**Date: July 10, 2015**

**Project**: **Acquisition of Control of Maine Coast Hospital**

**Proposal by: Eastern Maine Healthcare Systems**

**Prepared by: Larry Carbonneau, Manager, Healthcare Oversight**

**Richard S. Lawrence, Senior Healthcare Financial Analyst**

**Directly Affected Party:**

**CON Recommendation: Approval**

**Proposed Approved**

**Per Applicant** **CON**

Estimated Capital Expenditure $ 8,718,508 $ 8,718,508

Maximum Contingency $ 0 $ 0

Total Capital Expenditure with Contingency $ 8,718,508 $ 8,718,508

Pro-Forma Marginal Operating Costs $ (2,068,875) $ (2,068,875)

# I. Abstract

## A. From Applicant

“Eastern Maine Healthcare Systems (“EMHS”) is the applicant in this Certificate of Need (“CON”) application, which proposes to change the membership of Maine Coast Healthcare Corporation (“MCHC”) and its affiliate, Maine Coast Regional Health Facilities, which does business under the assumed name Maine Coast Memorial Hospital (“MCMH”).”

“EMHS and MCHS and its affiliates, including MCMH, (collectively the MCHC parties) have executed a Member Substitution Agreement (the “Agreement”) dated February 10, 2015, setting forth the terms of a proposed affiliation of the MCHC Parties with EMHS (the “Affiliation”).

The proposed effective date for the Affiliation is September 27, 2015, subject to successful completion of due diligence and receipt of all necessary consents and approvals, including CON.”

“EMHS’ and MCMH’s care and management philosophies are community-based and well aligned. Board, management, and clinical leaders have met during the due diligence review to discuss the opportunities inherent in the Affiliation. The purpose of the Affiliation is to promote improved efficiencies in healthcare delivery, access, and population health in Hancock and Western Washington Counties. The application describes how the Affiliation will benefit patients and families and improve care across the region.”

“EMHS is an integrated delivery system providing a comprehensive continuum of healthcare services to communities throughout Maine. Based on revenues, EMHS is the second largest healthcare system in Maine. EMHS’ core services include acute care medical-surgical hospitals, an acute psychiatric hospital, physician practices, ambulatory care centers, nursing homes, home care agencies, and ground and air emergency care transport services. Since its creation in 1982, EMHS has evolved into a resource for primary, secondary, tertiary, trauma, home and community-based services. EMHS strives to maintain a culture of collaboration, integration and flexibility to meet the changing needs of Maine communities and to advocate on behalf of the residents of those communities. Member hospitals and other affiliates share common values and work collaboratively to ensure the highest quality care.”

“MCMH is a 64-bed full service hospital located in Ellsworth, Maine - the heart of the Downeast region. Ellsworth serves as the center of government and commercial activity for nearly 60,000 residents of Hancock and Western Washington Counties. MCMH opened its doors in 1956 and has steadily expanded service offerings to meet community needs. Currently, MCMH admits about 2,700 inpatients annually and its physicians perform more than 4,000 surgeries. The CON application outlines the important role that MCMHplays in offering a continuum of care in Hancock and Western Washington Counties. MCMH will work closely with EMHS affiliates such as Blue Hill Memorial Hospital, other providers in the region, and community stakeholders to promote and achieve the goals of the Affiliation.”

“The Financial Feasibility section describes anticipated post-affiliation impacts and the performance improvements underway by MCMHmanagement. Healthcare costs within the service area will not be adversely impacted by the Affiliation. Our counsel will be keeping the Maine Attorney General’s office informed about the Affiliation. A Hart-Scott-Rodino (“HSR”) premerger notification to the Federal Trade Commission/ Department of Justice is not expected to be required.”

## 

## B. Certificate of Need Unit Discussion

The transfer of ownership of Maine Coast Healthcare Corporation and its affiliates Maine Coast Memorial Hospital to Eastern Maine Healthcare Systems requires Certificate of Need approval. This requirement can be found at M.R.S. 22 §329 (1). “Any transfer of ownership or acquisition under lease or comparable arrangement or through donation or any acquisition of control of a health care facility under lease, management agreement or comparable arrangement or through donation that would have required review if the transfer or acquisition had been by purchase.”

# II. Fit, Willing and Able

## A. From Applicant

**Summary of the Project**

“Subject to the terms and conditions of the Agreement, MCHC shall become the sole member of MCMH. EMHS will also become the Class B member of MCMH with MCHC becoming its Class A member. MCMH will remain the sole member of its affiliates including Maine Coast Healthcare Foundation (the Foundation) and Maine Coast Medical Realty (Realty Corp.) (collectively MCMH, MCMH, Foundation and Realty are the MCMH Parties). For purposes of these projections, it is assumed that MCHC will become a direct, wholly controlled subsidiary of EMHS in accordance with the terms of the Agreement, included as Attachment A.”

