

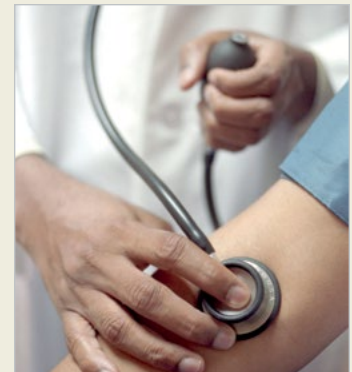
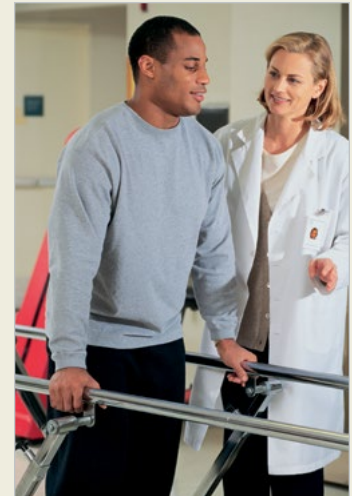


Maine Hospital Association

MAINE'S LEADING  
VOICE FOR HEALTHCARE

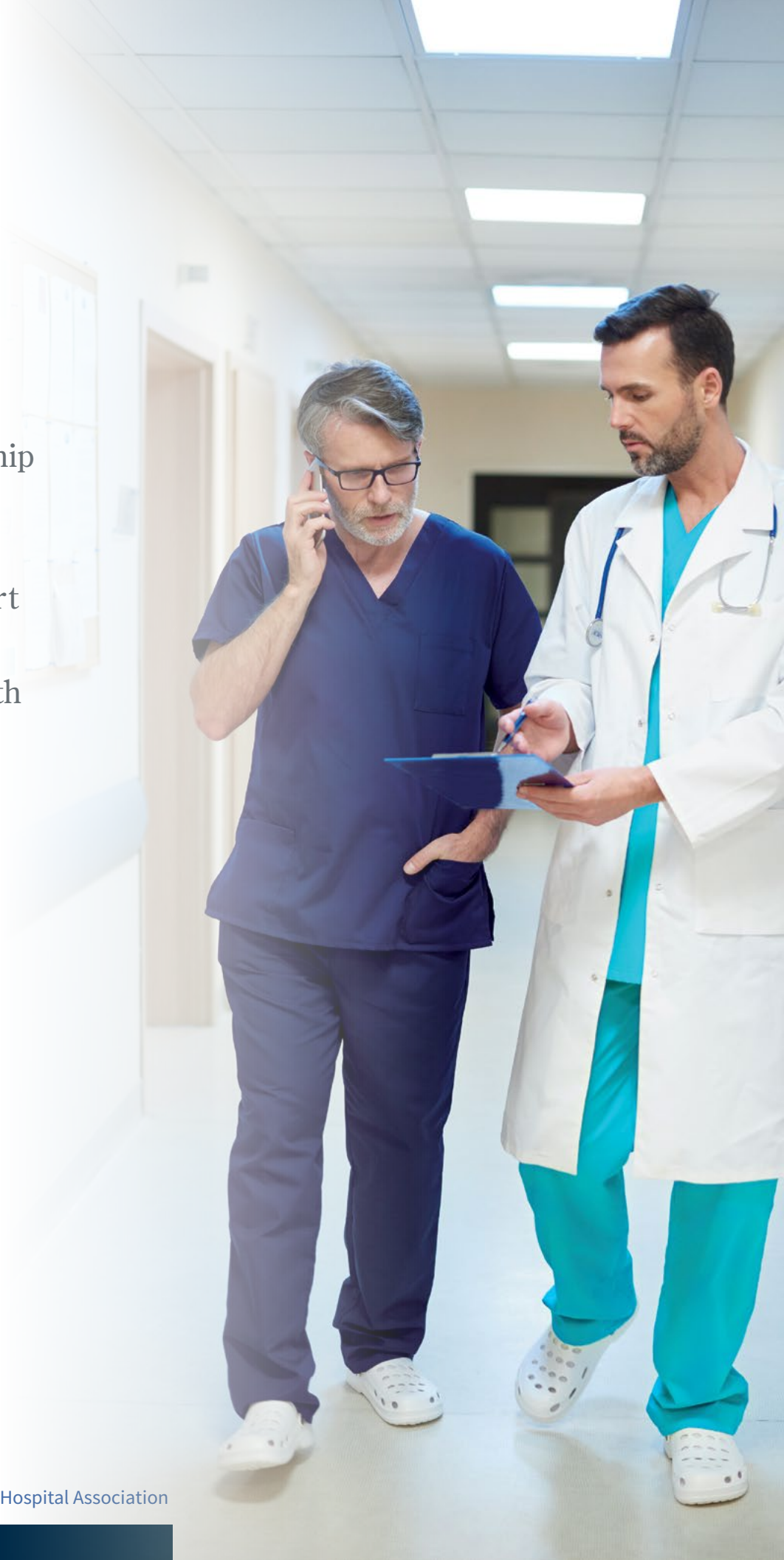
# Taking the Financial Pulse of Maine Hospitals: *An Overview*

A Report from the Maine Hospital Association



## Mission Statement

To provide leadership through advocacy, information and education to support its members in improving the health of the patients and communities they serve.



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## Introduction

*Taking the Financial Pulse of Maine Hospitals* is designed to provide interested legislators, hospital boards, and others with general information about Maine hospitals, and it will acquaint you with a number of facts concerning the financial challenges they face on a continuing basis.

While the style of the report is informal, the material it contains has been researched and verified for accuracy—and some of it will likely surprise you. For example:

- In any given year, between 40% and 50% of Maine hospitals operate at a loss.
- In 2016, the total value of uncompensated care provided (bad debt and free care) amounted to an unprecedented \$570 million.
- Since 2004, Maine hospitals have paid approximately \$1 billion into the state’s general fund in the form of a hospital tax.

But despite these and other challenges, there are a few bright spots:

- A gradual increase in the average number of “days cash on hand”—from a low of 40 in 2013 to the current 71.
- A dramatic increase in 340B Drug Program reimbursement from approximately \$40 million in 2012 to over \$100 million in 2016.

In this report, you will find descriptions and explanations of these factors and more, augmented with charts, graphs, and infographics. Also, a bit of historical background and some comparisons with national averages have been provided for perspective. Additional information is available at [www.themha.org](http://www.themha.org).

## Hospital Financial Viability

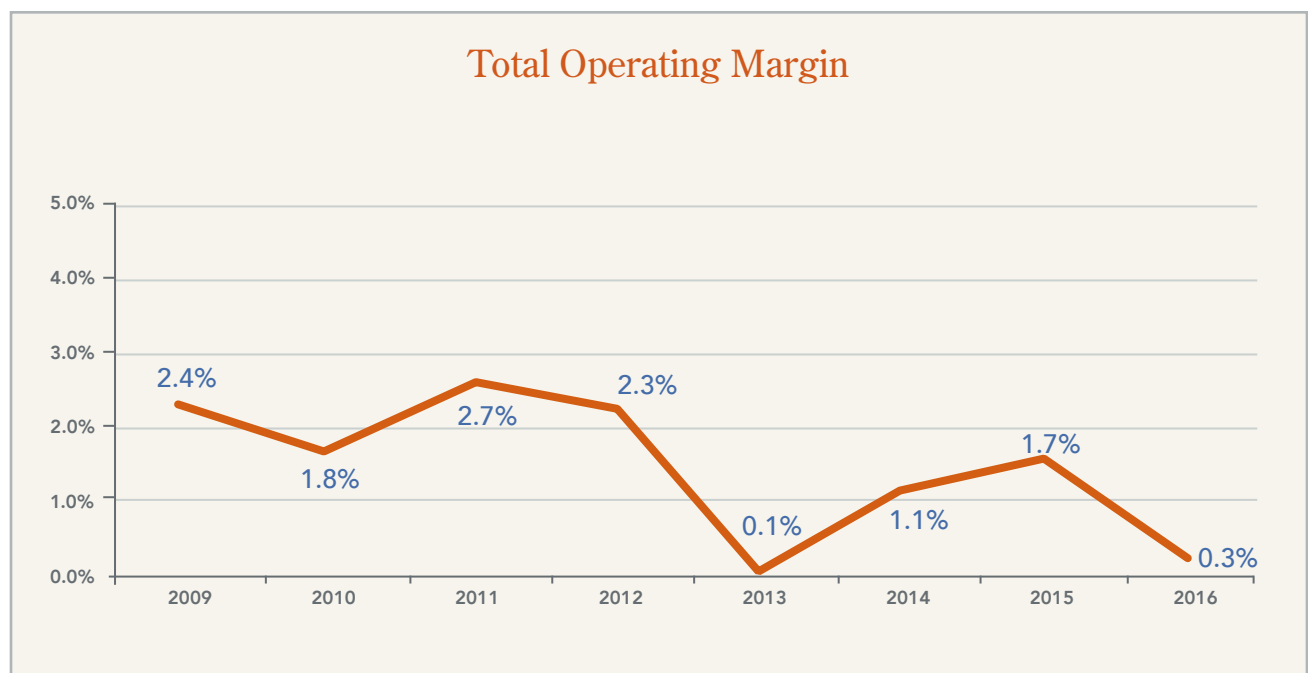
All of Maine's acute-care hospitals operate as not-for-profit entities, and Maine is one of only a few states where this is true. However, most not-for-profit businesses, including hospitals, need to maintain some level of financial reserves, which means they need to have slightly more in revenue than they have in expenses. In addition to capital investments and maintenance, these reserves help during difficult economic times and allow for unexpected expenses and revenue losses.

