M|H|A
Maine Hospital Association

Maine Hospital Association
Federal Issues

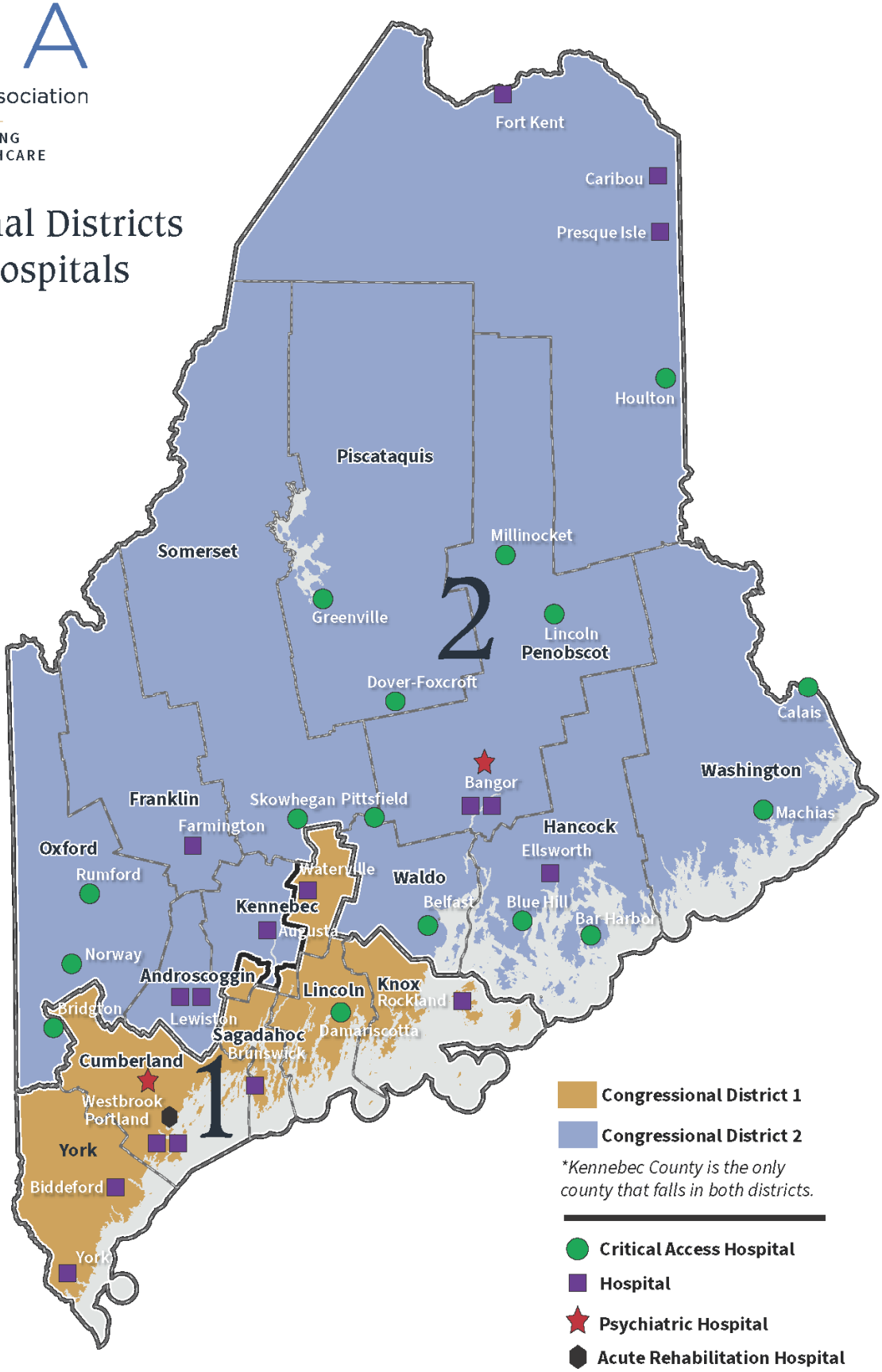
2025

MHA

Maine Hospital Association

MAINE'S LEADING VOICE FOR HEALTHCARE

Congressional Districts for Maine Hospitals



Caring for Our Communities

The Right Tool for the Right Job

As you know, Mainers like their chainsaws. For some jobs, they are the perfect tool.

