Hospital Issues for State Office Candidates

MHA
Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

A publication of the
Maine Hospital Association

September 1, 2024

What's Inside

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Dear Candidate for State Office,

On behalf of Maine's hospitals, the Maine Hospital Association (MHA) is pleased to provide you with this year's edition of ***Hospital Issues for State Office Candidates.*** We hope you find the information in the document useful as you campaign for state office.

Maine Hospital Association represents all 35 hospitals in Maine and advocates for hospitals on state issues before the Maine Legislature and state agencies.

MHA does not endorse candidates, issue questionnaires or compile scorecards. We are sending you this publication so that you can have a sense of the issues and concerns of Maine's hospitals.

We applaud you on your willingness to run for state office. It is a challenging job and can often seem thankless. But, it is also an extremely important job as you will decide policy matters, including healthcare-related issues, for the state.

Thank you for accepting this document and we hope it is useful to you. I'm happy to speak with you anytime about the issues raised in this publication or on other hospital matters.

Thank you,

Jeffrey Austin
Vice President of Government Affairs and Communications

About MHA

The Maine Hospital Association represents all 35 community-governed hospitals in Maine. Formed in 1937, the Augusta-based non-profit 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 of Maine's citizens.

Mission Statement

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

Hospital Costs and Value

At a recent conference, a military veteran discussed a horrific injury she suffered in combat, the life-saving treatment she received on site, the amazing care provided in Germany and then the year and a half of rehabilitation at Walter Reed National Military Medical Center.

When she opened the floor for questions, many were asked. However, no one asked how much the care cost. At the State House, it's often the dominant issue in committee rooms. People are always asking about cost because cost is a legitimate issue.

The government cares about cost because the State helps fund the Medicaid health insurance program. Employers care about cost because they help finance commercial insurance for their employees. And of course, the public cares because of their out-of-pocket costs.

Health care is expensive. That is not a point to be debated. The policy question is whether healthcare costs in Maine are reasonable. Are providers doing a good job of making care as affordable as can reasonably be expected given the cost of labor, supplies, pharmaceuticals, regulations and all the expenses that go into providing care?

The biggest challenge in answering that question is that there is no universally agreed-upon measuring stick. That said, a standard approach used in state policy discussions of healthcare and other policy topics is to compare the costs across states. It's not an easy math calculation.

There is also noise in the data. What if one state has an older population than another state? Is the higher cost in the older state reflective of "costs" or does it simply show the relative age in each state since it is universally true that healthcare costs increase as people get older. What about the states with high uninsured levels doesn't that pressure insurance rates differently across state lines?

There are many sources of data about healthcare costs. We would caution policymakers to be savvy consumers of healthcare cost information. Is the report covering all costs or only the commercially insured? Has the data been adjusted? How? Who paid for it? Are the methodology and data sources publicly available?

It's often best to rely on a variety of sources and see if there is some commonality among the sources.

One source that is generally accepted as credible is the Kaiser Family Foundation. They have a metric called "Hospital Adjusted Expenses per Inpatient Day" that is often cited in hospital circles. Despite the title, the data is comprehensive – it includes both inpatient AND outpatient costs.

On this metric, Maine ranks 25th nationally and just below the national average. Maine is also the lowest in New England. Maine is even lower when only non-profit hospitals are analyzed (Maine only has non-profit hospitals). A report commissioned by insurers and other payers, the so-called "Rand Report" similarly found that Maine was ranked 29th nationally using a completely different methodology.

Costs, generally speaking, are higher in the northeast than in most other parts of the country. Forbes ranks Maine as 23rd highest in terms of general cost of living. US News & World Report ranks Maine as 29th in terms of general affordability.

As such, hospital costs appear to be in line with the cost of living in Maine generally.

By comparison, Maine ranks 15th highest in per pupil spending on K-12 education.

Maine ranks between 23rd and 29th on cost of living.

Maine ranks 25th nationally on healthcare costs.

Maine ranks 15th nationally on k-12 education costs.

Another way to look at cost is the value question – is the service worth the cost?

That is, how does the relative cost compare to relative quality?

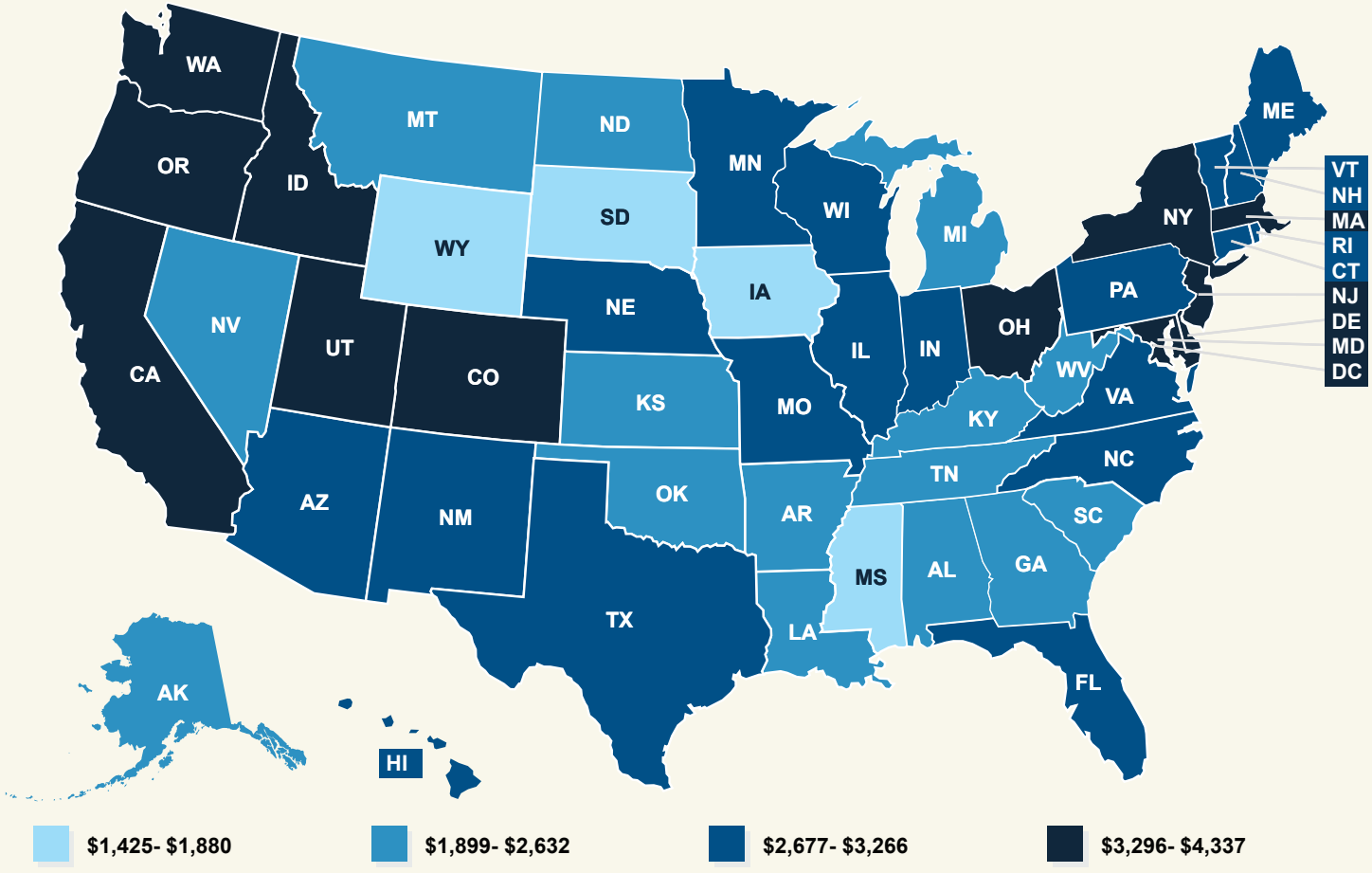
Measuring the quality of healthcare is difficult; compiling those measures into a single rank for a state is very difficult.