For the past twenty years or so, about 30% of Maine's hospitals have lost money from operations in any given year. (Fortunately, the hospitals comprising this 30% were not the same ones every year.) During the same period, the total operating margin at Maine's hospitals has hovered around 3%. This is a bit lower than in many other states, but most hospital leaders in Maine agree it is a fair operating margin, and many began using

it as a voluntary cap in 2002. The 3% operating margin was also seen as reasonable by Maine state government and became the statewide target for the Dirigo Health Program. Both this program and the voluntary cap were repealed in 2011, but aggregate hospital operating margins have remained at or below 3% ever since.

### A Troubling Trend

These fairly consistent financial results started to change dramatically in 2012, when the number of hospitals with negative operating margins more than doubled—from 9 in 2011 to 20 in 2012. At the same time, the total number of hospitals in Maine fell, so the percentage of Maine hospitals with negative operating margins jumped from the historical 30% to approximately 50%. Meanwhile, the total aggregate operating margin for all Maine hospitals slid from a historical norm of just under 3% to 2.3% in 2012 and then down to an unprecedented 0.1% in 2013. Most industry experts would agree that these trends are totally unsustainable.



#### Sources:

2009–2015 from Hospital Audited Financial Statements

2016 from MHA Quarterly Financial and Statistic Report—subject to change upon audit

### A Positive Turnaround?

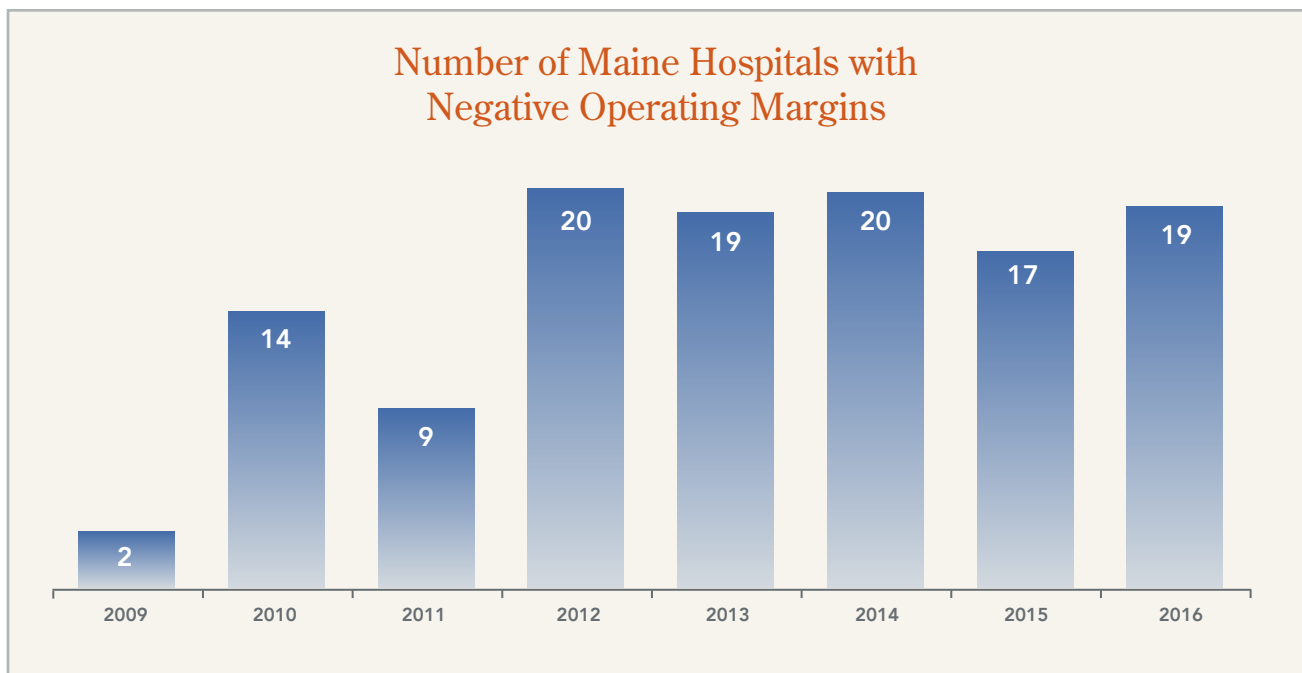
Things seem to begin to recover in 2015, when the total number of hospitals with negative margins dropped to 17 and the total operating margin grew to 1.7%. Although these were positive trends, things have obviously not returned to pre-recession levels.

### Unfortunately Not a True Turnaround

Although 2015 was a relatively better year, 2016 showed hospital finances returned to a point closer to the 2013 negative levels. In 2016, 19 of the 33 acute-care hospitals, or 57% of them, had negative operating margins, with the total operating margin for all of these hospitals being 0.3% (three tenths of one percent). Continuing reductions in reimbursement from government programs and the continuing explosion of uncompensated care provided by Maine hospitals led to many of these financial problems.

“Hospitals cannot continue to experience continued cuts to State and Federal Medicare and Medicaid reimbursement and remain financially viable.”

— *Steven Michaud, President  
Maine Hospital Association*



**Sources:**

2009–2015 from Hospital Audited Financial Statements

2016 from MHA Quarterly Financial and Statistic Report—subject to change upon audit

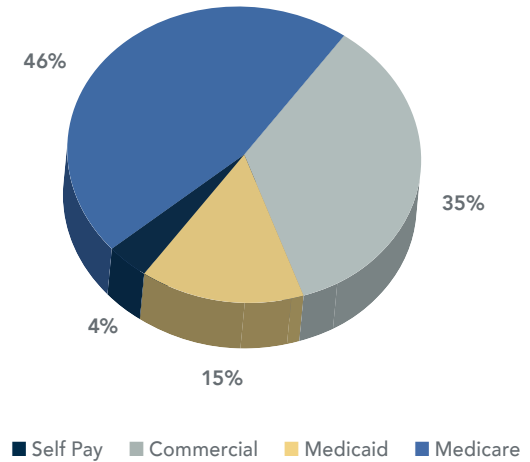
## How Hospitals Are Paid

Hospitals face an interesting challenge when it comes to their finances and how they are paid for their services. The two primary government payers, Medicare and Medicaid, account for approximately 62% of the average Maine hospital's "book of business." However, due to significant levels of underpayment, these hospitals only get about 55% of their actual revenue from these government sources. This forces Maine hospitals to shift the costs of caring for Medicare and Medicaid (MaineCare) patients to commercial health insurance carriers.

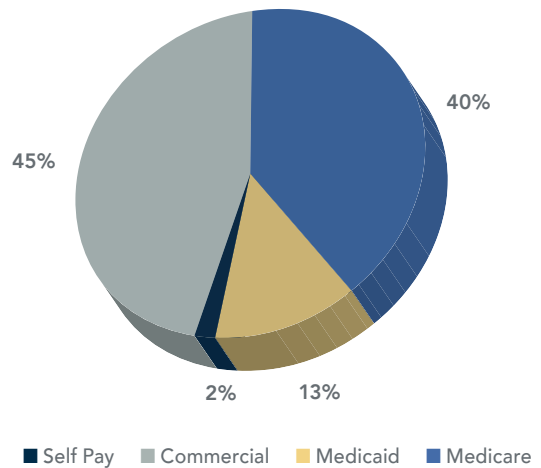
### Medicare

Medicare reimburses acute-care hospitals on a fixed-price system based on the diagnoses of the patients. Inpatient services include 756 different types of Diagnosis-Related Groups (DRGs), and hospitals are reimbursed a fixed amount per patient, depending on the category of his or her diagnosis. The average payment per DRG is \$6,000 and does not vary with how long the patient stays in the hospital. Outpatient services are similarly grouped into different Ambulatory Payment Classifications (APCs), which are based on the condition and diagnosis of the patient. There are 715 different APCs, and payments for these