But just as our patients don't want to see surgeons entering the operating room with a chainsaw in hand, hospitals are worried that we are in an era of policymaking by chainsaw.

We are not unmindful of the financial challenges the federal government faces. We simply ask that you choose the right tool for the job ahead.

The first few months of 2025 have been as rocky a time for hospitals in Maine as we can remember.

Large hospitals have had layoffs; smaller hospitals have closed units and one hospital in Maine has closed.

What is scary is that there really was no jarring event which has triggered the things we are seeing; we are not in a recession; there is not a new war; there is not a worldwide pandemic and so forth. And yet it's really tough out there now.

Top of mind for us is the potential for massive reductions in the Medicaid program.

We would ask you not to accept any premise that cuts to support for states is not a cut to patients. Medicaid is already the payer with the lowest reimbursement rates. Cutting federal financial support will only lead to further cuts to providers. Cuts we simply can't sustain.

As has been the case for several years now, we need 340B protected and Medicare Advantage reformed.

Hospitals are there 24-hours per day, seven days per week. There are no holidays, weekends or days off period. Hospitals in Maine are not only keeping their doors open, but are doing everything they can to help struggling nursing homes, ambulance providers and community behavioral health services going.

Thank you for the work you do and the efforts you make on our behalf. We look forward to seeing you during the American Hospital Association Annual Meeting.

About MHA

The Maine Hospital Association (MHA) represents all 32 community-governed hospitals in Maine. Formed in 1937, the Augusta-based nonprofit Association is the primary advocate for hospitals in the Maine State Legislature, the U.S. Congress and state and federal regulatory agencies. It also provides educational services and serves as a clearinghouse for comprehensive information for its hospital members, lawmakers and the public. MHA is a leader in developing healthcare policy and works to stimulate public debate on important healthcare issues that affect all Maine citizens.

Hospital Financial Condition

The financial situation of Maine's 32 hospitals is quite concerning.

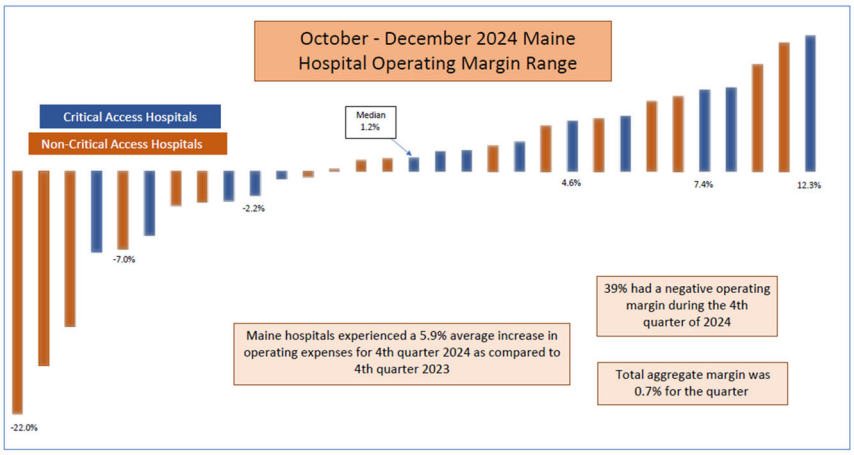
Inland Hospital in Waterville is closing after eighty-two years of service. This is the fourth hospital in Maine to cease operations in the past decade (St. Andrews (Boothbay), Parkview (Brunswick), Goodall (Sanford)).

Another 10 have ceased offering labor & delivery services including Mount Desert Island Hospital and Waldo Hospital in the past year.

Others have announced conversions (NMMC and Franklin Memorial) and mergers (CMHC).

And yet others have announced layoffs.

The Maine Hospital Association recently hired PYA, a national



healthcare consulting firm, to review Maine hospitals and put their financial condition in a national context. The picture is troubling.

Maine's larger hospitals (PPS) are:

Fifth Poorest -- Operating Margin

Second Most In Debt—Equity Financing Ratio

Fifth Oldest Facilities—Average Age of Plant.

Maine's smaller hospitals are seemingly better-off on average; however, a closer look at the data would show a handful of very strong CAH hospitals and several in financial trouble.

Financial Analysis

The PYA analysis can be found on the MHA website.