“MCMH will continue to operate in its current form as a Maine non-profit 501(c) (3) tax-exempt fully licensed acute care hospital. The day-to-day operation of MCMH will continue, subject to certain joint powers reserved to EMHS, including EMHS approval of certain MCMH financial and service initiatives, as set forth more specifically in the Agreement. Subject to the terms of the Agreement, MCMH will continue to offer the current its current array of health care services.”

**Profile of the Applicant**

Eastern Maine Healthcare Systems   
43 Whiting Hill Road  
Brewer Maine, 04412

<http://www.emhs.org/>

“EMHS, based in Brewer, Maine, is a nonprofit, 501 c-3 tax-exempt corporation. EMHS is a vertically integrated healthcare system serving Maine. EMHS’ Mission is as follows: *EMHS partners with individuals and communities to improve health and well-being by providing high quality, cost effective services.* EMHS is committed to collaborative relationships to achieve the Triple Aim: Better care, better health and lower costs for Maine residents.”

“EMHS’ vision 2020 is *to be a nationally recognized model of excellence in healthcare.* Through collaboration with community organizations, better coordination of care for patients and redefining exceptional care, EMHS is the architect of a promising new future of healthcare. As described herein, the proposed affiliation will support and enhance the EMHS vision.”

“EMHS is comprised of more than 30 organizations, including eight hospitals: Acadia Hospital (“Acadia”), The Aroostook Medical Center (“TAMC”), Blue Hill Memorial Hospital (“BHMH”), Charles A. Dean Memorial Hospital (“C.A. Dean”), Eastern Maine Medical Center (“EMMC”), Inland Hospital (“Inland”), Mercy Hospital (“MH”) and Sebasticook Valley Health (“SVH”). EMMC is the EMHS flagship hospital, providing a full complement of sub-specialty care, trauma services, and the latest in advanced technologies and imaging capabilities.”

“Hospitals in the region refer patients to EMMC for major operations and consultations with sub-specialists, and when sophisticated intensive care facilities are required. Acadia is a free-standing tertiary psychiatric hospital serving all of Maine. Blue Hill Memorial Hospital is a primary care, critical access hospital operating in rural Hancock County. Brief descriptions of EMHS member hospitals follow.”

“Other non-hospital EMHS members include Affiliated Healthcare Systems, Rosscare, Mercy VNA, Eastern Maine HomeCare, and EMHS Foundation. Through its subsidiaries, EMHS provides medical laboratory services throughout New England, operates one of the largest integrated healthcare support networks in all of New England, develops cooperative retirement housing units, and holds significant ownership interests in several non-subsidiary companies providing services such as nursing home care.”

“EMHS’ accountable care organization (“ACO”), Beacon Health LLC (“Beacon”), developed an infrastructure to contract for risk-based payments and a full continuum of care management services. Beacon Health’s care management program received National Committee for Quality Assurance (“NCQA”) certification in 2014, placing this service on par with care management services provided by national insurance agencies. Beacon manages over 100,000 covered lives under a range of value-based contracts, including the Medicare Pioneer Demonstration, and is participating in MaineCare’s Accountable Communities Initiative. EMHS was one of the original 32 systems selected to participate in the CMS Pioneer demonstration. In 2014, Anthem contracted with Beacon in a risk sharing program covering 40,000 Maine residents.”

“EMHS has an established record in delivering high quality care, is nationally recognized for health information technology expertise, and was one of 2012’s Top 100 integrated health networks as recognized by IMS Health, a leading provider of healthcare information, services and technology. EMHS member hospitals are recognized for their patient safety results. Most of the affiliated primary care practices have achieved primary care medical home designation by the NCQA. EMHS was selected as one of only 17 Federal Beacon grantees, which highlighted collaboration across care sites and excellence in health information technology. EMHS has also been recognized with the National Health System Patient Safety Leadership Award from the National Business Group on Health and the VHA.”

“EMHS has a long and successful history of integrating hospitals and other healthcare organizations into its system. The Maine DHHS CON Unit has consistently found EMHS to be fit, willing and able to enter into affiliation transactions.”