Nevertheless, various groups do it; one that does this work specifically for hospital quality is the Leapfrog group which we discuss on page 6. Leapfrog ranks Maine as 9th best for hospital quality; whereas on cost Maine is ranked as 25th highest. As such, Maine's hospital quality is very good and relative to cost hospital quality is excellent. In fact, when you compare relative cost to quality, Maine is 12th or top 25% nationally.

Again, healthcare costs are high and quality can always be improved. But policymakers who are trying to keep an eye on these issues can take comfort that Maine's hospital costs are only average nationally but its quality is very good.

Hospitals are a very good value in Maine.

Hospital Adjusted Expenses per Inpatient Day | KFF | Timeframe: 2022



Source: https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day/view/print/?activeTab=map&currentTimeframe=0&selectedDistributions=expenses-per-inpatient-day&print=true&sortModel=%7B%22colId%22:%22Expenses%20per%20Inpatient%20Day%22,%22sort%22:%22desc%22%7D

Maine Hospitals are Among the Best in the Country

The top priority for Maine hospitals is to provide high-quality care, which, according to the federal government agency charged with improving the quality of healthcare nationwide, means "doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results."

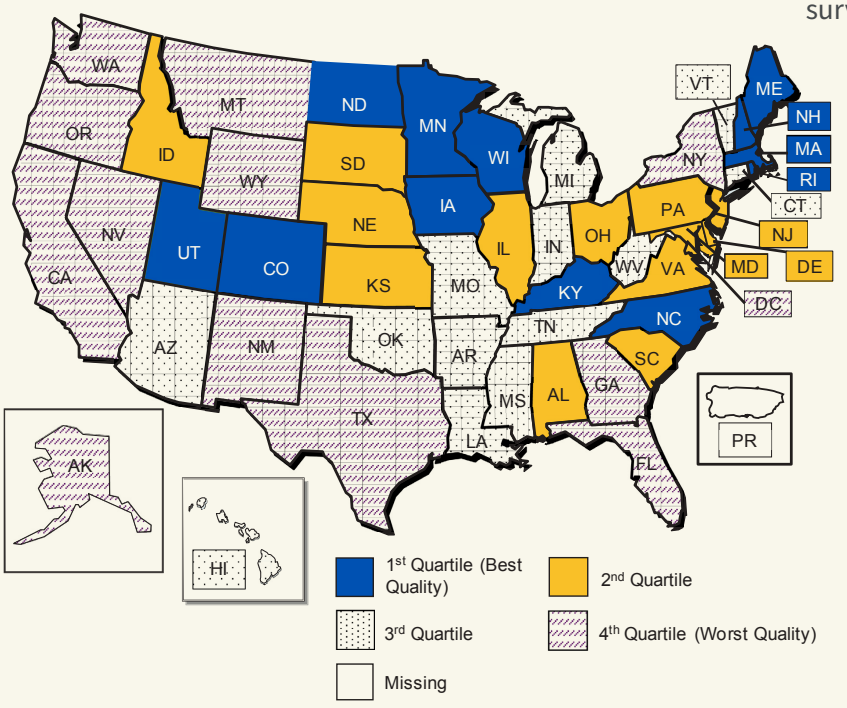
Over the years, national organizations that evaluate hospital quality have begun to move away from state-level evaluations and have focused on hospital-specific quality reports. As a result, it's harder to quantify the superior quality that Maine hospitals offer overall. Nevertheless, there are still some state-level comparisons.

According to a five-year (2015-2020) retrospective analysis, the *National Healthcare Quality and Disparities Report*, by the federal government's Agency for Healthcare Research and Quality (AHRQ), Maine healthcare is in the top quartile nationally. That same report found that Maine is in the top quartile for having the fewest disparities in the quality of care among different ethnic groups.

Maine hospitals have consistently been top performers of the Leapfrog Group's Hospital Safety Scores. In the spring 2024 report, Maine ranked 9th in the country (second in New England to Rhode Island). This is a modest increase from our previous ranking (11th) two years ago.

Overview of U.S. Healthcare System Landscape

Figure 31. Overall quality of care, by state, 2015-2020



How is quality measured?

There are essentially two kinds of quality metrics – those that measure processes of care and those that measure outcomes.

A **process measure** will compare a hospital's performance to an accepted best practice. For example, how often a hospital provides an aspirin within one-hour of a patient's heart attack.

An **outcome measure** will generally look at the prevalence of a condition or circumstance. For example, how many patients are readmitted to the hospital for heart-related problems within 30 days of being discharged following treatment for a heart attack.

Hospitals know that quality is not just about how to treat the illness, it's also about how to treat the patient. The Centers for Medicare and Medicaid Services' *Hospital Compare* provides the national standard for measuring patients' own assessments of the experience during their care. Hospitals are required to use a standard survey that asks patients about their experiences during a recent hospital stay. The questions are about different facets of patient experience, such as how well doctors and nurses communicated, how well patients believed their pain was addressed, and whether they would recommend the hospital to others.

We believe the Legislature plays an important role in promoting quality healthcare and we want to work with you toward that end.

Source: AHRQ
https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2021qdr.pdf

Hospitals Provide Vital Public Services as Private Entities

Maine's hospitals provide a valuable public service. They receive payment from both the state and federal governments to provide care. Maine's acute-care hospitals are all nonprofits.

These forces combine to obscure the fact that Maine's hospitals are private organizations. Hospitals are governed by Boards of Trustees made up of local leaders. These trustees are best able to weigh the costs and benefits of the myriad decisions hospitals have to make. While no system of governance is perfect or without challenges, it is a far better system, we believe, than having the Legislature attempt to govern all hospitals from Augusta.

Each year, legislation is filed that is not respectful of hospitals' private status. These bills would:

- Establish in state law compensation for hospital employees;
- Require hospital board meetings to be open to the public; and
- Give the press access to internal medical documents.

These bills have historically been rejected and should continue to be rejected.

Many entities perform services and receive payment from the government. The Bath Iron Works CEO's pay is not capped in statute, the Board meetings of BIW are not open to the public and the internal files of private companies remain protected.

Maine's private hospitals should not receive fewer basic protections than other private entities.

That said, as nonprofits, there are thousands of pages of information about hospitals open to the public. As but one example of our commitment to transparency, each year the hospitals in Maine provide enormous amounts of financial data to the Maine Health Data Organization (MHDO). MHDO is a quasi-government agency that compiles and publicizes healthcare information. Hospitals and insurance carriers are the source of that information. In fact, hospitals and insurance carriers not only provide data to MHDO, the hospitals and carriers fund this agency via an assessment.

MHA asks that legislators continue to resist inappropriate intrusions into Maine's private hospitals.