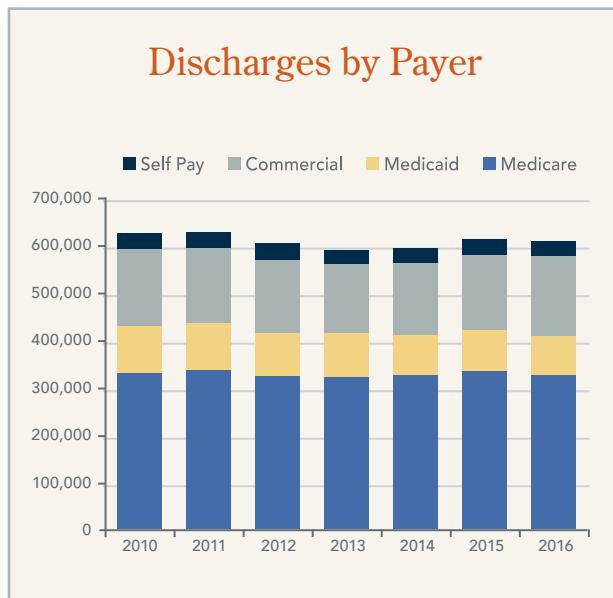
## Utilization by Payer



## Payments by Payer



## Discharges by Payer

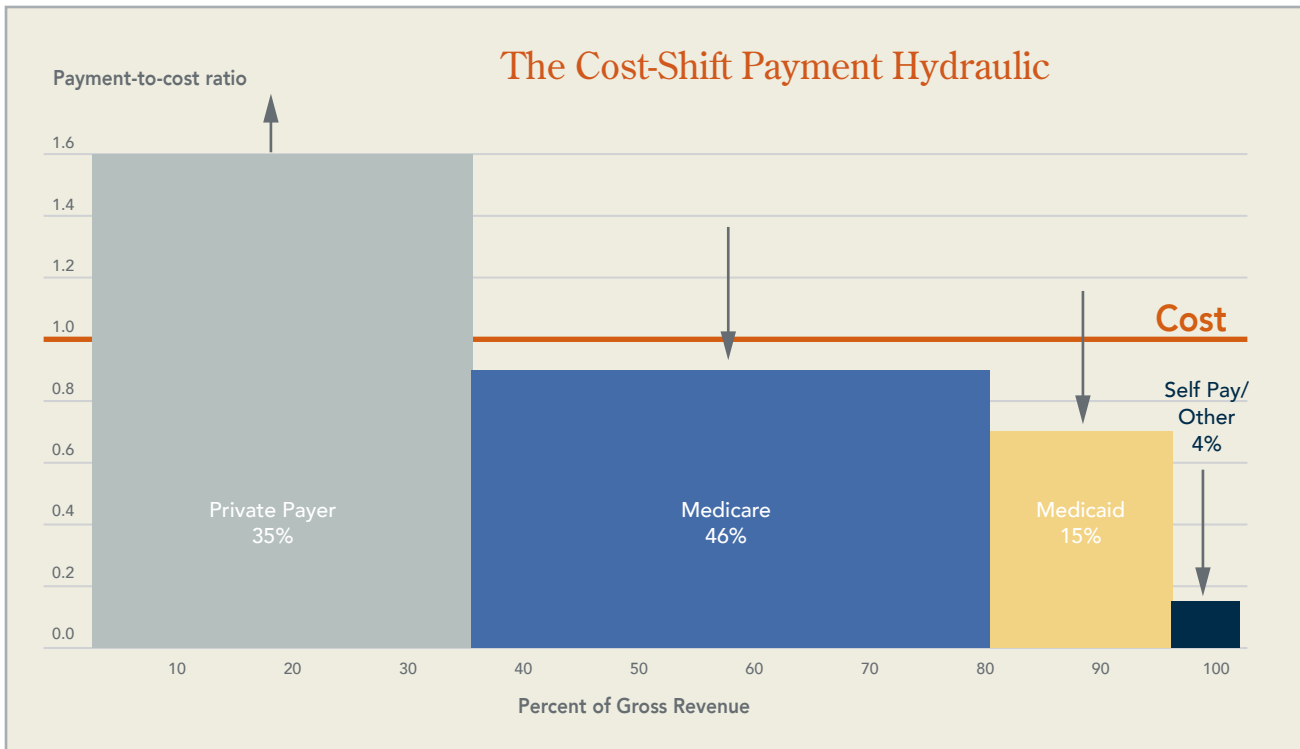


services range from \$10 to \$32,000, depending on the severity and complexity of the patient's needs.

Maine hospitals are reimbursed approximately 87% of the cost of treating patients covered by Medicare.

### MaineCare

In 2011 and 2012, the state largely converted its MaineCare payment system over to a DRG/ APC structure similar to that used by Medicare. Unfortunately, the state chose to set the MaineCare rates significantly lower than the Medicare rates by paying only 76% of the DRG rate and 83.7% of the APC rate.



Maine Hospitals are reimbursed approximately 72% of the cost of treating patients covered by MaineCare.

#### Commercial Health Insurance

Unlike government payers, each commercial health insurance carrier in Maine negotiates the terms of reimbursement with each individual hospital in the state. Obviously, this has created hundreds of different payment arrangements. These arrangements have historically been based on a discount from the “usual and customary” charges of the hospital—meaning that they rely on patient volume to drive the negotiated rates and the total amount of reimbursement.

Recently, hospitals and commercial carriers have been transitioning parts of these contracts to incentive-based arrangements involving quality measures. This transition has been slow to take hold, but despite the slow transition, experts anticipate that incentive-based arrangements will become more and more common in the next few years.

#### How Hospitals Spend Their Money

Hospitals have some degree of flexibility in terms of establishing their budgets, but most of the expenses are fixed or related to salary and benefits and supplies. Providing good-quality healthcare is labor-intensive, with a full 57% of a hospital’s budget related in some way to paying employees.

The second largest portion of a hospital budget is spent on supplies including prescription drugs. Pharmaceutical costs are exploding all over the country, and hospitals as large purchasers of pharmaceuticals have seen their costs for these important supplies increase at an unprecedented rate. Fifteen percent of a hospital’s budget is spent on items such as drugs, medical supplies, and office supplies.

Many of the other expenses in a hospital are smaller portions of the budget but are still necessary to operate the facility in a quality manner. These smaller portions are often grouped into an “all other” category and include information technology costs, insurance costs, utility costs, and the costs for contracted services. These all-other costs total 28% of a hospital’s budget.

## Critical Access Hospitals

Sixteen Critical Access Hospitals (CAHs) provide essential medical care to rural Maine. Each CAH maintains 25 or fewer beds and directly contributes an average of 329 jobs to the local economy. While their healthcare services have bolstered rural areas, CAHs are supported by a fragile financial foundation.

### Bridging Gaps in Access to Care

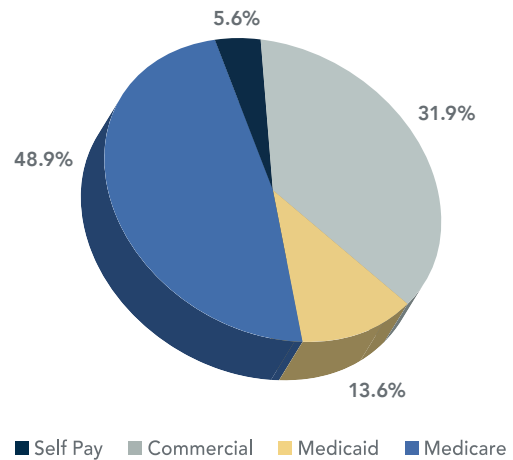
CAHs' service to Maine's rural communities plays an important role in the state's healthcare landscape. Each year:

- 164,000** patients are treated in CAH emergency departments;
- 1.5 million** outpatient visits are to CAHs;
- 15,000** patients are admitted to CAHs; and
- 1,300** babies are delivered at CAHs.

### Delicate Lifelines

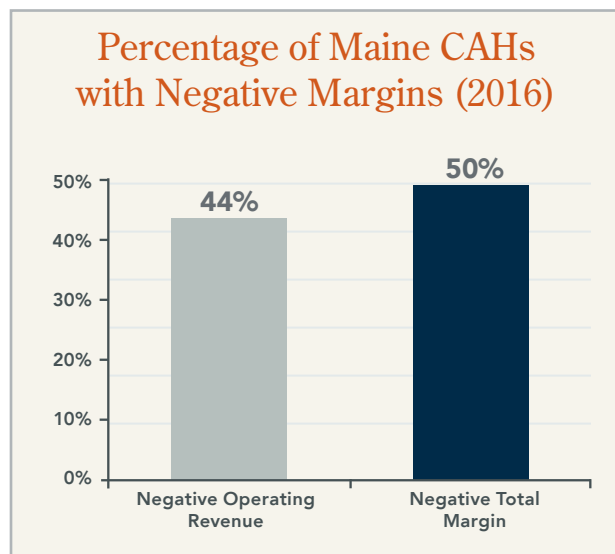
CAHs' small size means that they can only focus on providing the most essential medical services, in contrast to higher-volume hospitals that have more resources and flexibility to offer a wider range of services. CAHs simply do not have the same economies of scale as their larger counterparts.

## CAH Percentage of Gross Revenue by Payer



More than 62% of their revenue comes from government payers, such that any payment reductions to Medicare or MaineCare would have an immense impact on CAHs' ability to provide access to beneficiaries in rural communities.

CAHs make up nearly 45% of Maine's hospitals but receive approximately 14% of total MaineCare payments to hospitals.