Questions

•How did Maine, New Hampshire, and Vermont Hospitals compare to median national metrics?

•How did hospitals "rebound" post-COVID (a comparison of 2019, 2021 and 2023 financial data)?

•What is the relative risk profile of Maine hospitals as compared to other states?

Metrics Used

Profitability: measures financial performance and earnings

•Total Margin – Overall profitability as a percentage of total net revenue.

•Operating Margin – Profitability from core hospital operations.

•Return on Equity (ROE) – Effectiveness in generating returns from equity investment.

Capital Structure: evaluates financial leverage and funding sources

•Equity Financing Ratio – Percentage of assets funded by equity vs. debt.

•Cash Flow to Total Liabilities – Ability to cover total liabilities using operating cash.

Liquidity: measures short-term financial health

•Current Ratio – Ability to cover short-term obligations with current assets.

•Net Days in Patient A/R – Efficiency in collecting payments from patients and insurers.

Operational Efficiency: evaluates resource utilization and infrastructure investment

•Average Age of Plant – Indicates hospital capital investment needs based on asset age.

•Occupancy Rate – Measures hospital bed utilization and capacity efficiency.

Incomplete Work Product Draft

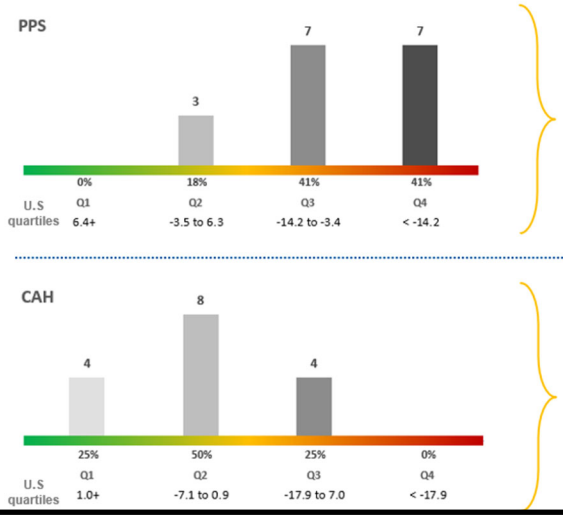
Ranking of Maine Hospitals to National Indicators

Ranking of 2023 Median Financial Metrics to U.S. States
PPS (50 states) and CAH (45 states)
Lower Score Better

	Metric	Maine PPS	Maine CAH
1	Total Margin	39	29
2	Operating Margin	46	17
3	Return on Equity	21	28
4	Current Ratio	26	33
5	Net Days in Patient A/R	42	5
6	Equity Financing Ratio	49	24
7	Cash Flow to Total Liabilities	22	31
8	Average Age of Plant	46	40
9	Occupancy Rate	21	9

- Most of Maine's rankings were in the bottom quartile when compared nationally for PPS hospitals, as discussed in more detail on the following page.
- CAH facilities ranked slightly more favorable overall to national medians.

Operating Margin (National Quartiles)



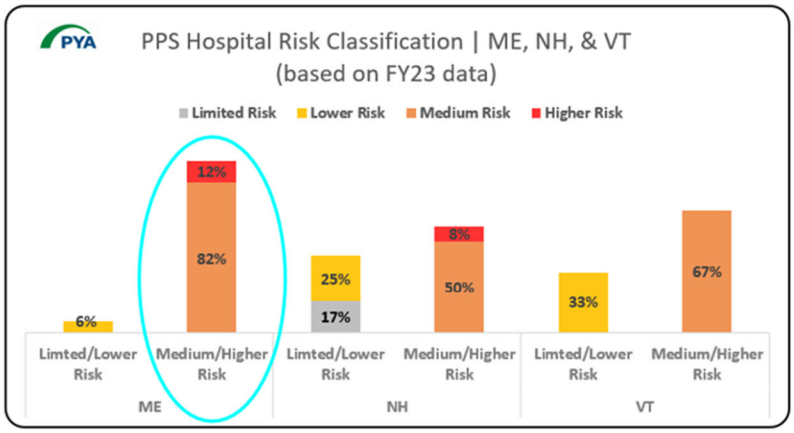
There are a few CAH hospitals with strong margins and an equal number with negative margins. As such, the averages can be a bit misleading and we recommend looking at CAHs with more focus on the individual hospital.