Violence Against Healthcare Workers is Unacceptable

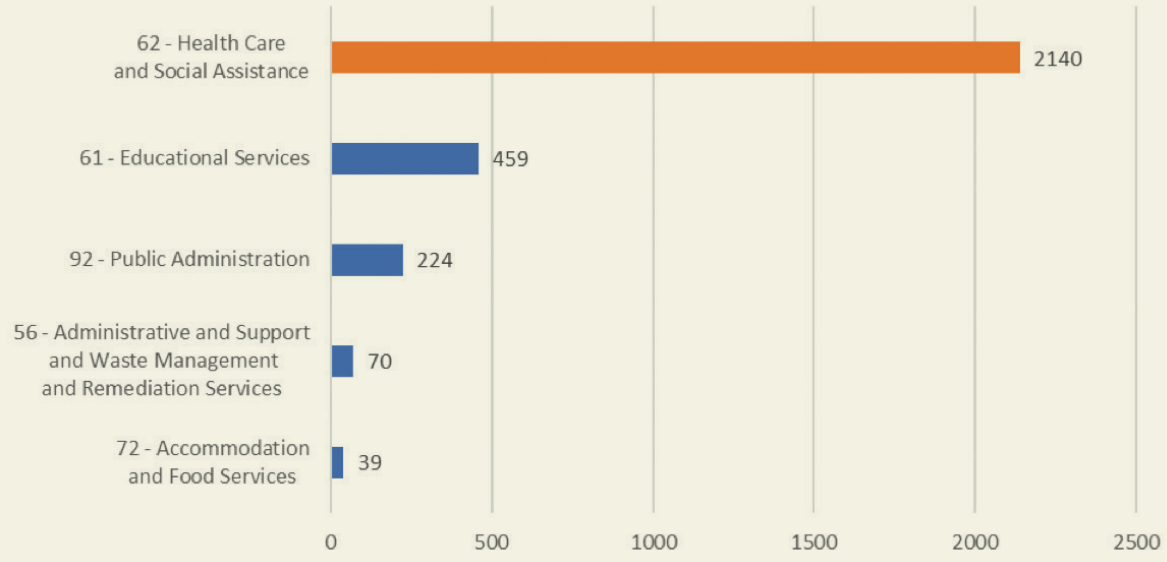
Violence against healthcare workers is an epidemic. Hospitals and health systems have long had robust protocols in place to detect and deter violence against their team members. Since the onset of the pandemic, however, violence against hospital employees has markedly increased — and there is no sign it is receding. According to data from Press Ganey, more than 5,200 nursing personnel were assaulted in the second quarter of 2022. On average, two nurses were assaulted every hour, which is about 57 assaults per day. The analysis found that most attackers were patients.[1] Workplace violence has severe consequences for the entire healthcare system. Not only does it cause physical and psychological injury for healthcare workers, but workplace violence and intimidation make it more difficult for nurses, doctors and other clinical staff to provide quality patient care. Nurses and doctors cannot provide attentive care when they are afraid for their personal safety, distracted by disruptive patients and family members, or traumatized from prior violent interactions. In addition, violent interactions at healthcare facilities tie up valuable resources and can delay urgently needed care for other patients. Studies show that workplace violence reduces patient satisfaction and employee productivity and increases the potential for adverse medical events.

While workplace violence occurs in every healthcare setting, nearly 50% of all incidents occur in emergency departments, often driven by unmet behavioral health needs requiring prolonged stays in a nontherapeutic environment. Maine Health Maine Medical Center in Portland reported in March of 2024 that over the past three and a half years, 4,230 care team members have been impacted by workplace violence. These incidents most often and more severely impact healthcare workers in security, nursing and nursing support services.

More recently, the American College of Emergency Physicians published the results of its January 2024 survey of emergency physicians. The survey showed the following:

- More than nine in ten (91%) of emergency physicians indicated that they have been threatened or attacked in the past year.
- Nearly three-quarters (71%) of emergency physicians believe that violence in the emergency department is

Top 5 Industries Suffering Intentional Injury by Other Person Resulting in Lost Time (Maine, 2012-2021)

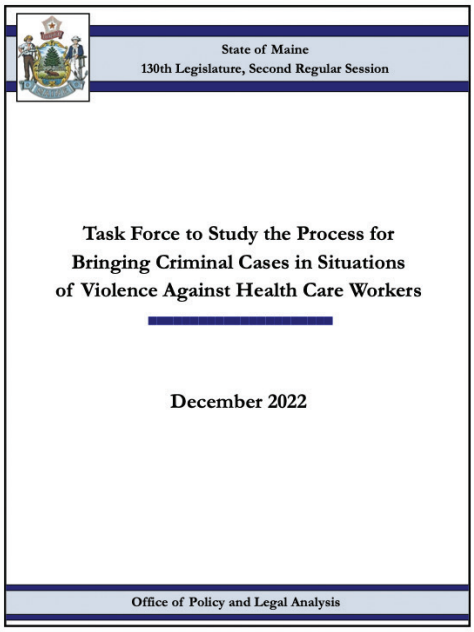


worse than last year.

- Nearly half (48%) said that legislation to strengthen workforce protections would make them feel safer on the job.

For medical professionals, being assaulted or intimidated can no longer be tolerated as "part of the job." Hospitals are taking many steps to prevent or reduce violence, including investing in additional security personnel, security systems with panic buttons, and advanced de-escalation and self-protection training for staff. We need our criminal justice partners—police and prosecutors—to recognize this problem and help us address it and we continue to strengthen our partnerships with public safety at a regional level. Further, the MHA has worked with members to further streamline data collection of workplace violence incidents so that we can better understand and respond from a policy and educational standpoint.

In 2022, the Legislature convened a study group to look at this issue in Maine. As a result, the 131st Legislature enhanced and clarified the felony penalty for certain assaults against hospital workers and we are appreciative for that. However, it also found that very few cases are ever brought by prosecutors and even when cases are brought, actual jail time is rarely imposed. For example, in 2022 there were only 2 convictions for assault against healthcare workers. In each case the perpetrator was sentenced to 3 years in jail; however, the first individual only served 111 days and the second only served 7 days. The Legislature needs to continue to monitor this situation and help us hold perpetrators of this violence accountable.


State of Maine
130th Legislature, Second Regular Session

Task Force to Study the Process for Bringing Criminal Cases in Situations of Violence Against Health Care Workers

December 2022

Office of Policy and Legal Analysis

Quote of an ED RN

"I was punched in the face by a patient. From that injury I sustained a concussion. I had to stay in the dark for three days because it was almost impossible to keep my eyes open in the daylight. I had a constant headache and would vomit if I changed position. I was out of work for 3 weeks before I was cleared to go back. But I am not alone. I could share many stories of close colleagues who have been assaulted. We get spit on. We get called names, and some have had their lives threatened."

COPS & COURTS

Last year, Maine made assaulting an emergency medical worker a felony. The problem of patient violence remains

Cost Shift

The Maine Legislature is responsible for setting the state's Medicaid (known as MaineCare) budget each year. Although the federal government covers a majority of the cost of the program, it is the state government that determines reimbursement amounts within federal guidelines.

Medicaid Undercompensates Hospitals. Medicaid does not fully compensate hospitals and doctors for the cost of providing care to Maine's Medicaid population.

Hospitals are compensated differently based upon their organization. Payment systems for inpatient and outpatient services are structured differently. That said, Medicaid provides 72 cents in reimbursement for each dollar of care provided in the aggregate. The rate reform process that is due to be implemented in SFY 2025 will improve the situation for hospitals; however, there will still be a Medicaid underpayment and hospitals had to finance most of the rate increases themselves

Cost Shifting. Medicaid is not the only payer that does not fully cover its costs. Neither does Medicare. Also, most uninsured patients pay very little toward their cost of care.

Accordingly, those covered by commercial insurance have to pay more than their share to cover the losses caused by others in the system.

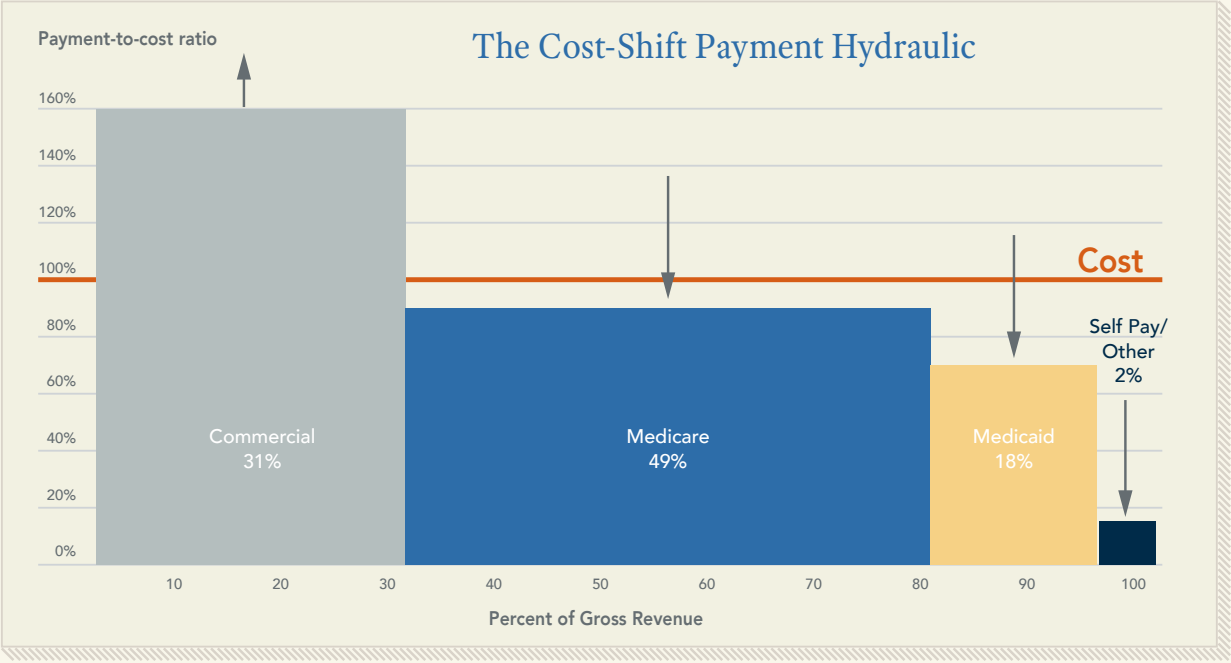
Like other providers in Medicaid, hospitals continue to experience losses because Medicaid reimbursement is below the actual cost of providing care to Medicaid patients.