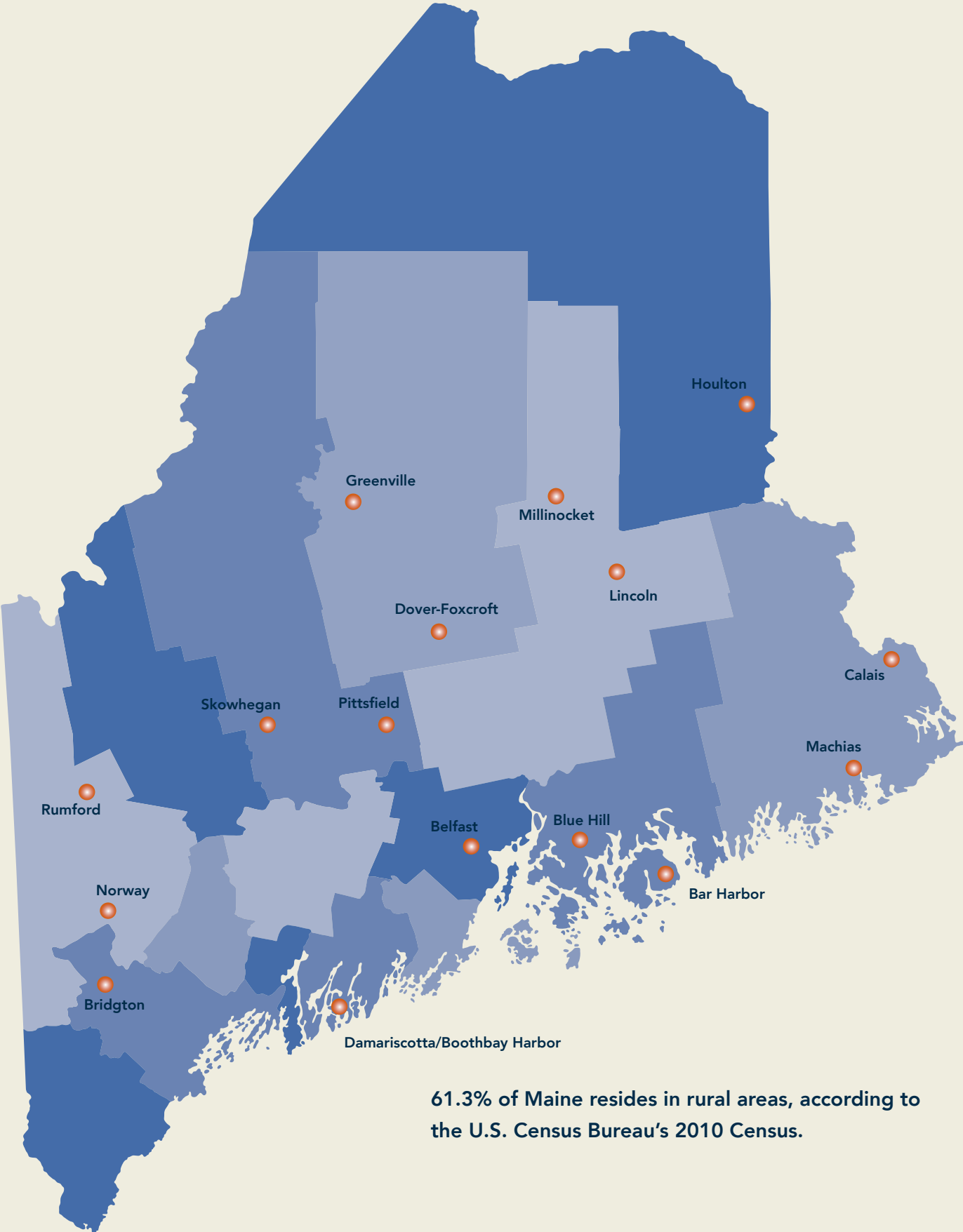


“Critical Access Hospitals provide important healthcare services to people in many of Maine’s rural communities. These small hospitals are also vital parts of the economy in many parts of the state.”

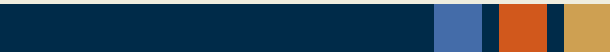
—Tom Moakler, CEO  
Houlton Regional Hospital



MAINE'S 16 CRITICAL ACCESS HOSPITALS



61.3% of Maine resides in rural areas, according to the U.S. Census Bureau's 2010 Census.



## Tracking Uncompensated Care

### Free Care

All of Maine's acute-care hospitals operate as not-for-profit entities and serve all patients regardless of their ability to pay. Many of these patients don't have access to private or public health insurance, so there is no reimbursement for the services provided to them.

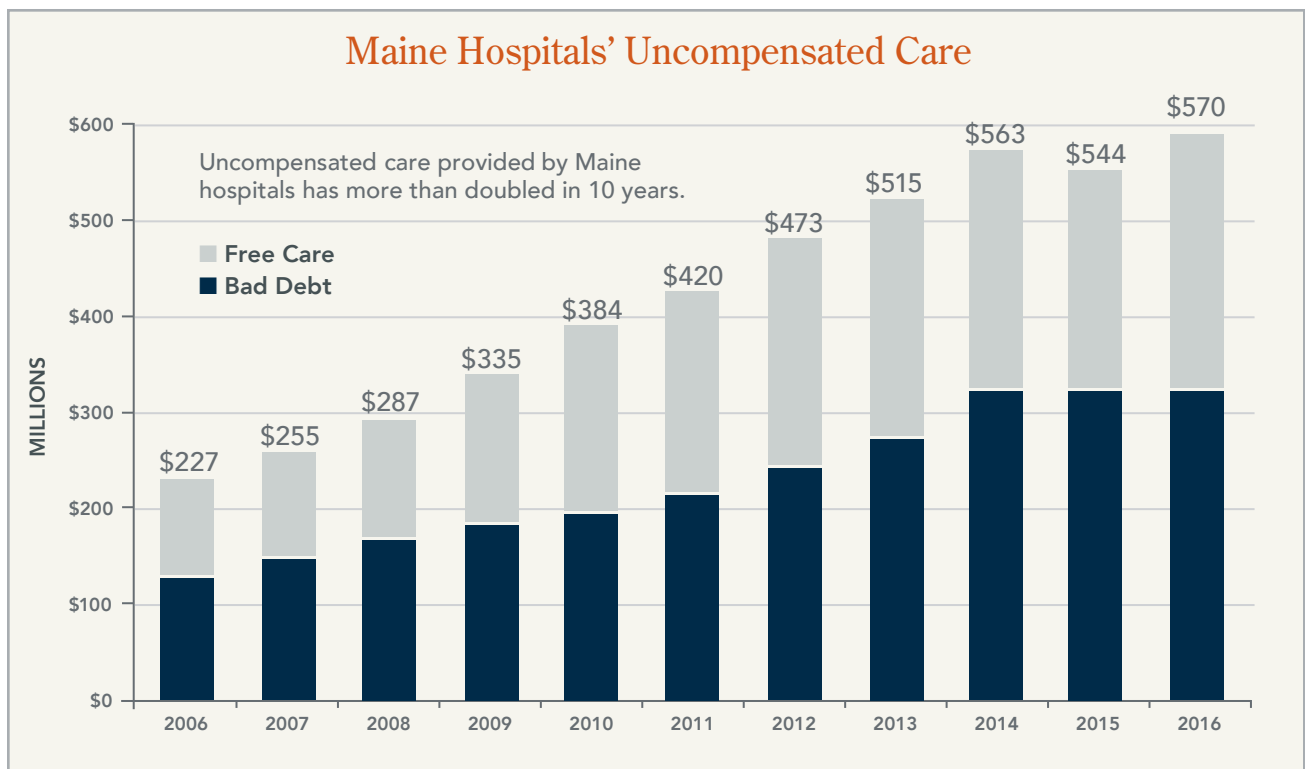
Depending on income, a person may qualify to receive services at no charge under the state's free care law or a hospital-specific policy. Under Maine law, all patients with incomes under 150% of the federal poverty level can receive medically necessary services free of charge. This is referred to as free care or charity care. Many hospitals also choose to provide free care to patients above this income level and may establish a sliding price scale based on income.

In 2015, hospitals in Maine provided approximately \$226 million in free care to patients. This is slightly less than double the amount provided in 2008, when hospitals provided \$122 million in free care.

### Positive Trends

According to preliminary data, it appears that the amount of free care provided in 2016 will be similar to that in 2015. If this holds true, it will be the first time since 2004 that Maine hospitals have not seen a significant two-year average increase in free care.

Part of the reason for this trend is an improving economy and a lower unemployment rate, but experts also point to the large number of people now receiving health insurance through the Federal Health Insurance Exchange. In 2014, 85,000 Maine people received insurance through the Exchange. In 2016 that number dropped a bit, but not significantly, with 73,500 people receiving insurance through the Exchange. Some of these people likely had previous coverage through other sources, but many others are newly covered. The improving economy and the availability of coverage through the Exchange certainly seems to have produced the desired result: more patients receiving healthcare coverage and a reduction in the amount of free care provided by hospitals.



### Bad Debt

Sometimes, patients are unable or unwilling to pay their bills if they are uninsured or if their insurance copayments are too high. This is especially true if the patient has a high-deductible health insurance plan.

Maine hospitals absorbed approximately \$318 million in bad debt in 2015—more than double the amount written off in 2007. Unlike the trend in free care, however, preliminary data indicate that bad debt amounts soared in 2016 to approximately \$325 million. This is an increase of 2.2%, a rate of increase that is clearly unsustainable.

Free care and bad debt combine for a whopping total of \$570 million in uncompensated care provided by Maine hospitals—double the amount provided in 2007.