MHA also asked PYA to assess Maine hospitals for their closure risk as compared to our Northern New England neighbors of New Hampshire and Vermont.

Again, Maine looks worse. A full 94% of Maine hospitals were Medium or High risk, as compared to 58% and 67% for NH and VT respectively.

Risk Classifications – PPS Hospitals

Total Hospitals Evaluated: 35



- Based on our risk profile metrics and weighting criteria, Maine had the highest % of PPS hospitals classified as medium/higher risk.

Maine & Medicaid (2024)

Total Enrollment: 421,000

Medicaid Expenditures: $4.7 Billion

State: $1.7 Billion

Federal: $3.0 Billion

Medicaid Spending Per Enrollee (2021):

- **All Full-Benefit Enrollees:**
  - **ME: $8,700**
  - **US: $7,600**
- **Seniors:**
  - **ME: $19,000**
  - **US: $19,000**
- **Individuals with Disabilities:**
  - **ME: $25,000**
  - **US: $18,500**
- **Adults:**
  - **ME: $4,500**
  - **US: $5,500**
- **Children:**
  - **ME: $3,300**
  - **US: $3,000**
- **ACA Expansion Adults:**
  - **ME: $5,100**
  - **US: $6,500**

Source: Kaiser Family Foundation

Please Protect Medicaid

The House budget resolution calls for $880 billion in reductions from programs overseen by the Energy & Commerce Committee.

There is no parallel reduction in the Senate budget resolution.

Clearly, the threat to Medicaid is real.

The Congressional Budget Office has provided a "score" for a list of possible cuts to Medicaid.

Finance Cuts

- Per Capita Cap
- FMAP Changes
- Provider Assessments ("Tax & Match")

Provider Reimbursement

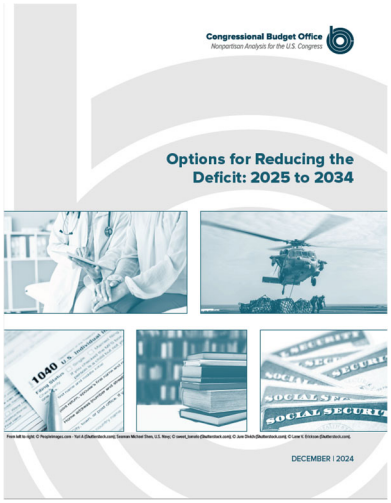
- State Directed Payments in Managed Care States – Not in Maine
- Nursing Home Staffing Rule Reversal – We Support

Eligibility

- Work Requirements
- Continuous Enrollment

Other Possible Cuts

- Enhanced Premium Tax Credits
- Site Neutral – Eliminate Facility Fees
- 340B Cuts/Restrictions
- Graduate Medical Education Cuts
- Reduce Medicare Bad Debt Payment



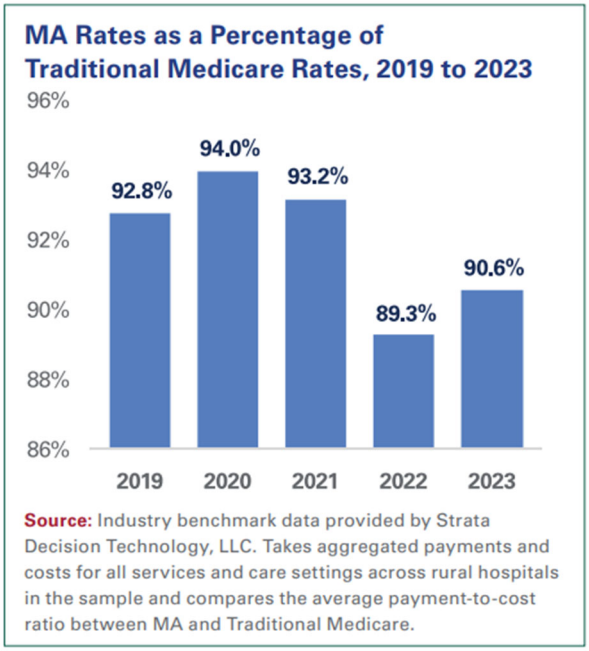
We have two requests.

First, oppose the House approach and do not include a proposal like the $880 billion reduction in the final reconciliation package.