The Bottom Line. The American Hospital Association recently reviewed the financial performance of rural hospitals nationwide. That analysis confirmed the negative impact that public payers like Medicaid and Medicare have on the bottom line financial performance of hospitals.

Among rural hospitals that consistently had positive operating margins, roughly 49% of their patients were covered by public payers (40% Medicare and 9% Medicaid). Among rural hospitals that had consistently negative margins, roughly 60% of their patients were covered by public payers (51% Medicare and 9% Medicaid). Maine is roughly 67% public payers (49% Medicare and 14% Medicaid).

	Medicare	Medicaid	Total Public Payors
Hospitals Nationwide that Make Money	40%	9%	49%
Hospitals Nationwide that Lose Money	51%	9%	61%
Hospitals in Maine	49%	18%	67%

Given the demographics of Maine, thousands of people are aging into Medicare and leaving the commercial market each year. As a result, the existing cost-shift challenge is only getting more difficult. This shifting caseload from the commercial market (where hospitals make money) to the public payers (where hospitals lose money) is a huge driver of financial challenge for hospitals.



Hospital Tax

Maine imposes an income tax on non-profit hospitals of approximately $180 million per year. This is by far the largest tax on non-profits in the state and one of the heaviest tax burdens on any industry in Maine. For example, among other industry-specific taxes, the hospital tax raises more revenue for the State of Maine than does the tobacco tax, liquor tax, tax on insurance carriers, the real estate transfer tax, tax on casinos, and the lottery.

The funding is informally dedicated to helping finance the cost of care provided by hospitals to Medicaid recipients.

The federal government covers roughly 72% of the costs of the Medicaid program and the state government covers the balance.

However, there are few limits on how the state government can raise "its" 28% of the program costs.

For the hospital portion of the Medicaid program, the state raises most of the money it needs by taxing hospitals.

Imagine if the state taxed K-12 public schools to pay for public education…that is what the state does to finance hospital care for public health insurance. It taxes the providers to pay for the service they provide.

At the end of the day, state government and Maine's taxpayers pay less than 6% of the total cost of hospital care for Medicaid recipients. Maine hospitals provide three times that amount themselves and the federal government provides the rest.

Maine hospitals are doing more than their share to help low-income families in Maine access healthcare.

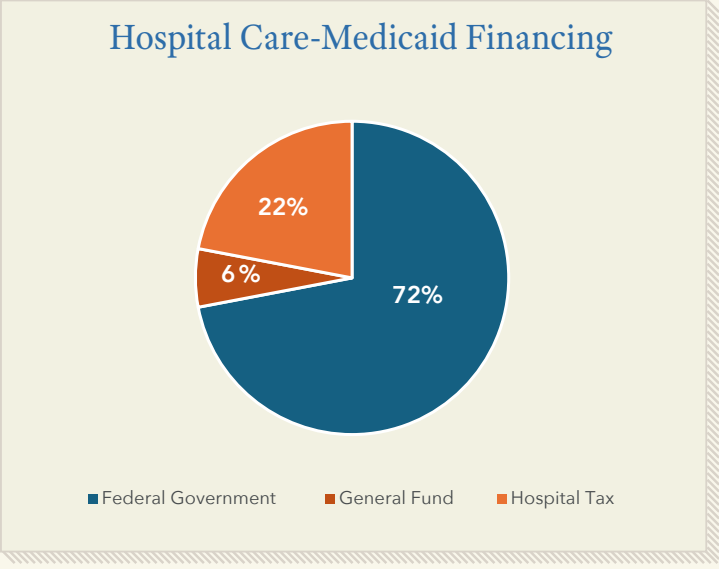
Hospitals in Maine contribute more than THREE times as much as the General Fund to financing the cost of hospital care provided to Medicaid patients. Hospitals are paying their own way.

Total Anticipated Medicaid Payments to Hospitals: $825M

Federal Funding: $595 million

Hospital Tax: $180 million

State General Fund: $50 million



Maine Hospital Finances

The financing of healthcare in the United States is complicated, to say the least. Hospitals in Maine are emblematic of that complexity. Healthcare financing just doesn't look or act like financing in most other segments of our economy. There is no doubt that healthcare is expensive, but as you can see from the table on the next page, the money that flows into hospitals doesn't stay there, it flows right back out.

Operating Margins. As the table shows, sixteen hospitals had negative margins in 2022 – this is almost half of all 34 hospitals in Maine (note: some hospitals are legally related and combine their balance sheets). During 2022, the aggregate operating margin for all hospitals in Maine was -2.2%%.

> For the first quarter of 2024, almost 60% of hospitals had negative margins and the aggregate margin for all hospitals combined was – 1%.

A persistent contributor to lower margins at hospitals is uncompensated care. This is the combination of both free care and bad debt.

Free Care—care provided for which no payment is sought; and

Bad Debt—care for which payment is sought but not received.

Bad debt has grown over the past decade due to the recent trend of employers moving their employees into high-deductible health insurance plans. When those workers can't afford the higher deductibles, the bills go unpaid and hospital bad debt rises.

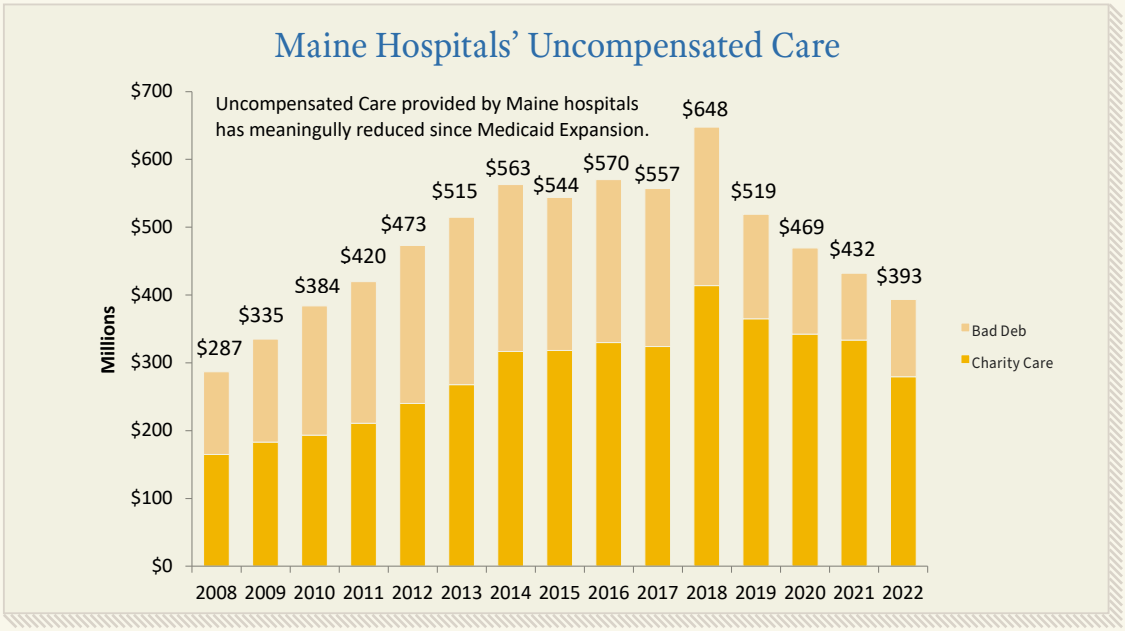
Charity care has fallen, largely because of increased coverage from both Medicaid expansion and the subsidies in the individual market.