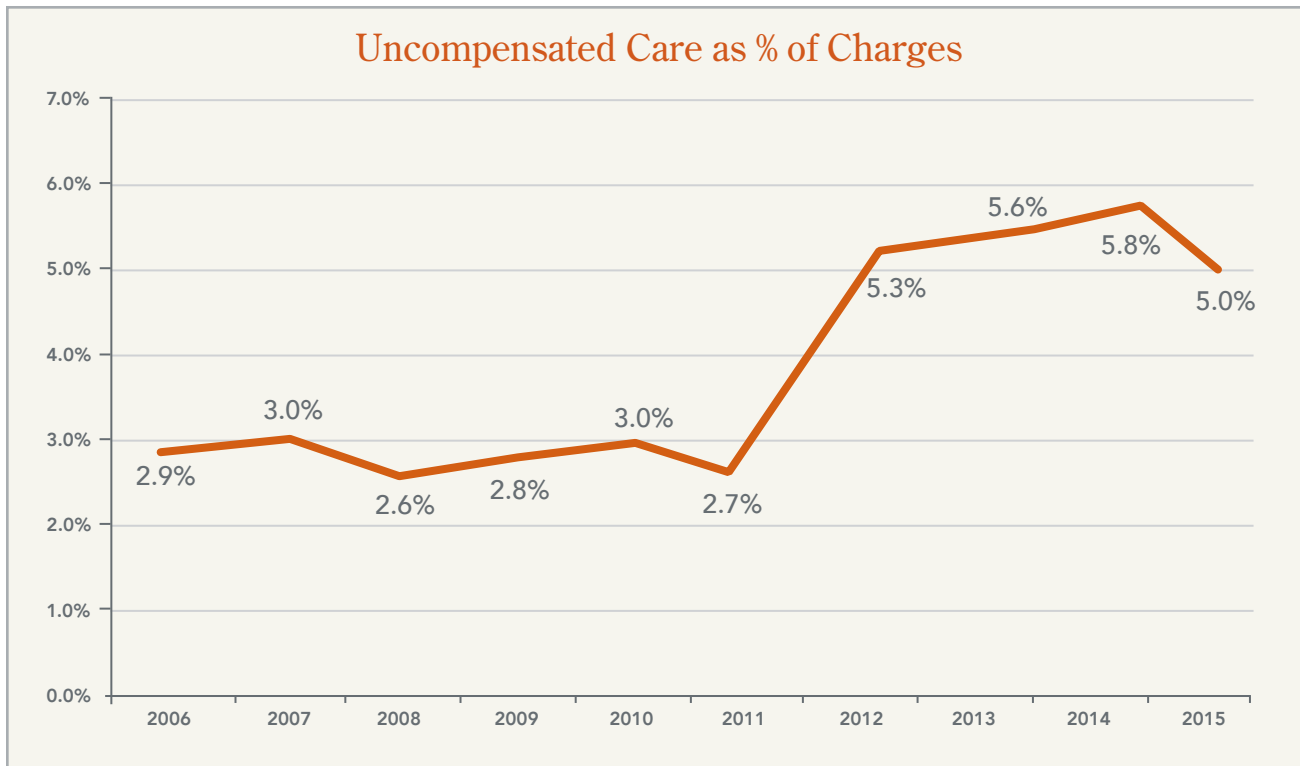
Some of this is mitigated by additional patients receiving coverage through the Federal Health Insurance Exchange. However, any benefit from a decrease in free care is being wiped out by the

increase in various types of bad debt that have to be written off.

### Percentage of Charges

Nationally, the average hospital sees uncompensated care as approximately 5.9% of total charges, while Maine hospitals have historically seen uncompensated care as approximately 3% of charges. Unfortunately, we have seen a dramatic increase in this factor, with the uncompensated care percentage increasing at an alarming rate—to 5%, just below the national average.

**Maine hospitals are experiencing a dramatic increase in uncompensated care—totaling \$570 million in 2016.**



## The Hospital Tax

Since 2004, Maine hospitals have been required to pay a tax to the State of Maine’s general fund. The tax is based on the hospital’s net patient service revenue, which is taxed at a rate of 2.23%. In State fiscal year 2016, the total amount of revenue generated by the hospital tax was \$103 million. Since the inception of the hospital tax in 2004, hospitals have paid close to \$1 billion to the general fund.

Fortunately, a series of supplemental payments were instituted at the same time the hospital tax was created. These so-called “supplemental pool payments” are in no way directly related to the hospital tax, but because they were instituted at the same time, many people think they are related, and they are often referred to as “match payments.” In fiscal year 2016, the total amount of these supplemental pool payments was \$81 million.

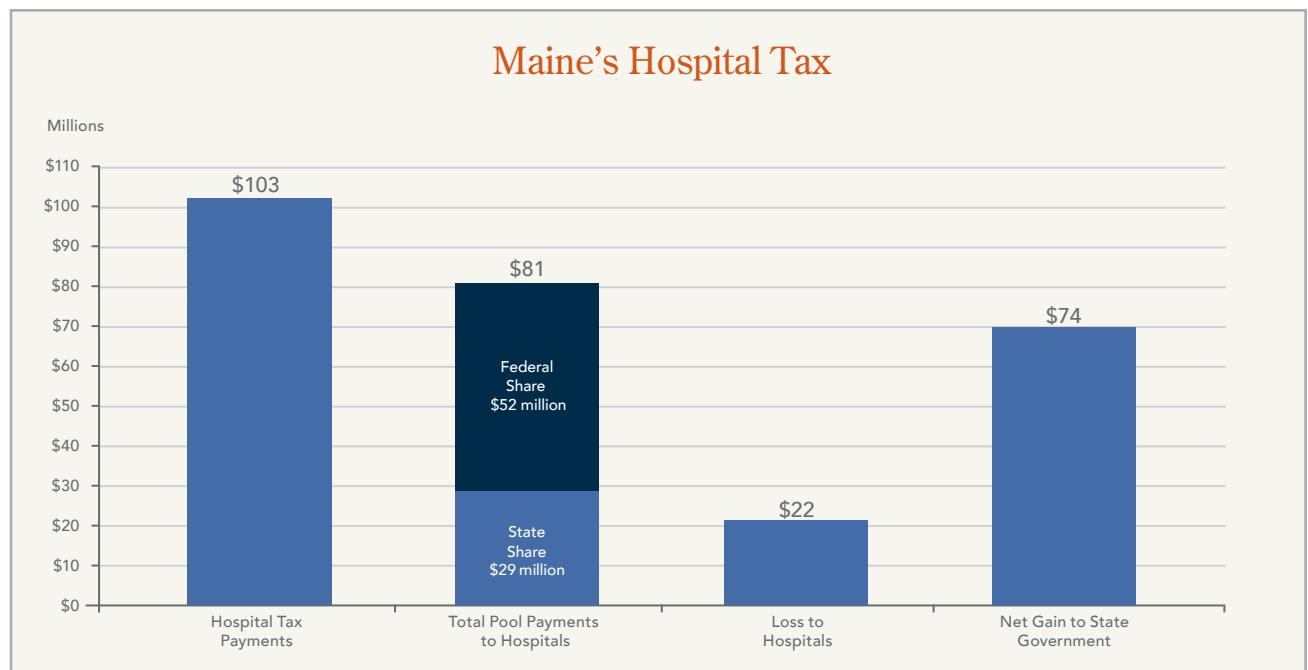
Taken together, this means that hospitals suffered a net loss of \$22 million. Conversely, the general fund sees a net gain of \$74 million associated with the hospital tax and the supplemental pool payments.

Because the hospital tax monies go directly into the general fund, there is no clear link to how they are actually spent. On the other hand, \$74 million could be considered as funding the state share of MaineCare.

### A Special Medicaid Payment Structure for Critical Access Hospitals

Maine has a unique mechanism for reimbursing Critical Access Hospitals for the detrimental impact of the state’s hospital tax. In 2004, the state began reimbursing Critical Access Hospitals 117% of their allowable costs. During the recession, however, this was reduced to 109%, and this level of reimbursement is still in place today. Even with this funding mechanism, most Critical Access Hospitals suffer a net loss due to the hospital tax.

**Since the inception of the hospital tax in 2004, Maine hospitals have paid close to \$1 billion into the general fund, and in fiscal year 2018, suffered a net loss of \$22 million.**



## Days Cash on Hand

An important indicator of financial health in any business is how long the business could cover its expenses with the cash it has access to. This measure is called “days cash on hand,” and it varies dramatically with the type and size of the business.

Nationally, hospitals average approximately 100 days cash on hand at any given time, but the number varies with the size of the hospital. For example, the ratings agencies Fitch and Standard and Poor’s report that larger hospitals, which they typically measure, have approximately 185 days cash on hand. By contrast, OPTUMInsight specializes in ranking smaller community hospitals around the country and reports that those hospitals average about 35 days cash on hand.

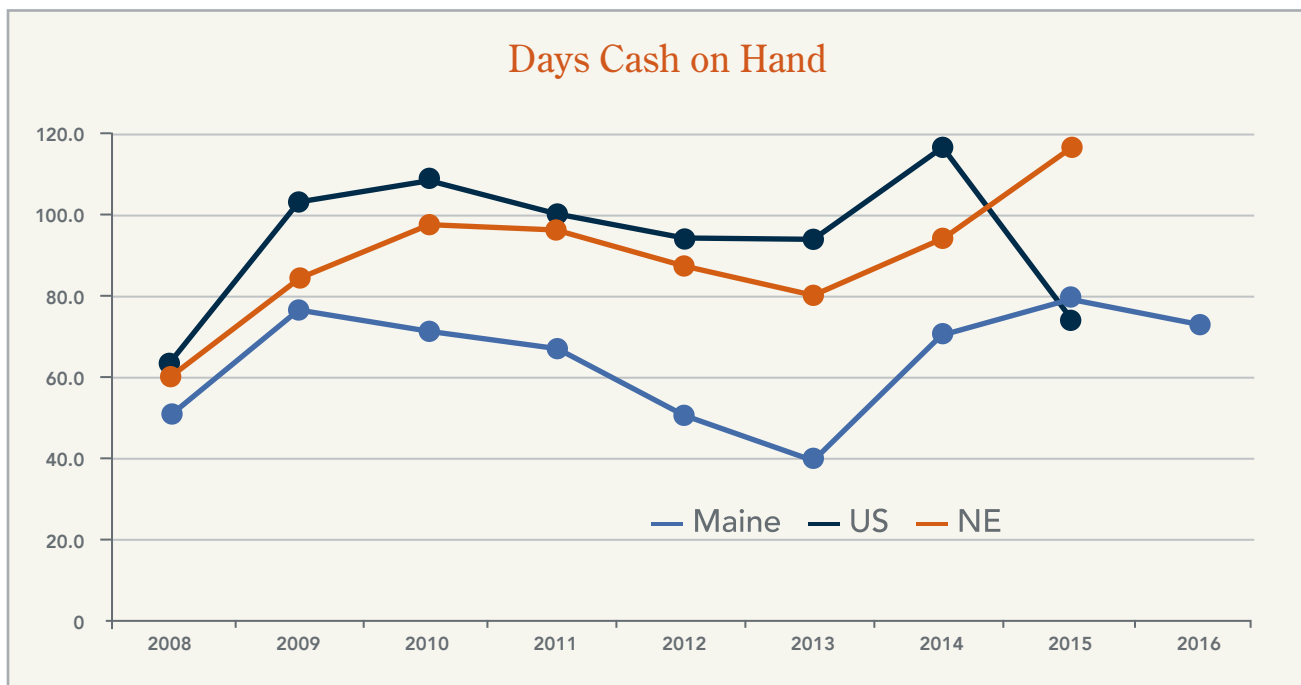
Maine hospitals have historically held approximately 80 days cash on hand. However, they were negatively impacted beginning in 2009 when state government purposely began to incur a large MaineCare debt to hospitals. This debt reached its