Second, if any cuts such as these emerge from any of the ongoing conversations, please remain in touch with us as you have so far.

Medicare Advantage Regulation

The Medicare Advantage (MA) program has expanded rapidly and now accounts for more than half of total Medicare enrollment. While MA offers some benefits, certain plans reimburse hospitals below cost, delay or deny payments, and impose significant administrative hurdles, especially to rural hospitals, which have seen the fastest growth in MA recently. These risks exacerbate existing challenges like staffing shortages and unfavorable payer mixes.



Reimbursement well below the cost of care: Traditional Medicare often pays less than the cost of care, and increasingly rural hospitals report that MA plans pay even less — only 90.6% of Traditional Medicare rates on a cost basis, according to industry benchmark data provided by Strata Decision Technology, LLC (see chart).

Diminished access to quality care: Delays, denials, and excessive prior authorization from certain MA plans can hinder timely care: 81% of rural clinicians report quality reductions due to insurer requirements, and MA patients face 9.6% longer stays before post-acute care compared to similar Traditional Medicare patients.

Administrative burdens and payment challenges: Delayed or denied MA payments worsen rural hospitals' finances and increase administrative burdens. Nearly 4 in 5 rural clinicians report higher administrative tasks in five years, with 86% seeing negative impacts to patient outcomes.

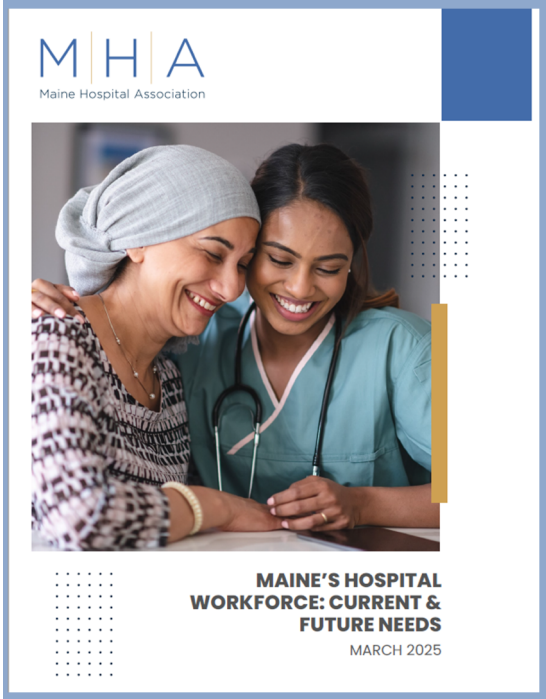
Please don't give-up on regulating Medicare Advantage plans.

American Hospital Association recommendations for Medicare Advantage improvement:

1. **Streamline prior authorization processes to protect timely access to medical care and drugs covered under the medical benefit.**
2. **Cost-based reimbursement for CAHs from MA plans.**
3. **Ensure prompt payment from insurers for medically necessary, covered health care services delivered to patients.**
4. **Require MA plan clinician reviewers who review coverage denials (adverse determinations) to provide their name and credentials and attest they meet existing CMS rules and have relevant training and expertise in the requested service.**
5. **Improve data collection, reporting and transparency in the MA program with a focus on metrics that are meaningful indicators of patient access, such as appeals, grievances and denials.**
6. **Expand network adequacy requirements for certain post-acute sites of care.**

Hospital Workforce

In February 2025, the Maine Hospital Association conducted a survey of its members to assess current workforce needs and project future requirements based on the age distribution of the existing workforce.