“EMHS Hospital Affiliations Timeline

* + 1992 EMHS opens Acadia Hospital
  + 1998 Inland Hospital joins EMHS
  + 1998 Charles A. Dean Memorial Hospital joins EMHS
  + 1999 The Aroostook Medical Center joins EMHS
  + 2001 Sebasticook Valley Health joins EMHS
  + 2006 Blue Hill Memorial Hospital joins EMHS
* 2013 Mercy Hospital joins EMHS
* *2015 Proposed –MCMH joins EMHS*

Figure 1 below depicts EMHS’ organizations chart.

**Figure 1: Post-affiliation Organizational Chart**



**Note:** Beacon Health LLC included due to relevance to the Transaction. Other JV relationships are not included in Figure 1.

**Table 1: EMHS’ Clinical Service Provider Organizations**

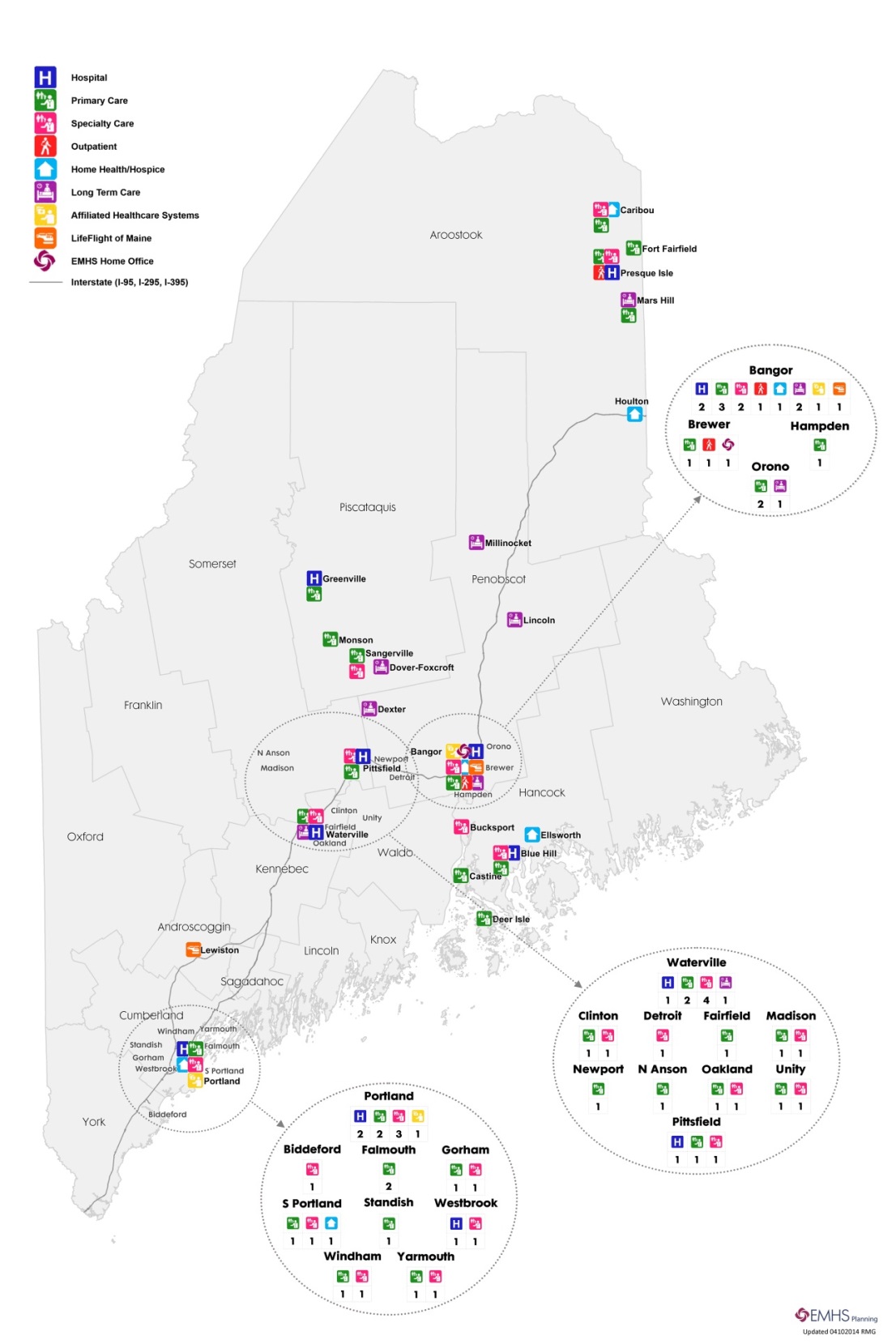
| **Organization** | **Description** |
| --- | --- |
| **Acadia Hospital**  268 Stillwater Ave  Bangor, ME 04401 | Acadia Hospital: Acadia is a 100 bed non-profit, acute-care hospital and community mental health agency, located in Bangor, Maine, providing both hospital-based and community-based mental health and substance abuse treatment services to the people of Maine. Acadia was the first psychiatric hospital in the US to receive Magnet recognition from the American Nurses Association.  Acadia currently is contracted to provide tele-psychiatry services to Maine Coast Memorial Hospital’s emergency department. |
| **Affiliated Healthcare Services (AHS)**  931 Union Street  PO Box 940  Bangor, ME 04401 | Affiliated Healthcare Services (AHS): AHS is a Maine-based company that has built one of the largest healthcare support networks in all of New England. AHS provides regional referral lab, materiel management, transcription, and collection services and offers ground ambulance transportation. AHS has several retail pharmacy locations. |

