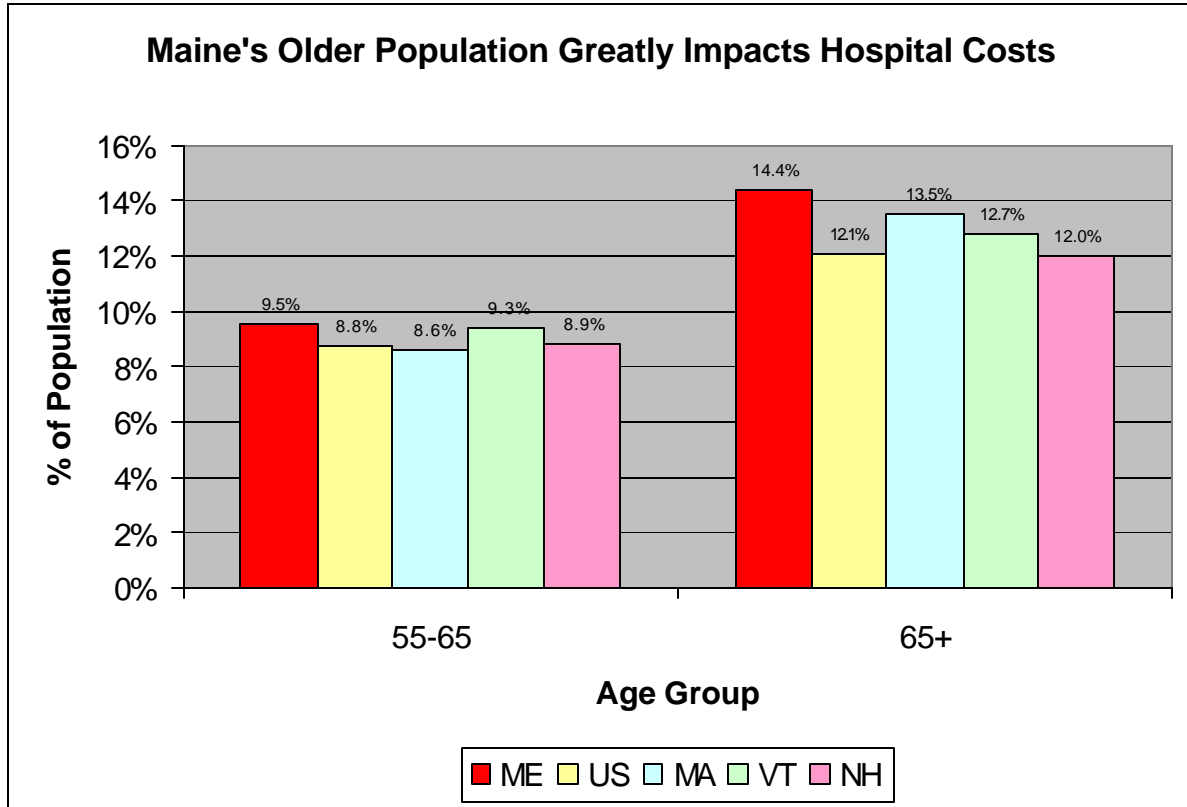


- Medicaid (MaineCare) pays only 75 percent of what it costs to care for Medicaid beneficiaries.
- Maine hospitals are not immediately reimbursed for the services they provide Medicaid patients. Instead, hospitals are paid a weekly Prospective Interim Payment (PIP) that is based on the estimated number 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.

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

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.

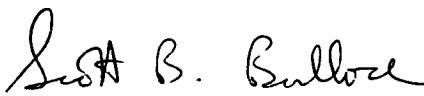
We must recognize and reduce variation in practice by using clinical, evidence-based protocols to improve the quality of care available in the hospital and in the community to reduce health care through reduced utilization.

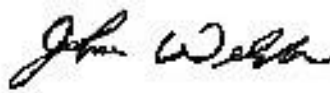
Recommendations:

- 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	New England Rehabilitation Hospital Portland
The Aroostook Medical Center Presque Isle	Northern Maine Medical Center Fort Kent
Blue Hill Memorial Hospital Blue Hill	Parkview Adventist Medical Center Brunswick
Bridgton Hospital Bridgton	Penobscot Bay Medical Center Rockport
Calais Regional Hospital Calais	Penobscot Valley Hospital Lincoln
Cary Medical Center Caribou	Redington-Fairview General Hospital Skowhegan
Central Maine Medical Center Lewiston	Rumford Hospital Rumford
Charles A. Dean Memorial Hospital Greenville	St. Andrews Hospital Boothbay Harbor
Down East Community Hospital Machias	St. Joseph Hospital Bangor
Eastern Maine Medical Center Bangor	St. Mary's Regional Medical Center Lewiston
Franklin Memorial Hospital Farmington	Sebastiancook Valley Hospital Pittsfield
Goodall Hospital Sanford	Southern Maine Medical Center Biddeford
Houlton Regional Hospital Houlton	Spring Harbor Hospital Westbrook
Inland Hospital Waterville	Stephens Memorial Hospital Norway
MaineGeneral Medical Center Augusta/Waterville	Waldo County General Hospital Belfast
Maine Coast Memorial Hospital Ellsworth	York Hospital York
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	