Tax Exemption.
State government has long recognized the financial challenges of hospitals by providing them with certain tax exemptions. Hospitals are very grateful to their municipal hosts for the valuable services they provide.

The clear justification for the hospital tax exemption is that non-profit hospitals provide a public service. Medical care, particularly emergency care and care for the needy, would have to be provided by the government if private hospitals weren't there. Nationally, 20% of hospitals are run by the government; in Maine, only one is a quasi-municipal entity.

Hospitals have earned their tax exemption and we hope our partners in government continue to support our mission.

Maine Hospitals' Uncompensated Care



Maine Hospitals Comparison of Operating Margins

	2011	2014	2015	2016	2017	2018	2019	2020	2021	2022
Bridgton Hospital	14.82%	7.27%	4.05%	-0.27%	1.81%	-3.12%	-4.05%	4.04%	9.64%	15.90%
Calais Community Hospital	-2.14%	-9.02%	-5.23%	-3.49%	-6.58%	-2.28%	-3.24%	13.48%	5.61%	N/A
Cary Medical Center	8.16%	3.63%	3.17%	-1.00%	-1.35%	1.41%	1.28%	1.31%	4.51%	0.00%
Central Maine Medical Center	-2.76%	1.76%	2.95%	-1.84%	-3.18%	-3.15%	-4.83%	-2.63%	-4.53%	-5.70%
Coastal Healthcare Alliance*		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	-0.28%
Down East Community Hospital	-2.23%	-5.35%	-0.57%	2.00%	1.60%	0.27%	4.11%	5.27%	15.84%	N/A
Franklin Memorial Hospital	1.57%	-4.20%	-0.69%	-6.21%	-6.38%	-7.18%	-12.02%	-0.03%	0.38%	-2.95%
Houlton Regional Hospital	-0.42%	-1.73%	-1.46%	-2.40%	-1.07%	-0.79%	-1.20%	0.14%	7.72%	5.80%
LincolnHealth	*	-1.26%	2.47%	0.52%	3.39%	3.58%	2.62%	-1.76%	5.76%	4.52%
Maine Medical Center	2.43%	3.50%	3.51%	4.73%	4.60%	4.60%	4.60%	0.26%	3.93%	-1.78%
MaineGeneral Medical Center	4.84%	-3.61%	-6.15%	0.05%	-4.26%	0.42%	1.23%	-1.48%	-1.14%	0.90%
Mid Coast Hospital	4.39%	2.54%	1.91%	0.60%	1.65%	0.36%	2.85%	-8.64%	2.12%	-9.71%
Millinocket Regional Hospital	1.72%	-9.04%	-3.12%	-2.90%	-4.66%	-20.89%	-6.54%	-1.16%	10.47%	1.90%
Mount Desert Island Hospital	-1.43%	-2.43%	1.12%	0.51%	3.93%	2.96%	0.85%	2.40%	10.28%	10.50%
Northern Light A.R. Gould Hospital	3.02%	-3.14%	0.14%	-10.44%	0.94%	2.56%	-0.38%	-0.39%	-2.22%	-7.10%
Northern Light Acadia Hospital	4.13%	2.30%	4.68%	6.33%	19.82%	5.90%	15.56%	10.50%	10.71%	6.10%
Northern Light Blue Hill Hospital	2.26%	5.27%	6.46%	2.72%	2.34%	10.86%	4.50%	7.06%	13.24%	15.90%
Northern Light C. A. Dean Hospital	10.49%	-1.59%	-1.20%	-10.93%	6.26%	11.00%	10.02%	6.31%	18.60%	3.30%
Northern Light Eastern Maine Medical Center	2.49%	2.50%	5.49%	3.83%	3.25%	1.01%	5.18%	-4.00%	5.16%	-8.00%
Northern Light Inland Hospital	3.66%	-2.31%	0.31%	-0.80%	1.20%	-4.00%	-7.69%	-3.97%	2.73%	-10.90%
Northern Light Maine Coast Hospital	5.45%	-6.52%	-9.68%	-7.43%	-7.52%	-5.58%	2.26%	-6.66%	-1.03%	3.30%
Northern Light Mayo Hospital	1.13%	-1.88%	-0.02%	-3.27%	-3.60%	-2.96%	-5.94%	-8.13%	7.82%	8.00%
Northern Light Mercy Hospital	-8.38%	1.15%	-10.22%	-7.92%	-1.85%	0.69%	5.28%	-5.31%	3.42%	-5.10%
Northern Light Sebasticook Hospital	3.22%	6.49%	3.31%	3.95%	10.40%	13.83%	10.00%	6.77%	17.68%	17.70%
Northern Maine Medical Center	-0.37%	0.50%	1.50%	0.40%	13.30%	0.70%	0.82%	2.50%	4.29%	-3.54%
Penobscot Valley Hospital	1.99%	-3.90%	-5.24%	-9.84%	-8.72%	-5.44%	-1.93%	8.04%	8.12%	-9.80%
Redington-Fairview General Hospital	-0.91%	-3.65%	-3.65%	0.01%	0.12%	0.17%	2.65%	2.26%	3.48%	1.80%
Rumford Hospital	11.34%	0.94%	-1.23%	-2.44%	-0.29%	-4.22%	-2.30%	6.33%	6.32%	9.90%
Southern Maine Health Care	*	N/A	-3.41%	-2.83%	-0.17%	-2.26%	1.85%	-7.07%	7.49%	-4.53%
Spring Harbor Hospital/Maine Behavioral Healthcare	0.55%	0.41%	0.43%	-1.63%	2.26%	1.48%	1.43%	-2.08%	-5.84%	-16.22%
St. Joseph Hospital	9.05%	8.97%	1.33%	2.20%	0.63%	-9.42%	0.72%	-0.33%	-0.25%	-5.40%
St. Mary's Regional Medical Center	2.71%	-1.67%	-1.68%	1.01%	-0.52%	-11.93%	-0.41%	-6.06%	-3.63%	-22.59%
Stephens Memorial Hospital	4.51%	6.38%	4.95%	2.54%	2.10%	2.18%	4.20%	6.45%	13.20%	13.81%
York Hospital	1.88%	-1.91%	-0.51%	-1.45%	-1.60%	-1.17%	-3.89%	-8.33%	3.09%	-1.20%

*Pen Bay Medical Center & Waldo County General Hospital merged to form Coastal Healthcare Alliance in 2022

Color Code

- Operating Margins < 0
- Operating Margins 0–4.99%
- Operating Margins 5%+

Source: Maine Health Data Organization
Audited Financial Statements

Maine's Aging Healthcare Workforce: The Impending Cliff

While some steady progress has been made over the past several years to address the severe healthcare workforce shortages across the state, there remains much to do. In fact, Maine is second in the nation, behind New Hampshire, for the number of healthcare job postings per capita[1] demonstrating the ongoing demand for workers.

This demand is unlikely to cease, as Maine's aging workforce continues to approach retirement. The share of workers in the 55-64 age range has nearly doubled in Maine over the last 20 years from 11 percent in 2001 to 20 percent in 2021. The share of workers aged 35-44, 29 percent, and 45-54, 26 percent, has dropped to 21 and 20 percent over the same timeframe, respectively.