|  |  |
| --- | --- |
| **Beacon Health LLC**  797 Wilson St.  Brewer, ME 04412 | Beacon Health is a limited liability corporation with accountable care functions, including risk contracting, provider network development, population health management and related data analytics.  Beacon Health is contracted to provide care managers based in MCMH’s primary care practices. |
| **Blue Hill Memorial Hospital (BHMH)**  57 Water Street  Blue Hill, ME 04614 | Blue Hill Memorial Hospital (BHMH): BHMH is a 25-bed critical access hospital, located in Blue Hill, Maine. BHMH offers primary and selected specialty healthcare services. Primary care practices are located in Blue Hill, Castine, and Stonington.  BHMC collaborates with Maine Coast on obstetrics care. |
| **C.A. Dean Memorial Hospital (C.A. Dean)**  364 Pritham Avenue  Greenville, ME 04441 | C.A. Dean Memorial Hospital (C.A. Dean): C. A. Dean is a 25-bed critical access hospital located near Moosehead Lake in Greenville, Maine. C.A. Dean is also the home to Northwood Healthcare, a primary care practice with offices in Greenville, Monson and Sangerville. C.A. Dean provides acute, skilled, and nursing facility beds, as well as 24-hour emergency medical services and a ground ambulance program. |
| **Eastern Maine Medical Center (EMMC)**  489 State Street  Bangor, ME 04401 | Eastern Maine Medical Center (EMMC): EMMC, located in Bangor, Maine, is a 411 bed hospital serving communities throughout central, eastern, and northern Maine. EMMC and its medical staff of more than 400 active medical staff physicians provide three-quarters of the primary-care hospital services offered in the Bangor area, as well as specialty and intensive services to the northern two-thirds of the state. EMMC is implementing a facility modernization project which will upgrade patient rooms, surgery, and heart services, among others.  EMMC is a regional resource for healthcare and health information, a source of support and assistance for area physicians and other healthcare providers, and a training ground for the health professionals of the future. EMMC also provides outreach clinics to many local hospitals in the region, allowing easier access for patients and supporting the role of those hospitals in their communities.  A selected list of recent recognitions follows:   * Maine Tobacco-Free Hospital Network 2014 Gold Award for a tobacco-free environment. (November 2014) * EMMC receives “A” in patient safety measures from the Hospital Safety Score by The Leapfrog Group (November 2014) * EMMC Vascular Laboratory Receives Three Year Accreditation by the Intersocietal Accreditation Commission (September 2014) * EMMC was recognized as “Most Wired” by the American Hospital Association. (July 2014) * EMMC earns recognition in exceptional performance with top awards for Exceeding Patient Expectations and Best Overall Performer from Avatar Solutions, (May 2014) * EMMC Stroke Care receives 2014 With The Guidelines®—Stroke Gold-Plus Quality Achievement Award,. (April 2014) * EMMC celebrated zero preventable errors in the Centers for Medicare & Medicaid Services’ core measures for heart attack, heart failure, pneumonia, and surgery for the months of July and August, 2013 * EMMC Named the First General and Bariatric Surgery Robotic Epicenter, September 2012.   EMMC specialists currently provide cardiology, oncology, neurology, and pharmacy management services to supplement MCMH services in Ellsworth. |
| **Inland Hospital**  200 Kennedy Memorial Drive  Waterville, ME 04901 | Inland Hospital: Inland Hospital is a 48 bed hospital in Waterville, Maine. Inland affiliates include Lakewood, a 105-bed continuing care center on the hospital campus; and 18 primary and specialty care physician offices in Waterville and surrounding communities. Lakewood provides a continuum of skilled nursing and rehabilitation services, secure dementia care and long term care services. |
| **LifeFlight of Maine (LOM)**  **Bangor Crew Quarters** EMMC, Kagan 4 489 State Street Bangor, ME 04401 | LifeFlight of Maine (LOM): Formed in 1998, LOM provides 24/365 critical care medical transport with LOM-owned helicopters and ground critical care using ambulances provided by Meridian Mobile Health in Bangor and United Ambulance in Lewiston. LOM has transported approximately 17,000 patients since inception. LOM is a non-profit LLC, equally owned by EMHS and Central Maine Healthcare Corporation. |
| **Mercy Health System of Maine**  144 State St  Portland, Maine 04101 | Mercy: Mercy is a 230 licensed bed not-for-profit community health care system sponsored by the Sisters of Mercy of the Americas. In October 2013, Mercy became a member of EMHS. With the addition of Mercy, EMHS united a network of providers and hospitals from Portland to Presque Isle. MHSM’s home care affiliate, VNA, offers home care and hospice services in the Greater Portland area.    Selected recognitions follow:   * Mercy’s orthopedic program was the first to be certified in Maine for hip, knee and spine by the Joint Commission in 2012. * Scored an “A” rating for patient safety by The Leapfrog Group. 2014 * 100% private room policy. * Nationally recognized as a U.S. News & World Report Best Hospital, earning Maine’s best ranking for patient satisfaction.   Since joining EMHS, Mercy has seen improved financial results; information systems have been upgraded; and Mercy’s staff has been integrated into EMHS’ system services model. |
| **Rosscare**  885 Union Street Suite 221  PO Box 404  Bangor , Maine  04402 | Rosscare: Rosscare improves the lives of older adults through a network of senior services that provide resources, education, housing, and support services for older adults, their families, and caregivers throughout the EMHS service region. Rosscare is in a joint venture relationship with First Atlantic Corp to operate six nursing homes in northern and eastern Maine. |
| **Sebasticook Valley Health (SVH)**  447 North Main Street  Pittsfield, ME 04967 | Sebasticook Valley Health (SVH): SVH is a 25-bed, critical access hospital in Pittsfield, Maine, with a wide range of outpatient services and three primary care locations throughout central Maine. SVH has been recognized for the following:   * One of the top ten critical access hospitals in the United States for clinical excellence by the VHA. * Workplace Wellness Excellence - Platinum by Well Workplaces of America (WELCOA). * SVH Family Care primary care practices received the highest level certification as a Patient Centered Medical Home from the National Committee for Quality Assurance (NCQA).   For the second year in a row, SVH received recognition as one of the best rural hospitals in the United States by The Leapfrog Group. |
| **The Aroostook Medical Center (TAMC)**  140 Academy Street  Presque Isle, ME 04769 | The Aroostook Medical Center (TAMC): TAMC is an 89 bed hospital and the leading provider of healthcare services in northern Maine. It is driven by its mission to restore, maintain and improve the health of friends and neighbors in a compassionate and professional environment. TAMC provides a full range of hospital, primary and specialty services and is affiliated with Mars Hill nursing home. |