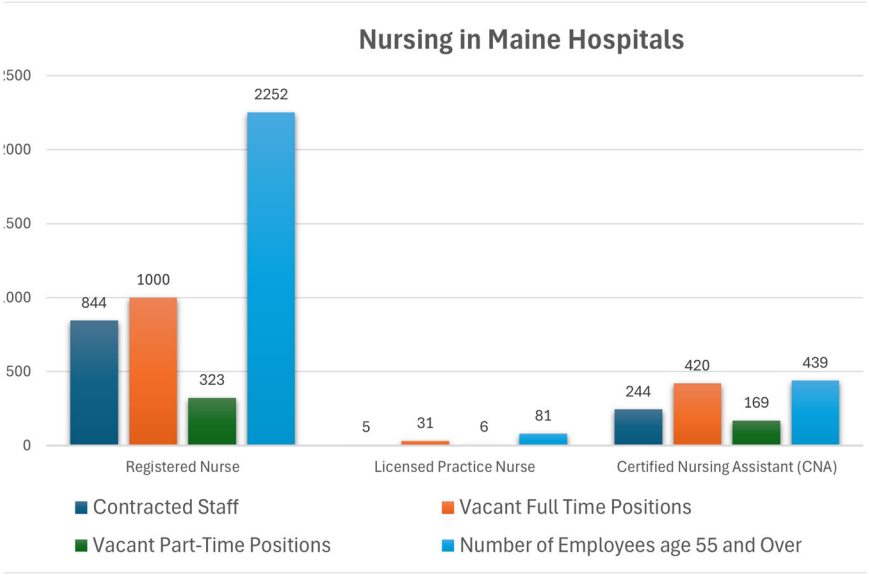


Of the 32 members surveyed, 27 responded, yielding an 82% response rate. The survey gathered data on the number of full-time and part-time budgeted positions currently being recruited, as well as the number of employees aged 55 or older by healthcare occupation.

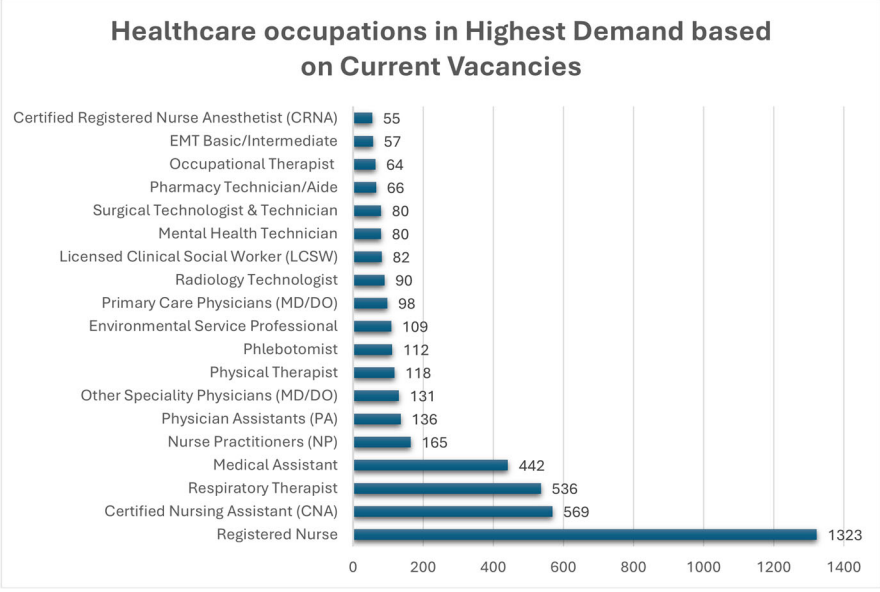
Additionally, hospitals were asked about their investments in salary increases, traveler expenses, and workforce development initiatives.

The report is on the MHA website.

Maine hospitals are actively recruiting for 4,227 budgeted positions, which include 3,090 full-time and 1,137 part-time roles. Beyond filling open positions, hospitals have significantly invested in retaining their current workforce, reporting $472 million in salary increases between 2023 and 2025 representing a 14% increase that outpaces inflation. Furthermore, hospitals have invested an additional $150 million in physician fees and salaries during the same period, reflecting a 22% increase.