With an estimated 74,860 healthcare workers in Maine, 20,961 are 55 years or older; thus, 30% of Maine's healthcare workforce will retire within 10 years, if not sooner based on current trends.[2]

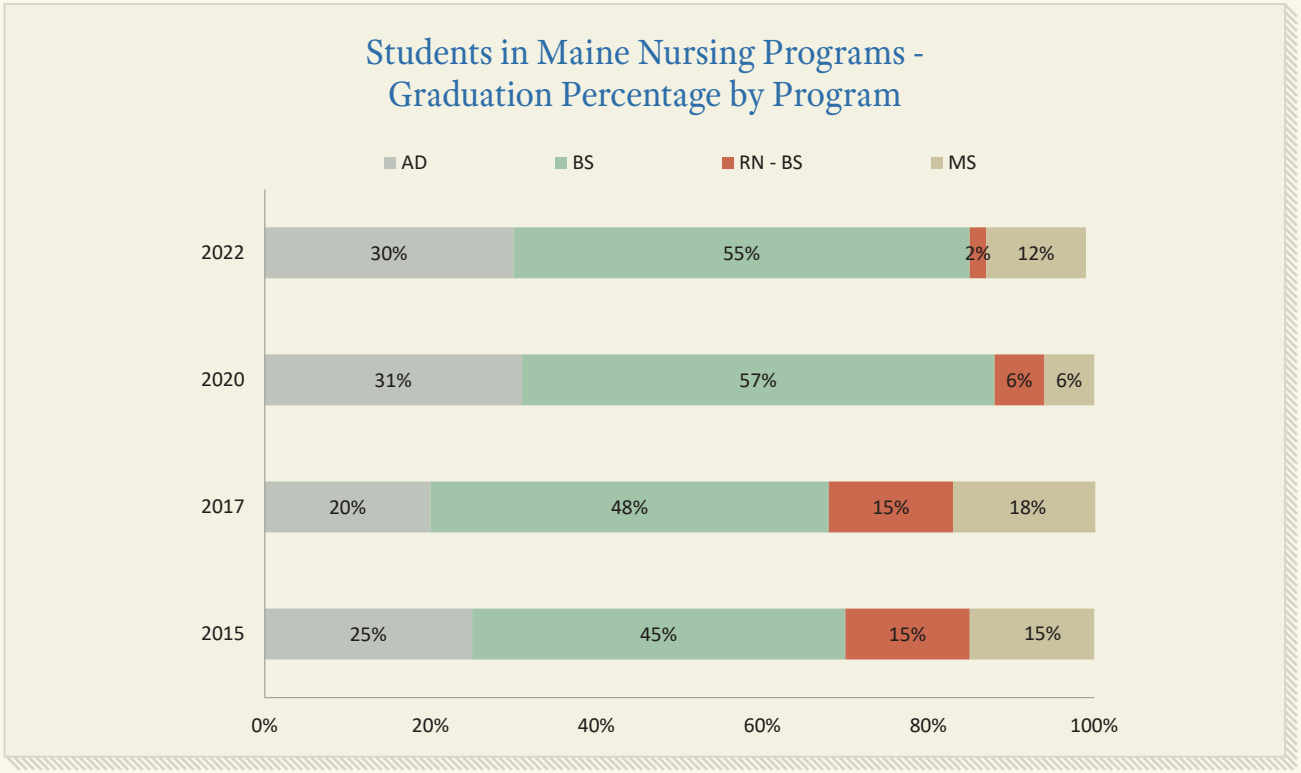
When we surveyed our members in May of 2023, the top five clinical roles needed the most in Maine hospitals were Registered Nurses, Certified Nurse Assistants, Certified Medical Assistants, Respiratory Therapists, and Imaging Technicians (Radiology, Ultrasound and Echography).

Decrease in graduations and graduates.
Despite significant focus, we have seen a troubling decrease in the number of nursing graduates from Maine programs between 2017 and 2022.[3]

In addition to fewer graduates, training programs for many healthcare roles have reported a drop in applications to programs, and of those who are accepted, an increase in those who are leaving before graduation.

The most significant barriers were noted as the following, in no particular:

- Limited access to clinical sites and clinical sites closing or limiting students.
- Lack of flexibility to do clinical training programs online (remote) or partially online.
- Lack of transportation.
- Inability to return to school full time while also working.
- Lack of childcare options.
- Lack of housing options.
- Overall, lack of student preparedness due to the impacts of COVID-19 and its disruption to prior education.



Direct care workforce is in crisis. In addition to our shortages of hospital-based clinical roles, the direct care workforce shortage has led to an unprecedented number of long-term care facility closures, unstaffed residential and skilled nursing beds, and limited home health capacity. As a result, Maine hospitals, on any given day, have over 300 patients who are ready for discharge and awaiting placement in another setting. Many of these patients wait weeks to months.

Our healthcare workforce shortage, including direct care workers, has clogged our healthcare system and created a situation where patients languish in the wrong care setting and those that need acute care cannot receive it. In addition to the increased cost burden, patients and their families suffer, and health outcomes are negatively impacted when individuals cannot access the appropriate level of care in the right setting.

Investments in strengthening our clinical workforce are needed. Strategies should include, but are not limited to, investing in programs that offer associate degrees and certifications by funding free tuition, increased broadband access, and increased remote/satellite learning capacity, incentivizing clinical sites to take more learners, investing in housing and childcare programs, while also incentivizing individuals to pursue a career in healthcare.

Physician Shortages. In addition to the clinical and direct care workforce, there continues to be a significant concern regarding physician workforce, particularly in rural areas. Maine ranks 1st in nation for number of physicians aged 60 or older, with 39.3%, or 1,746, and 50th in the nation for the proportion of physicians aged 39 or younger, with only 525 physicians, or 11.8%.[4] Maine's rural hospitals are finding that their physician workforce is rapidly retiring and that attracting new physicians to rural communities is becoming increasingly difficult. In a recent survey conducted in October of 2023, Maine hospitals reported:

- Maine Hospitals were actively recruiting 385 full-time physicians.
- On average, it takes 277 days to recruit one physician in Maine, with some taking as little as two months and others taking two or more years.
- Maine Hospitals use many strategies to recruit, including offering loan forgiveness, sign on bonuses, and schedule flexibility.

What do physician shortages mean for patients?

- "We have 300+ referrals in a backlog for obstetric/gyn care. It's a 1 year wait for first appointment."
- "After over three years of searching, we just hired one gastroenterology(GI) physician who is a J1 candidate. The GI practice still needs 3 more doctors."
- "Our Ears, Nose & Throat (ENT) practice is currently seeking 4 FTEs with only 1.6 FTE remaining. We are currently scheduling new "operative" referrals 9 months out, with a backlog of 167 referrals."
- "Positions filled with temporary staff come at an extreme cost and lower quality of care."
- "We see more people delaying needed care due to access or seeking care in the emergency department."

Investments in recruiting and retaining physicians to Maine are needed, with a particular focus on bringing physicians to rural areas. Strategies should include, but are not limited to, investing in programs that provide medical school loan debt forgiveness, train foreign physicians living in Maine so that they can reach their full potential, support rural clinical training experiences, and provide sponsorships to family medicine physicians to complete an OB Fellowship in exchange for their practicing full spectrum rural medicine.

1 Healthcare Job Listings per capita, by state. Beckers Hospital Review, https://www.beckershospitalreview.com/rankings-and-ratings/healthcare-job-listings-per-capita-by-state.html

2 Maine Department of Labor's Center for Workforce Information and Research, "2022 Maine Healthcare Occupations Report," Prepared by Andrew Daws on, Senior Economic Analyst, September 15, 2022. https://www.maine.gov/labor/cwri/publications/pdf/2022MEHealthOccupationsReport.pdf

3The State of the State's Nursing Education Programs: 2022 Survey Results, Prepared by Susan B. Sepples PhD, Associate Professor of Nursing College of Science, Technology and Health, University of Southern Maine.

4 Association of American Medical Colleges (AAMC), 2021 State Physician Workforce Data Report, January 2022. https://store.aamc.org/downloadable/download/sample/sample_id/506/

Too Many Patients Are Stuck in Hospitals

One of the most persistent challenges facing Maine hospitals is patients who are stuck and awaiting proper placement.

There are two general categories of people who are stuck: patients who need to leave the hospital and patients who came to the emergency room with behavioral health needs.

Emergency Room Crisis

A typical person stuck in the emergency room is an adolescent with behavioral health needs.

Some of these kids need to be admitted so they can receive inpatient psychiatric service. More, though, need appropriate residential placement or can be at home with intensive community supports.

Most frustratingly is when the adolescent has an appropriate, state-funded, residential placement and that residential provider 'dumps' the child at an emergency room because they can no longer handle the child's behavior. These kids can remain in the hospital for weeks at a time.