**EMHS Sites of Care**

The sites of care map that follows, Figure 2, depicts the range and depth of EMHS services across Maine. EMHS has over 90 points of care, many of which house multiple practices and services. EMHS’ accountable care organization, Beacon Health LLC, reaches beyond sites of care to manage 100,000 covered lives, deploying population health services throughout Maine.”

**Figure 2: EMHS Sites of Care (pre-MCMH)**

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**Key Personnel**

“EMHS has a strong governance and management team working with MCHC leaders on affiliation transitional issues. A brief summary of the EMHS Board Chair and management team and their areas of expertise follow. Resumes of key staff are included in Attachment B.”

**EMHS Board Chair: Evelyn S. Silver, PhD**

“Dr. Silver has served on the EMHS Board of Directors since 2006. She has served in several leadership roles, becoming Chair of the Board in June, 2014. As a member of the EMHS Board, she has fiduciary responsibility for oversight of an integrated healthcare system serving patients and their families across the State of Maine. Dr. Silver graduated from Tufts University, has a master’s degree from Harvard University, and earned her doctorate degree in Educational Administration from the University of Maryland. She retired in 2011 from the University of Maine as Senior Advisor to the President. She has served on numerous community committees and task forces in the region. Dr. Silver brings a wealth of wisdom and compassion to her work on the Board, along with her finely honed organizational and administrative skills. She is committed to leading the organization into an era of exceptional quality of care with an emphasis on cost reduction and advocacy for exceptional healthcare service integration at EMHS.”