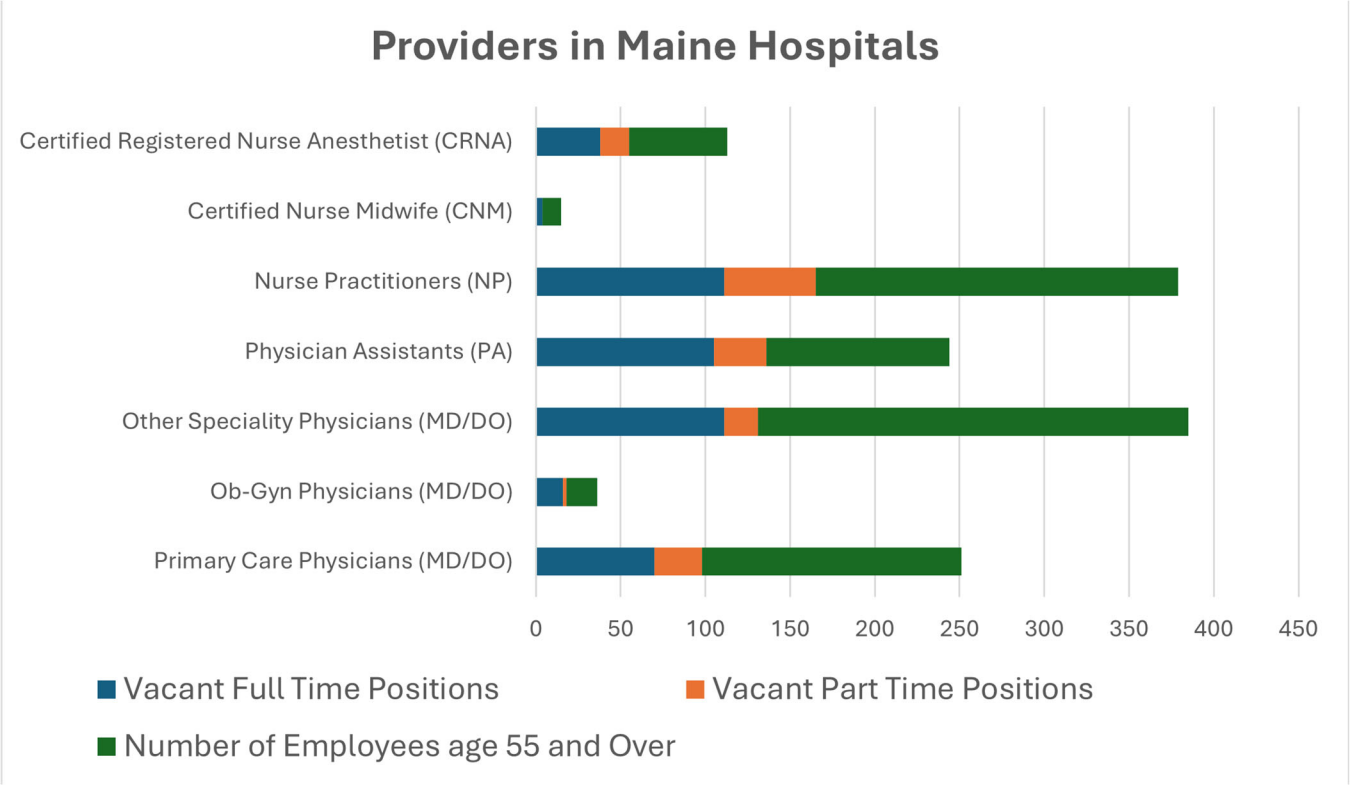


Encouragingly, compared to previous years, the demand for contracted labor (or "travelers") has decreased, with total expenditures falling by 29% between 2023 and 2025. This suggests a stronger workforce and greater success in



recruitment and pipeline development. Hospitals are also focused on strengthening their workforce pipelines by "growing their own" through workforce development initiatives. On average, hospitals reported investing $426.29 per employee in workforce development efforts, totaling $16,751,732 across 26 reporting hospitals in the past year.

These efforts include partnerships with academic institutions, funding earn-while-you-learn programs, offering classroom-based education for clinical programs, hosting clinical rotations, providing tuition reimbursement and remission for clinical training, offering clinical faculty to academic programs, and providing clinical certification and leadership education courses.



Despite these substantial investments and early signs of progress, hospitals face significant challenges due to a limited recruitment pool and an increasing number of employees aged 55 or older. The aging workforce in Maine's hospitals mirrors the broader healthcare sector and the state as a whole. According to the Office of the State Economist's June 2023 report, Maine's prime working-age population (ages 20-64) is projected to decline by 5.3% from 2020 to 2030, as the Baby Boomer generation continues to age out of the cohort. By 2030, the youngest Baby Boomers will be 66 years old. The concern is compounded by the expected 2% decline in Maine's younger working-age population over the same period, leaving fewer individuals to fill critical healthcare positions as the Baby Boomer generation retires.

This demographic shift presents one of the most significant challenges we will face over the next five to ten years. The aging workforce in Maine hospitals mirrors the state's overall population trends and, as our members have noted, "tells a true story—one that many do not want to believe."