peak of \$500 million in 2013, and Maine hospitals saw their average days cash on hand nearly cut in half—to only 40 days. This level of cash availability was dangerously low and threatened the stability of many Maine hospitals.

Thankfully, this debt was repaid in September of 2013, and hospitals currently report about 71 days cash on hand. While not yet back to pre-debt levels, this is certainly a healthier level than in recent years.

Even with the MaineCare debts resolved, 8 Maine hospitals still reported having less than 20 days cash on hand at the end of 2016.

**While hospitals nationally average 100 days cash on hand, Maine hospitals average about 70 days—and 8 reported only 20 days cash on hand at the end of 2016.**



## Medicare and MaineCare Cuts

Maine’s hospitals have absorbed enormous cuts in both Medicare and MaineCare over the last several years.

Payments for services provided to Medicare patients have been reduced by a total of \$416 million since 2010. These cutbacks included cuts to hospital spending that were enacted as part of the Affordable Care Act and the 2013 sequestration effort that mandated a 2% across-the-board reduction in all Medicare payments.

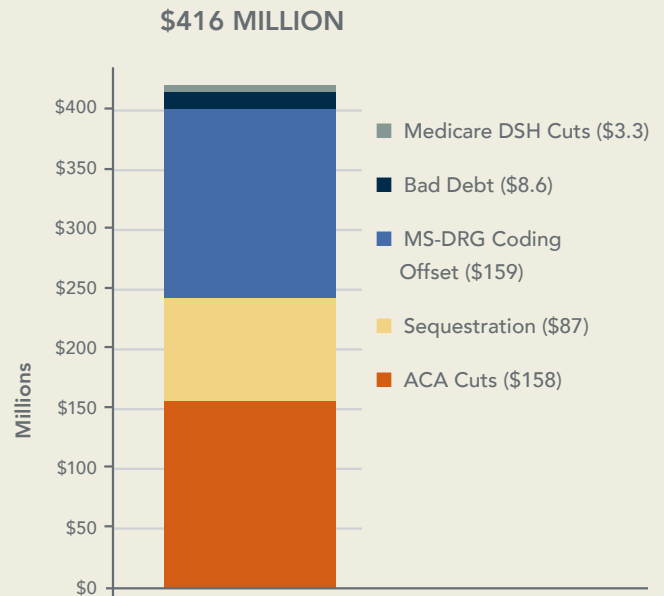
Any additional cuts to Medicare hospital reimbursement would be unsustainable and would harm Medicare patients.

## Since 2010, Maine hospitals have lost \$416 million in Medicare payments and \$132 million in funding for MaineCare.

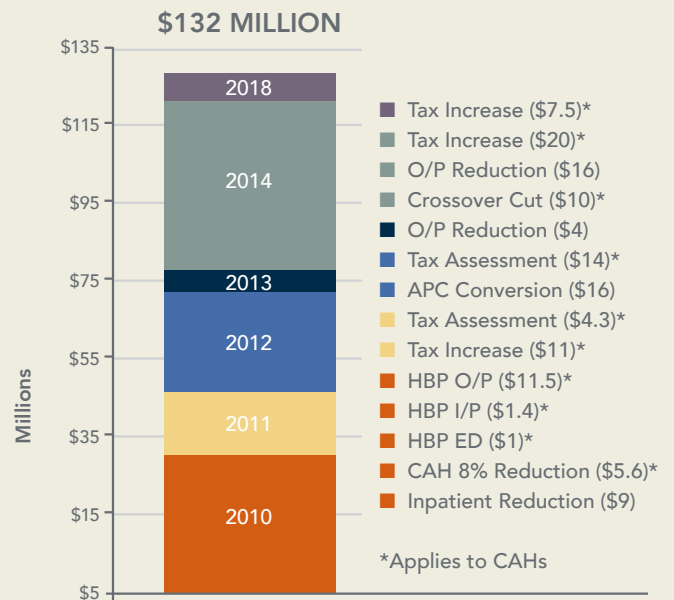
It is well documented that Maine has chosen not to expand the MaineCare program, as was foreseen by the Affordable Care Act. In fact, Maine has reduced the number of people covered under MaineCare by approximately 22%. These two actions have resulted in the loss of hundreds of millions of dollars for Maine’s hospitals.

In addition to these coverage reductions, the Maine Legislature has reduced rates of reimbursement and raised taxes on hospitals—for a total funding loss of \$132 million over the last several years. Any further reductions in MaineCare funding would be unnecessary and very detrimental for Maine’s hospital system.

## Hospitals have absorbed \$416 million of new Medicare cuts since 2010.



## Hospitals have absorbed \$132 million of new Medicaid cuts since 2010.



## The 340B Drug Discount Program is an Increasingly Important Factor in Bolstering Hospital Finances in Maine.

The 340B Drug Discount Program was created in 1992 and provides eligible hospitals with access to discounted drug prices for their patients receiving outpatient hospital services. Eligible hospitals include those that provide a disproportionate amount of care to low-income patients, Critical Access Hospitals (CAHs), Rural Referral Centers, Sole Community Hospitals (SCH) and Children’s Hospitals.

The 340B Drug Discount Program requires pharmaceutical manufacturers to provide prescription drugs to qualifying hospitals and other covered entities at or below a “340B ceiling price” established by the federal Health Resources and Services Administration. These prescription drugs are then provided to all hospital patients with the exception of those patients on the Medicaid program. Medicaid patients are covered under a similar drug discount program administered by state Medicaid agencies.

In 2010, the Affordable Care Act made all Critical Access Hospitals, Sole Community Hospitals and Rural Referral Center Hospitals categorically eligible to participate in the 340B Drug Discount Program. By extending these benefits to these small rural hospitals, approximately one-third of all U.S. hospitals now participate in the 340B program, yet pharmaceuticals purchased at 340B pricing account for only 2% of all medicines purchased in the United States each year. This program produces significant savings for these safety-net hospitals, generally between 20% and 50% of the drug’s cost.

Maine has 16 Critical Access Hospitals and 3 Sole Community Hospitals. The Affordable Care Act’s extension of the 340B program saves these hospitals approximately \$15 million per year.

The aggregate operating margin of all of the CAH and SCH hospitals combined is substantially less than \$15 million. Elimination of the 340B benefit would wipe out the operating margins for those hospitals that actually have positive margins. Half of these small hospitals were in the red in 2016. In total, 25 Maine hospitals currently qualify for the 340B Drug Discount Program and receive a collective benefit estimated to be \$105 million per year.

Any significant changes to the 340B Drug Discount Program would have a negative impact on hospitals and the low-income patients that benefit from this important program. It is especially important to retain 340B eligibility for the nation’s rural hospitals that benefited from the changes in the Affordable Care Act.

### Maine Hospitals Currently Eligible for the 340B Program:

The Aroostook Medical Center  
Blue Hill Memorial Hospital  
Bridgton Hospital  
C.A. Dean Memorial Hospital  
Calais Regional Hospital  
Central Maine Medical Center  
Down East Community Hospital  
Eastern Maine Medical Center  
Houlton Regional Hospital  
Inland Hospital  
LincolnHealth  
Maine Medical Center  
MaineGeneral Medical Center  
Mayo Regional Hospital  
Millinocket Regional Hospital  
Mount Desert Island Hospital  
Northern Maine Medical Center  
Pen Bay Medical Center  
Penobscot Valley Hospital  
Redington-Fairview General Hospital  
Rumford Hospital  
Sebastcook Valley Health  
St. Mary’s Regional Medical Center  
Stephens Memorial Hospital  
Waldo County General Hospital

# Maine Hospitals and the Economy

Maine’s hospitals are some of the most active economic forces in the state, employing thousands and spending billions of dollars.