There are dozens of kids each month who sit in emergency rooms unnecessarily waiting for placement. And as we discussed on page 8 of this document, many of these kids can get violent and assault our staff.

Keeping kids waiting for weeks in the emergency room for services is wrong and it has to change.

The Portland Press Herald recently reported on a 13-year old child named Abby that has been living for over 200 days in the emergency room in Skowhegan while waiting for the appropriate residential placement that can handle both her significant mental and physical needs.

Two years ago, the federal Department of Justice reviewed the care of kids in Maine and identified the fact that the Department of Health & Human Services personnel who are supposed to respond to kids in crisis simply send them to hospitals.

"We are set up for if you have a heart attack, go to the ER. If you have a broken pelvis, we can fix your hip," Dr. John Comis said. "It is not the ideal place for a patient like Abby. You could have people screaming in the next room or going through drug withdrawal symptoms. It's a real stretch for an ER to provide 24/7 psychiatric care."

Comis said a decade ago, it was uncommon to have psychiatric patients languishing in emergency departments for months, waiting for services. Now, it's a common sight, and while hospitals have adapted to the changes, such patients are better served by receiving care at facilities designed for them to live and get mental health treatment.

Sue Bedard said they've tried everything to secure Abby a placement, but there are long waiting lists for some, and other group homes can't take her in because she has both physical and mental health needs. Trying to help her – and so far being unable to – feels hopeless and frustrating.

"We are totally drained in every way," Sue Bedard said. "When we wake up in the morning, the first thing we think is, 'Oh, my God, my daughter is still in the hospital.' Every night, we cry and pray knowing that our daughter is still there."

$4.75
Sunday,
July 14, 2024

Maine Sunday Telegram

EST. 1862

WEATHER:
Mostly sunny, hot and humid
High near 90
Details, B8

'The system's messed up'

Family of Portland shooting victim are frustrated with the pace of justice

Four men have been charged in the 2022 death of Darry Coffin, setting off a tangled web of criminal cases that has made closure elusive.

By EMILY ALLEN
Staff Writer

BRUNSWICK — Terry Leonard speaks of his youngest brother, Derald "Darry" Coffin, the way only an older brother can.

They grew up together in a four-boy household in Brunswick. Leonard, eight years older, talks about those days with ease — their childhood home, Darry's close relationship with his brother Jerry, who died of cancer when they were in their 20s, and Darry's uncanny (and sometimes annoying) gift for all things mechanical.

TERRY LEONARD
Brother of the shooting victim

"It made me so mad because he's one of those guys where if he touched something, he became an expert on it," said Leonard. "It didn't matter what he did, whether it was painting, working on a car, fishing – he was just that guy

A 13-YEAR-OLD BINGHAM GIRL HAS BEEN LIVING IN A HOSPITAL EMERGENCY DEPARTMENT SINCE DECEMBER

Derek Davis/Staff Photographer

Last week, Abby Bedard, 13, reaches for her mother's hand at Redington-Fairview General Hospital in Skowhegan, where she has been staying in the emergency department since before Christmas. Abby has cerebral palsy, epileptic seizures and numerous mental and developmental health challenges, including behaviors she cannot control.

NO PLACE ELSE TO GO

Officials acknowledge Maine doesn't have adequate resources to provide proper care for children like Abby Bedard, who have both physical and mental health challenges.

Patients Awaiting Discharge

At the other end of the spectrum are patients who have received care in the hospital and are ready to leave, but for whom there is not a safe place to which they can be discharged.

A typical person stuck in a hospital bed is a geriatric patient who did need some medical care and is ready for discharge, however there is no safe location to which they can be sent.

Frequently, they have been living on their own unsuccessfully and now need a long-term care placement. Other times, they have had long-term care placement, but due to their behaviors, are no longer welcome to return to their former home.

> "When families request crisis services and none are available, caseworkers and other State contractors often direct families to emergency rooms or law enforcement."

The other large population that can get stuck in the emergency room is an adult with developmental disabilities. Overwhelmingly, the individuals in this situation do not need hospital care but instead need residential placement. And again, these folks frequently had a placement that is no longer willing to provide the care.

For these situations, we know what the patient needs – appropriate residential placement – but the service is either not offered or is being denied to the particular patient in question.

These situations create three hardships: first and foremost, the patient is stuck and forced to stay at a hospital when they should be home; second, the hospital suffers significant financial loss because there is little or no reimbursement for these extended stays and, third, sometimes these individuals get violent and assault our staff.

This issue has received some positive attention from the Legislature in the past few years, but more needs to be done.

Drug Discount Program Needs Protection

The 340B Drug Discount Program was created by Congress in 1992 and provides eligible hospitals and other providers like FQHCs (Federally Qualified Health Centers) with access to discounted drug prices for their patients receiving outpatient services. Eligible hospitals include those that provide a disproportionate amount of care to low-income patients, Critical Access Hospitals (CAH), Rural Referral Centers, Sole Community Hospitals 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 Health Resources and Services Administration. These drugs are then provided to all hospital patients with the exception of those patients on the Medicaid program.

HRSA is the federal oversight agency. Here is the very brief description of the purpose of the 340B program on the oversight entity's website:

"The 340B Program enables covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."

The 340B program is not a carrier discount program, a consumer discount program, or a discount program for PBMs or even government payers. It's for hospitals and other providers. It is under attack in multiple courts and misinformation is being spread about the purpose of the program.

The Challenge. Carriers and 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.

Currently, 27 Maine hospitals qualify for the 340B Drug Discount program and receive a collective benefit estimated to be $282 million a year. However, the program had been larger before Pharma began to unilaterally undermine the program. Since their campaign to kill 340B began, hospitals in Maine have lost over $100M per year. Eliminating the 340B benefit would have a devastating impact on hospital financial health.

If they succeed in their goal of reducing the benefit of 340B, hospitals and other smaller providers will lose crucial support, patients will see no financial relief and pharmaceutical companies will laugh all the way to the bank. If the carriers are successful in court, the financial viability of hospitals in Maine will be in jeopardy.

If the 340B program were to go away, consumers would see no benefit, and hospitals, FQHCs and other providers would lose millions because the big pharmaceutical companies would simply raise their prices.

Nationally, twenty-eight states have either enacted state-level laws to protect their hospitals and other providers or they are considering such legislation now.

Maine should as well and to that end, MHA will be pursuing legislation this year to protect our ability to participate in the 340B program.

340B Hospitals

Bridgton Hospital
Calais Community Hospital
Central Maine Medical Center
Down East Community Hospital
MaineHealth Franklin Hospital
MaineHealth Lincoln Hospital
MaineHealth Maine Medical Center
MaineHealth Pen Bay Hospital
MaineHealth Stephens Hospital
MaineHealth Waldo Hospital
Houlton Regional Hospital
MaineGeneral Medical Center
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 Inland Hospital
Northern Light Maine Coast Hospital
Northern Light Mayo 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

Conclusion

Thank you for accepting this open letter from the Maine Hospital Association.

MHA is non-partisan and does not endorse candidates for office. We are not asking that you fill out a questionnaire or take a pledge. We simply ask that you review the information in this document as you seek to shape public policy in Maine.

Maine hospitals are proud of the fact that they provide some of the best quality care in the country. Providing high-quality care, with both competence and compassion, is the primary mission of Maine hospitals. Hospitals are committed to continual improvement.

Hospitals are open 24 hours per day, 365 days per year. They provide care to all patients, regardless of their ability to pay. There are 35 hospitals statewide. All of the general hospitals are nonprofit (one is government affiliated). Maine's hospitals are community governed by 450 trustees statewide.

Delivering healthcare in rural areas is a challenge. If independent providers are unavailable, which is often the case in rural areas, Maine hospitals are there to provide care to everyone.

Hospitals subsidize many services not historically associated with hospitals, including primary care practices, nursing homes and behavioral health clinics to help expand access to care. These services would not exist in many Maine communities without the backing of local hospitals.

Hospital care has evolved to the point where keeping people out of hospitals is as central to their mission as is taking care of those in hospitals. Our members are doing more and more in the areas of primary care, care management and general public health in order to prevent the need for expensive procedures and hospitalizations. The transformation of hospitals from intensive care facilities to integrated healthcare networks is ongoing. No matter what changes the healthcare landscape may bring, hospitals are committed to keeping the focus on patient care.