Preserve 340B Drug Discounts

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.

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 Health Resources and Services Administration. These drugs are then provided to all hospital patients with the exception of those patients on the Medicaid program.

Currently, 26 Maine hospitals qualify for the 340B Drug Discount program and receive a collective benefit estimated to be $250 million a year. This is a reduction of $50 million over the past few years. Eliminating the 340B benefit would have a devastating impact on hospital financial health.

If the hospitals that received 340B discounts were to lose them, their aggregate operating margin would be NEGATIVE $220 million.

The Challenge. Pharmaceutical companies are taking increasingly aggressive action to undermine the intent of the program and are having an impact. They are unilaterally choosing to no longer provide drugs at the 340B discount price and they are challenging aspects of the program in court.

One of their tactics is to limit the number of pharmacies a hospital can partner with (contract pharmacies). As such, hospitals are understandably preserving their relationships with the largest pharmacy in their area; smaller local pharmacies are forced out of a hospitals' network of partners. This is wrong.

Hospitals, FQHCs and Pharmacies in Maine have partnered to pursue state-level legislation to protect against unfair cuts.

Yet, legislative attacks on the 340B program in Washington DC are still a major concern. If they succeed in their goal of reducing the benefit of 340B, hospitals will lose crucial support, patients will see no financial relief and pharmaceutical companies will laugh all the way to the bank. Please oppose these efforts and continue to support the 340B program.

340B Hospitals

Bridgton Hospital

Central Maine Medical Center

Houlton Regional Hospital

MaineGeneral Medical Center

MaineHealth Franklin Hospital

MaineHealth Lincoln Hospital

MaineHealth Maine Medical Center

MaineHealth Pen Bay Hospital

MaineHealth Stephens Hospital

MaineHealth Waldo Hospital

Millinocket Regional Hospital

Mount Desert Island Hospital

Northern Light A.R. Gould Hospital

Northern Light Blue Hill Hospital

Northern Light C.A. Dean Hospital

Northern Light Eastern Maine Medical Center

Northern Light Maine Coast Hospital

Northern Light Mayo Hospital

Northern Light Mercy Hospital

Northern Light Sebasticook Valley Hospital

Northern Maine Medical Center

Penobscot Valley Hospital

Redington-Fairview General Hospital

Rumford Hospital

St. Mary's Regional Medical Center

St. Joseph's Healthcare

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Chrissi Maguire, President and CEO, Mount Desert Island Hospital

2025

MHA Member Hospitals

Bridgton Hospital, Bridgton
Cary Medical Center, Caribou
Central Maine Medical Center, Lewiston
Houlton Regional Hospital, Houlton
MaineGeneral Medical Center, Augusta & Waterville
MaineHealth Behavioral Health, South Portland
MaineHealth Franklin Hospital, Farmington
MaineHealth Lincoln Hospital, Damariscotta & Boothbay Harbor
MaineHealth Maine Medical Center, Portland & Biddeford
MaineHealth Mid Coast Hospital, Brunswick
MaineHealth Pen Bay Hospital, Rockport
MaineHealth Stephens Hospital, Norway
MaineHealth Waldo Hospital, Belfast
Millinocket Regional Hospital, Millinocket
Mount Desert Island Hospital, Bar Harbor
New England Rehabilitation Hospital, Portland
Northern Light Acadia Hospital, Bangor
Northern Light A.R. Gould Hospital, Presque Isle
Northern Light Blue Hill Hospital, Blue Hill
Northern Light C.A. Dean Hospital, Greenville
Northern Light Eastern Maine Medical Center, Bangor
Northern Light Maine Coast Hospital, Ellsworth
Northern Light Mayo Hospital, Dover-Foxcroft
Northern Light Mercy Hospital, Portland
Northern Light Sebasticook Valley Hospital, Pittsfield
Northern Maine Medical Center, Fort Kent
Penobscot Valley Hospital, Lincoln
Redington-Fairview General Hospital, Skowhegan
Rumford Hospital, Rumford
St. Joseph Hospital, Bangor
St. Mary's Regional Medical Center, Lewiston
York Hospital, York

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VOICE FOR HEALTHCARE

33 Fuller Road
Augusta, ME 04330
Phone: 207-622-4794
Fax: 207-622-3073
www.themha.org