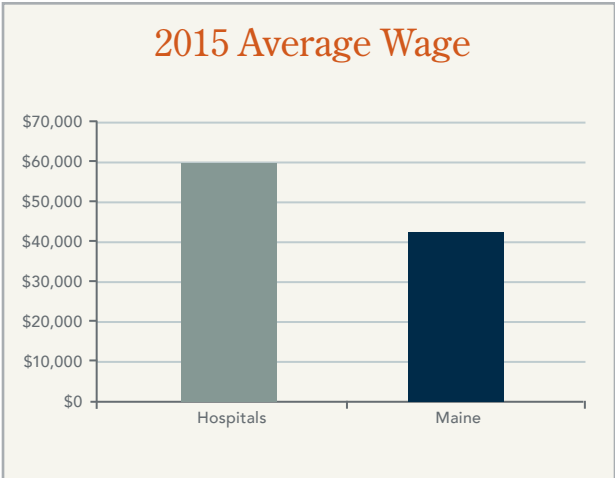
In 2016, Maine hospitals directly employed almost 33,000 people and paid over \$2.5 billion in direct wages and benefits. Total hospital spending was \$5.7 billion, including \$5.5 billion in operating expenses and \$232 million in capital expenditures for things like construction projects, vehicle purchases, and to buy equipment like computers. As that money circulated throughout the Maine economy, it generated an additional \$4.5 billion in related economic activity leading to a total economic contribution of over \$10 billion. This \$10 billion in turn supported a total of 67,000 jobs, \$4 billion in wages and benefits, and almost \$400 million in state and local taxes paid by employees, contractors, and customers.

In addition to these statewide contributions, Maine hospitals play important roles within their regions. They provide access to medical care that allows rural communities to sustain their populations, and they employ thousands of rural residents. In nine of Maine’s sixteen counties, hospitals are the largest private employer.

There are a variety of jobs within hospitals, but generally speaking, hospital jobs are good jobs that pay above-average wages and provide important employee benefits such as health insurance and retirement benefits. In 2015, the average wage of a hospital employee was \$60,500, fully 45% higher than the state average.

Since 2001, economic activity associated with hospitals has grown considerably faster than the overall Maine economy. Hospital jobs have increased by 36% as opposed to all of Maine’s other industries, which have experienced basically flat job growth during the same period. Total hospital wages have increased by 136% in the last fifteen years compared to a 46% increase for all other industries. The growth in wages reflects an increase in the number of hospital jobs combined with an even larger increase in average pay compared to other industries.

Healthcare in Maine and around the country is expensive, largely because it is very labor-intensive and has high input costs. These healthcare costs also provide an important economic benefit, especially considering the large percentage of payments that come to Maine from the federal government through Medicare, Medicaid, Tricare, and other programs.





## Maine Hospitals Comparison of Operating Margins

	2011	2012	2013	2014	2015	2016
Acadia Hospital	4.13%	4.14%	9.47%	2.30%	4.68%	6.33%
Aroostook Medical Center, The	3.11%	-2.03%	1.11%	-3.14%	0.14%	-9.90%
Blue Hill Memorial Hospital	2.34%	2.09%	4.34%	5.27%	6.46%	2.70%
Bridgton Hospital	14.82%	3.45%	3.19%	7.27%	4.05%	-0.27%
Calais Regional Hospital	-2.14%	-8.84%	-6.95%	-9.02%	-5.23%	-3.49%
Cary Medical Center	8.16%	-1.05%	-3.91%	3.63%	3.17%	-1.00%
Central Maine Medical Center	-2.76%	-1.08%	-4.36%	1.76%	2.95%	-1.84%
Charles A. Dean Memorial Hospital	10.44%	1.96%	3.69%	-1.59%	-1.20%	-10.90%
Down East Community Hospital	-2.23%	-2.48%	-4.53%	-5.35%	-0.57%	2.00%
Eastern Maine Medical Center	2.58%	9.18%	4.58%	2.50%	5.49%	3.90%
Franklin Memorial Hospital	1.57%	-0.29%	-9.78%	-4.20%	-0.69%	-6.21%
Houlton Regional Hospital	-0.42%	-4.43%	-8.90%	-1.73%	-1.46%	-2.40%
Inland Hospital	3.66%	0.99%	1.17%	-2.31%	0.31%	-0.78%
LincolnHealth	*	*	*	-1.26%	2.47%	0.52%
Maine Coast Memorial Hospital	5.45%	-1.28%	-0.47%	-6.52%	-9.68%	-5.20%
Maine Medical Center	2.43%	3.29%	1.05%	3.50%	3.51%	4.73%
MaineGeneral Medical Center	4.84%	3.52%	3.16%	-3.61%	-6.15%	0.05%
Mayo Regional Hospital	1.13%	-2.40%	-4.37%	-1.88%	-0.02%	-3.30%
Mercy Hospital	-8.38%	-6.76%	-4.21%	1.15%	-10.22%	-7.92%
Mid Coast Hospital	4.39%	0.89%	1.38%	2.54%	1.91%	0.60%
Millinocket Regional Hospital	1.72%	-1.77%	-1.63%	-9.04%	-3.12%	-2.90%
Mount Desert Island Hospital	-1.43%	-4.27%	-1.78%	-2.43%	1.12%	0.51%
Northern Maine Medical Center	-0.37%	29.61%	4.56%	3.17%	2.34%	0.50%
Pen Bay Medical Center	2.05%	-4.04%	-0.04%	0.94%	-3.35%	-6.76%
Penobscot Valley Hospital	1.99%	-0.42%	-2.01%	-3.90%	-5.24%	-9.84%
Redington-Fairview General Hospital	-0.91%	-0.87%	-2.85%	-3.65%	-3.65%	0.01%
Rumford Hospital	11.34%	-1.18%	-1.58%	0.94%	-1.23%	-2.44%
Sebastiack Valley Health	3.22%	0.76%	4.68%	6.49%	3.31%	3.95%
Southern Maine Health Care	*	*	*	*	-3.41%	-2.83%
Spring Harbor Hospital/Maine Behavioral Healthcare	0.55%	-1.90%	1.74%	0.41%	0.43%	-1.63%
St. Joseph Hospital	9.05%	5.38%	8.04%	8.97%	1.33%	2.20%
St. Mary's Regional Medical Center	2.71%	-2.60%	0.07%	-1.67%	-1.68%	1.01%
Stephens Memorial Hospital	4.51%	5.44%	3.97%	6.38%	4.95%	2.54%
Waldo County General Hospital	8.69%	4.75%	1.96%	-1.54%	6.71%	5.73%
York Hospital	1.88%	-1.06%	-1.12%	-1.91%	-0.51%	-1.45%

Source: Maine Health Data Organization, Audited Financial Statements

\* Not Available

Color Code:

	Operating Margins < 0
	Operating Margins 0–4.99%
	Operating Margins 5.0%+

## Tying Payment to Quality and Value

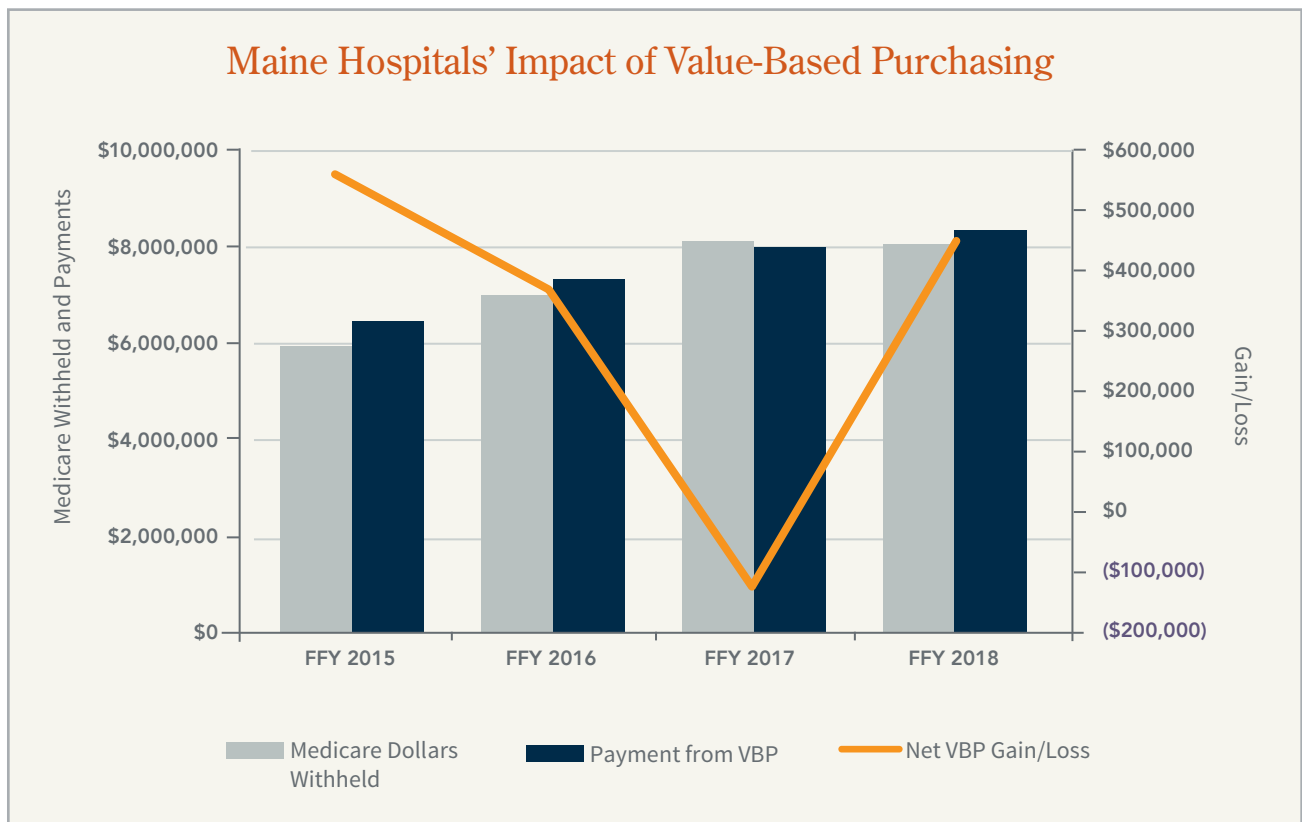
Traditionally, the federal Medicare program has paid hospitals and physicians based upon the number of patients that they serve and the number of individual medical services that they provide. The Affordable Care Act started to change this “fee for service” payment system to one that begins to pay hospitals and physicians for the quality and value of the service they provide in addition to the number of patients they treat. To begin this transition, the federal Centers for Medicare and Medicaid Services formulated two specific goals:

The first was tying 30% of Medicare fee-for-service payments to quality and value through alternative payment models by 2016 and 50% of Medicare fee-for-service payments to quality and value by 2018. CMS announced that it had met its 2016 goal nearly a year ahead of schedule.