**EMHS President and CEO: M. Michelle Hood, FACHE**

“Ms. Hood received a Bachelor of Science degree in 1978 from Purdue University and a Master of Healthcare Administration from Georgia State University in 1981.  She is a Fellow of the American College of Healthcare Executives.  Ms. Hood came to EMHS in April 2006 from Billings, Montana where she was President and CEO of the Sisters of Charity of Leavenworth Health Systems, Montana Region, as well as President and CEO of its flagship hospital, St. Vincent Healthcare. In her more than eight years as President and CEO of EMHS, Ms. Hood has provided leadership and vision that anticipates both advances and obstacles. In addition to overseeing a system of health delivery services, she focuses on healthcare policy developments at the state and national levels, positioning EMHS to innovatively address the very specific needs and challenges of improving the health status of the people of Maine. Ms. Hood works at making connections and building creative partnerships that work for Maine communities, strengthening the economic and educational climate of the state, and ensuring that EMHS is a desirable place to work for more than 10,000 dedicated professionals. The end of 2014 marked Michelle’s completion of her tenure as the Chair of the American Hospital Association’s Health Care Systems Governing Council. She is the immediate past Chair of the Maine Hospital Association Board and serves on the University Of Maine System Board Of Trustees.”

**EMHS Senior V.P., CFO and Treasurer: Derrick Hollings, CPA**

“Mr. Hollings is senior vice president, treasurer and chief financial officer for EMHS. He is responsible for system-wide oversight of finance, treasury, self-insurance programs and property management, as well as for developing a financial roadmap to guide the System, consistent with its strategic financial plan, and for insuring integrity and consistency of consolidated financial information reported by EMHS. Mr. Hollings came to EMHS in April, 2012 from United Medical Center where he served as the Executive Vice President of Hospital Operations and Chief Financial Officer at a 350-bed urban hospital located in Washington, DC. Mr. Hollings was also a senior partner at RequestHealth, LLC, a consulting practice focused on providing interim management services to hospitals in a chief financial officer transition. Mr. Hollings has also held chief financial officer roles at Stamford Health System (Stamford, CT), Howard University Hospital (Washington, DC), University of Massachusetts Medical Center (Worcester, MA) and MediVision, Inc. (Boston, MA). Mr. Hollings graduated from the University of Alabama-Birmingham and is a Certified Public Accountant.”

**EMHS Senior V.P. and Chief Transformation Officer:** **Richard W. Freeman, MD, MPH, ScD, FACP**

“Dr. Freeman, a general internist, was appointed Senior Vice President and Chief Transformation Officer in July, 2011. He is responsible for guiding the transformation of EMHS from volume-based reimbursement and care delivery models to value-based models. Prior to joining EMHS, Dr. Freeman served concurrently as chief medical officer for two subsidiary multi-specialty group practices of Spectrum Health System in west Michigan. Dr. Freeman holds an undergraduate degree from Cornell University, graduate degrees in public health and epidemiology from the Johns Hopkins Bloomberg School of Public Health, and Doctor of Medicine from University of Maryland School of Medicine. His early career included service as Vice President for Medical Affairs, Johns Hopkins Bayview Medical Center; as President and COO of CareAdvantage, Inc., a medical management firm serving BlueCross BlueShield plans; and as Director in the Healthcare Division of Navigant Consulting, Inc.”

**EMHS Senior V.P. and Chief Medical Officer: Robert A. Thompson, MD**

“As senior vice president and chief medical officer for EMHS, Dr. Thompson is responsible for leading clinical improvement through high level policy and quality structure development, leading to achievement of the Triple Aim of improved health of populations, a superior experience for our patients, and a bending of the cost curve for purchasers and patients. He is involved in developing physician leaders and aligning providers through the development of a robust quality structure and leveraging physician leadership throughout the patient care spectrum. Dr. Thompson has been a physician leader for over 20 years. He was executive medical director at Altru Health System until 2010, and then was chief quality and medical officer at Asante, a health system in Southern Oregon. During Dr. Thompson’s tenure at Asante, they were named as a Top 15 Health System in 2013 and 2014 by Truven Health Analytics. Dr. Thompson grew up in North Dakota and attended the University of North Dakota achieving a B.S. in biology with a minor in Russian languages as well as a medical doctor degree. Dr. Thompson completed a residency in Internal Medicine and a fellowship in Allergy/Immunology at the University of Iowa. He is board certified in internal medicine and allergy/immunology.”

**Board of Directors**

“EMHS and MCHC are committed to community-advised governance. Subject to the contingencies set forth in the Agreement, the Governing Boards of EMHS and MCHC/MCMH have approved the Affiliation. Directors include a broad range of skills and background. Complete Board listings are included in Attachment C.”