Maine citizens understand that hospitals are there 24 hours a day, 365 days a year and are ready to provide the care they need when needed. In a rural New England state, it can be a challenge to provide care where it is needed. To keep people out of the Emergency Room or to reduce hospitalizations, people need access to primary care and other preventative services.

Hospitals provide more primary care than any other group or organization in Maine. Maine hospitals will continue to lead the effort to ensure that all Mainers continue to have access to high-quality care at the right time, in the right setting.

The healthcare policy challenges facing the Governor and 132nd Legislature are not getting easier.

We look forward to working with you and we thank you for your willingness to review this information.

Thank you

To all of you running for office, thank you. Public service in the Legislature is an arduous task. Maine asks a great deal of citizen legislators and often it seems as if the only reward is criticism.

Thank you also for taking the time to read this material. If you have questions or would like to discuss this information, please feel free to contact the Maine Hospital Association and in particular, Jeffrey Austin, the Vice President for Government Affairs and Communications.

207-622-4794
jaustin@themha.org

MHA Member Hospitals

General Hospitals

Cary Medical Center—Caribou
Central Maine Medical Center—Lewiston
MaineGeneral Medical Center—Augusta and Waterville
MaineHealth Franklin Hospital—Farmington
MaineHealth Maine Medical Center—Portland, Biddeford and Sanford
MaineHealth Mid Coast Hospital—Brunswick
MaineHealth Pen Bay Hospital—Rockport
Northern Light A.R. Gould Hospital—Presque Isle
Northern Light Eastern Maine Medical Center—Bangor
Northern Light Inland Hospital—Waterville
Northern Light Maine Coast Hospital—Ellsworth
Northern Light Mercy Hospital—Portland
Northern Maine Medical Center—Fort Kent
St. Joseph Hospital—Bangor
St. Mary's Regional Medical Center—Lewiston
York Hospital—York

Critical Access Hospitals

Bridgton Hospital—Bridgton
Calais Community Hospital—Calais
Down East Community Hospital—Machias
Houlton Regional Hospital—Houlton
MaineHealth Lincoln Hospital—Damariscotta and Boothbay Harbor
MaineHealth Stephens Hospital—Norway
MaineHealth Waldo Hospital—Belfast
Millinocket Regional Hospital—Millinocket
Mount Desert Island Hospital—Bar Harbor
Northern Light Blue Hill Hospital—Blue Hill
Northern Light Charles A. Dean Hospital—Greenville
Northern Light Mayo Hospital—Dover-Foxcroft
Northern Light Sebasticook Valley Hospital—Pittsfield
Penobscot Valley Hospital—Lincoln
Redington-Fairview General Hospital—Skowhegan
Rumford Hospital—Rumford

Other

Private Psychiatric Hospitals
Northern Light Acadia Hospital—Bangor
MaineHealth Spring Harbor Hospital—Westbrook

State-Run Psychiatric Hospitals
Dorothea Dix Psychiatric Center—Bangor
Riverview Psychiatric Center—Augusta

Rehabilitation Hospitals
New England Rehabilitation Hospital—Portland

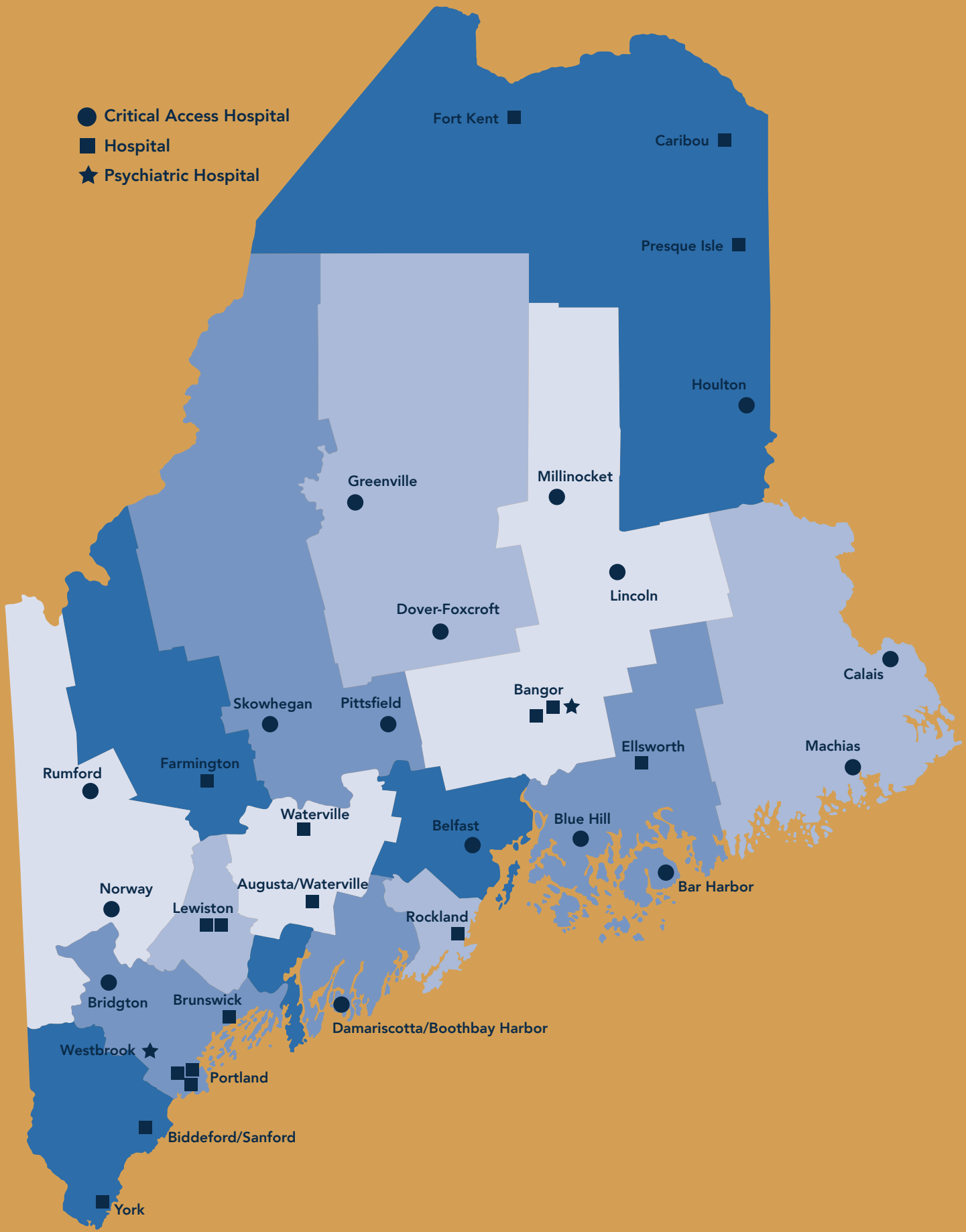
Multi-Hospital Health Systems
Central Maine Healthcare Corporation—Lewiston
MaineGeneral Health—Augusta
MaineHealth—Portland
Northern Light Health—Bangor

Types of Hospitals

- Prospective Payment System (PPS) Hospitals—16 hospitals;
- Critical Access Hospitals—16 hospitals;
- Psychiatric Hospitals (Institutes of Mental Disease)—2 hospitals; and
- Acute Rehabilitation—1 hospital.

Critical Access Hospitals must:

- Have no more than 25 beds;
- Cap inpatient stays at 96 hours; and
- Be in a rural or remote location.


Critical Access Hospital
Hospital
Psychiatric Hospital
Fort Kent
Caribou
Presque Isle
Houlton
Greenville
Millinocket
Lincoln
Dover-Foxcroft
Calais
Bangor
Skowhegan
Pittsfield
Ellsworth
Machias
Farmington
Rumford
Waterville
Belfast
Blue Hill
Bar Harbor
Norway
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Lewiston
Rockland
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Westbrook
Portland
Biddeford/Sanford
York

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