The second was to create Alternative Payment Models. Alternative Payment Models are structural in nature and offer healthcare providers financial incentives for meeting cost and quality targets, rather than paying hospitals and physicians based on the total number of services delivered. These Alternative Payment Models take many forms, including:

### Medicare Shared Savings Accountable Care Organizations (ACO)

Accountable Care Organizations are groups of healthcare providers who accept shared responsibility for the care of a defined population of patients and actively manage both the quality and cost of that care. There are approximately 480 Medicare Shared Savings Program Accountable Care Organizations (MSSP ACOs) operating around the country, four of which are currently operating in Maine. Three of these four MSSP ACOs are led by Maine’s hospitals and health systems.



### **Pioneer Accountable Care Organizations**

There were originally 22 Pioneer ACOs located around the country, but most have been transitioned to other models or disbanded altogether. Currently there are only eight Pioneer ACOs remaining, none of which are in Maine.

### **Next Generation Accountable Care Organizations**

There are 44 ACOs participating in the Next Generation ACO Model. There is currently one Next Generation ACO in Maine, which is Beacon Health led by EMHS. Beacon Health has been extremely effective in meeting the Next Generation ACO goals.

### **Medicare Advanced Primary Care Program**

There are currently 14 Medicare Advanced Primary Care Programs in Maine. All of these programs are led by Federally Qualified Health Centers (FQHCs) and include multiple hospitals as members.

### **Other Alternative Payment Models**

Other Alternative Payment Models located around the country but not currently operating in Maine include: Bundled Payments for Care Initiatives, Comprehensive Primary Care Models, Comprehensive End Stage Renal Disease Models, Medicare Care Choice Models, and the Maryland All-Payer Model

**“We predict that the Federal Government will continue to move toward tying payment to quality and value regardless of control.”**

*—Jack Barry, Regional Executive  
American Hospital Association*

The six different types of Accountable Care Organizations are by far the most common Alternative Payment Models operating in Maine. In fact, Maine is one of only a few states that have more than 20% of their population enrolled in an ACO.

Outside of the structural changes described above, there are other ways that CMS is incorporating quality and value into their existing fee-for-service payment programs.

To date, the hallmark of these new programs is that they automatically cut hospital payments first and then offer hospitals an opportunity to get some of that money (or even more) back based upon their performance.

### **Value-Based Purchasing Program**

This is a mandatory program for PPS hospitals that includes both an upside and a downside for hospitals by putting 2% of inpatient payments at risk. Payments to hospitals are initially reduced by 2% and then redistributed to hospitals based on their Total Performance Scores. The Total Performance Score is based on a number of factors including clinical care, efficiency, and cost reduction. This program is revenue-neutral, as all leftover funds are returned to the hospitals.

### **Medicare Readmissions Reduction Program**

This is a mandatory program for PPS hospitals with only downside risk. Medicare reduces all payments by up to 3% for hospitals with excess readmissions. Excess readmissions are determined by comparing the number of “predicted” 30-day readmissions for heart attack, heart failure, pneumonia, hip/knee replacement, and COPD with the number that would be “expected,” based on an average hospital with similar patients.



### Hospital-Acquired Conditions Reduction Program

This is a mandatory program for PPS hospitals with only downside risk. Under the Hospital-Acquired Conditions Reduction Program, Medicare reduces inpatient hospital payments by 1% for hospitals that rank in the worst-performing quarter of all applicable hospitals with respect to risk-adjusted HAC quality measures such as certain healthcare-associated infections.

### Quality Payment Programs for Physicians

The Medicare Access and Chip Reauthorization Act of 2015 mandated that Medicare payments to physicians be tied to quality and value. The Quality Payment Programs include 2 tracks—the default Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs).

Under MIPS, physician payments are adjusted based on four measured categories: Quality, Cost/Resource Use, Clinical Practice Improvement, and Advancing Care Information. A physician’s participation in an APM will also be rewarded under MIPS.

Data reporting for MIPS began on January 1, 2017, and will impact actual payments to physicians beginning in 2019. CMS will combine the scores across the categories to create a MIPS final score. Based on their MIPS final score, physicians will receive positive, neutral, or negative payment adjustments by Medicare of up to 4% in 2019, 5% in 2020, and rising gradually to a maximum of 9% in 2022 and beyond.

For the first two years of MIPS, CMS will not score MIPS participants on the cost/resource use category, and has reallocated the weight to the quality category.

Physicians seeing 20% of their Medicare patients through Advanced APMs with downside risk will receive a 5% incentive payment in 2019. Examples of Advanced APMS include Next Generation Accountable Care Organizations (such as Beacon Health) and Comprehensive Primary Care Plus (CPC+) programs. Currently, there are no CPC+ programs operating in Maine, but such programs offer potential benefits for Maine hospitals for the future.

## Merit-Based Incentive Payment Model (MIPS)

MIPS Performance Category	CY 2019 Final	CY 2020 Proposed	CY 2021 and beyond Proposed
Quality	60%	60%	30%
Cost/Resource Use	0%	0%	30%
Improvement Activities	15%	15%	15%
Advancing Care Information (ACI)	25%	25%	25%



**MaineCare is Also Moving to Tie Payment to Quality and Value**

***Primary Care Case Management***

MaineCare has operated a Primary Care Case Management Program (PCCM) for over 20 years, and it is the building block all of MaineCare’s value-based purchasing programs. As of July 2016, 152,548 MaineCare members were enrolled in 447 PCCM locations around the state.

***MaineCare Health Homes***

Health Homes are for members with specific chronic conditions. The Stage A Health Home involves a primary care practice working with a Community Care Team; while the Stage B Behavioral Health Homes are based in community mental health agencies. In July 2016, there were over 52,800 members enrolled in the Stage A Health Home program and nearly 6,000 members in Stage B Behavioral Health Homes. There are approximately 175 Health Home service locations and nearly 40 Behavioral Health Home provider organizations with over 100 service locations statewide.

***Accountable Communities Initiative***

As of July 2016, there were 77 practices from four organizations that had 52,019 members attributed to the Accountable Communities Initiative; 22,802 of these members also participate in Health Homes.

***Nonpayment for Certain Services***

MaineCare has also made a policy decision to stop or reduce payments for services deemed as unnecessary. The program reduces payment for low-level emergency department visits that could be done in a physician’s office. MaineCare also denies payment for hospital readmissions within 14 days for the same or similar diagnosis. Payment is also denied for any unfortunate situation that is classified as a “Never Event.”

## Types of Hospitals

### Prospective Payment

**System (PPS) Hospitals: 17**  
hospitals with 2,978 beds

**Critical Access Hospitals: 16**  
hospitals with 400 beds

### Psychiatric Hospitals

**(Institutes of Mental Disease): 2**  
hospitals with 178 beds

**Acute Rehabilitation: 1**  
hospital with 100 beds

### Critical Access Hospitals must:

1. Have no more than 25 beds;
2. Cap inpatient average length of stay at 96 hours; and
3. Be in a rural or remote location.

### Community Hospitals

Teaching Hospitals (6)

Tertiary Hospitals (3)

Critical Access Hospitals (16)

Sole Community Hospitals (3)

Psychiatric Hospitals (2)

Acute Rehabilitation Hospital (1)

## Member Hospitals

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

Houlton Regional Hospital—Houlton

Inland Hospital—Waterville

LincolnHealth—Damariscotta and Boothbay Harbor

Maine Coast Memorial Hospital—Ellsworth

MaineGeneral Medical Center—Augusta and Waterville

Maine Medical Center—Portland

Mayo Regional Hospital—Dover-Foxcroft

Mercy Hospital—Portland

Mid Coast Hospital—Brunswick

Millinocket Regional Hospital—Millinocket

Mount Desert Island Hospital—Bar Harbor

New England Rehabilitation Hospital—Portland

Northern Maine Medical Center—Fort Kent

Pen Bay Medical Center—Rockport

Penobscot Valley Hospital—Lincoln

Redington-Fairview General Hospital—Skowhegan

Rumford Hospital—Rumford

St. Joseph Hospital—Bangor

St. Mary's Regional Medical Center—Lewiston

Sebasticook Valley Health—Pittsfield

Stephens Memorial Hospital—Norway

Southern Maine Health Care—Biddeford and Sanford

Spring Harbor Hospital—Westbrook

Waldo County General Hospital—Belfast

York Hospital—York

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Maine Hospital Association

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