**Quality, Patient Safety, and Performance Improvement**

“EMHS members are focused on continuous quality assurance and improvement. EMHS reports clinical outcomes to CMS, Leapfrog and other quality and safety associations.”

“EMMC is the flagship and receives multiple referrals from the MCMH service region. EMMC is accredited by the Joint Commission (“TJC”) which is deemed by Medicare to conduct Condition of Participation (“COP”) surveys. EMMC’s most recent full, unannounced survey was conducted in November 2013. Following the review, the TJC issued a letter granting EMMC accreditation through November 8, 2016. EMMC’s transparent quality results can be found on the following website: <http://www.emmc.org/quality/> . MCMH’s quality results can be found on the following website: [MCMH's Quality and Safety](http://mcmhospital.org/site/index.php?option=com_content&view=category&layout=blog&id=185&Itemid=9). Quality results for all EMHS member hospitals are available on their websites.”

**CMS Compare Results**

“Attachment D includes recent Medicare data for MCMH and EMMC as compared to State and Federal results. These measures are categorized in three areas:

 **Survey of patients’ experiences:** How recently-discharged patients responded to a national survey about their hospital experience. For example, how well a hospital’s doctors and nurses communicate with patients and how well they manage their patients’ pain.

 **Timely and effective care:** How often and how quickly each hospital gives recommended treatments for certain conditions like heart attack, heart failure, pneumonia, children’s asthma, and for surgical patients.

 **Readmissions, complications and deaths:**

-How each hospital’s rates of readmission and 30-day mortality rates for certain conditions compare with the national rate.

-How likely it is that patients will suffer from complications while in the hospital.

-How often patients in the hospital get certain serious conditions that might have been prevented if the hospital followed procedures based on best practices and scientific evidence.”

“Data collection periods varied from 2010 to 2014, depending on the measure. These quality measures are available at [http://www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov/).”

“Results from these patient surveys indicate that in most instances EMMC and MCMH have results meeting and/or exceeding State and National averages in effective heart attack and heart failure care, pneumonia care and timely and effective surgical care. An area of note for EMMC and MCMH is timely admission to care units following the decision to admit when in Emergency Department care. EMMC’s wait times are affected by the complexity of cases arriving at EMMC, including patients with behavioral health issues. EMMC’s ED wait time is also affected by inpatient capacity issues causing back-up into the ED. This issue will be greatly mitigated when EMMC’s Modernization Project is fully implemented in 2017. MCMH’s wait time issue is operational in nature, which will be further discussed in Section IV.”

“The data show EMMC’s and MCMH’s results are as good as, or better than, the national rate for readmissions, complications and mortality rates.”

**Regional Support**

“The Transaction is supported by community based stakeholders. Attachment E includes letters of support from business, public health, and provider agencies.”

**Summary of Fit, Willing and Able**

“One of EMHS’ key values is, “Together We’re Stronger.” These words are reflective of EMHS’ history of successfully bringing hospitals and other organizations into its system. EMHS has demonstrated the available resources to improve the financial and quality results of current and new members, most recently with Mercy in October 2013. EMHS’ established record in the pursuit of quality care and patient safety, its nationally recognized health information technology record and being named as one of the Top 100 Integrated Health Networks by IMS further demonstrate its ability to facilitate this affiliation. EMHS has shown expertise in successfully integrating new member hospitals into the system health services continuum of care.”

“EMHS is fit, willing, and able to welcome MCMH as the newest EMHS member.”

## B. Certificate of Need Unit Discussion

### i. CON Standards

The relevant standard for inclusion in this section is specific to the determination that the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant's control meets industry standards.

If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the requirements of this paragraph are deemed to have been met if the services previously provided in the State by the applicant are consistent with applicable licensing and certification standards.

1. **CON Unit Analysis**

Eastern Maine Health Systems (EMHS) is based in Brewer, Maine. EMHS is a nonprofit, tax-exempt corporation. EMHS is a vertically integrated healthcare system serving southern, central, eastern, and northern Maine. EMHS includes more than 30 organizations, including eight hospitals. Maine Coast Memorial Hospital (MCMH) is part of Maine Coast Healthcare Corporation, a Maine nonprofit 501c3 tax-exempt corporation. MCMH is a 64-bed, full-service hospital based in Ellsworth, Maine serving Hancock and Western Washington Counties. MCMH is a major employer in Hancock County and employs 525 full time equivalent personnel. MCMH vision is: “Maine Coast Memorial Hospital will be the preferred community healthcare provider by delivering high-quality, coordinated, and accessible care.” MCMH is approximately 28 miles from Eastern Maine Medical Center, the largest hospital campus in the EMHS system with 411 beds.

The applicant submitted three measures of quality measures listed below:

* **Survey of patients’ experiences:** How recently discharged patients responded to a national survey about their hospital experience. For example, how well a hospital’s doctors and nurses communicate with patients and how well they manage their patients’ pain.
* **Timely and effective care:** How often and how quickly each hospital gives recommended treatments for certain conditions like heart attack, heart failure, pneumonia, children’s asthma, and for surgical patients.
* **Readmissions, complications and deaths:**
* How each hospital’s rates of readmission and 30-day mortality (death) rates for certain conditions compare with the national rate.
* How likely it is that patients will suffer from complications while in the hospital.
* How often patients in the hospital get certain serious conditions, that might have been prevented if the hospital followed procedures based on best practices and scientific evidence.

These quality measures are available at <http://www.hospitalcompare.hhs.gov>. CONU will summarize and analyze the latest data from the website. Data collected was from July 1, 2013 through June 30, 2014. (Data was downloaded from website – May 1, 2015.)

**1.) Patient Survey Results:**

Hospital Consumer Assessment of healthcare providers and Systems is a national survey that asks patients about their experiences during a recent hospital stay. The following chart summarizes results for Eastern Maine Medical Center and Maine Coast Memorial Hospital and compares them to the Maine and National averages.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Maine** | **Maine** | **National** |
| **Patient Survey Results** | **EMMC** | **Coast** | **Average** | **Average** |
| Patients who reported that their nurses "Always" communicated well. | 79% | 85% | 83% | 79% |
| Patients who reported that their doctors "Always" communicated well. | 79% | 85% | 84% | 82% |
| Patients who reported that they "Always" received help as soon as they wanted. | 62% | 68% | 73% | 68% |
| Patients who reported that their pain was "Always" well controlled. | 71% | 76% | 74% | 71% |
| Patients who reported that staff "Always" explained about medicines before giving it to them. | 66% | 68% | 69% | 65% |
| Patients who reported that their room and bathroom were "Always" clean. | 76% | 81% | 81% | 74% |
| Patients who reported that the area around their room was "Always" quiet at night. | 44% | 56% | 60% | 62% |
| Patients who “Strongly Agree” they understood their care when they left the hospital. | 54% | 58% | 59% | 52% |
| Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest). | 65% | 74% | 75% | 71% |
| Patients who reported YES, they would definitely recommend the hospital. | 74% | 80% | 77% | 71% |

The data shown in Exhibit 1: Patient Survey Results indicates that EMMC scores below Maine averages in all ten categories of patient survey results. EMMC scores equal to National averages in two categories, below National averages in 4 categories and above National averages in 4 categories of patient survey results. Maine Coast scores equal to Maine averages in 1 category, below Maine averages in 5 categories and above Maine averages in 4 categories of patient survey results. Maine Coast scores equal to National averages in 1 category, below National averages in 1 category and above national averages in 8 categories of patient survey results.

**2.) Timely and Effective Care:**

These quality measures show how often or how quickly hospitals give recommended treatments to get the best result for people with common conditions. We looked at available data pertaining to the most common conditions; heart attack care, pneumonia care, surgical care, emergency department, preventive care and children’s asthma care.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Timely Heart Attack Care** | **EMMC** | **Maine**  **Coast** | **Maine Average** | **National Average** |
| Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital | Not Available | Too few cases | 43 Minutes | 58 Minutes |
| *A* ***lower*** *number of minutes is better* |  |  |  |  |
| Average number of minutes before outpatients with chest pain or possible heart attack got an ECG | Not Available | 6 Minutes | 6 Minutes | 7 Minutes |
| *A* ***lower*** *number of minutes is better* |  |  |  |  |
| Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival | Not Available | Not Available | 85% | 60% |
| ***Higher*** *percentages are better* |  |  |  |  |
| Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival | Not Available | 100% | 99% | 97% |
| ***Higher*** *percentages are better* |  |  |  |  |
| Heart attack patients who got drugs to break up blood clots within 30 minutes of arrival | Not Available | Not Available | Not Available | 57% |
| Heart attack patients given PCI within 90 minutes of arrival | 100% | Not Available | 99% | 96% |
| ***Higher*** *percentages are better* |  |  |  |  |
| **Effective Heart Attack Care** |  |  |  |  |
| Heart attack patients given aspirin at discharge | 100% | 98% | 100% | 99% |
| ***Higher*** *percentages are better* |
| Heart attack patients given a prescription for a statin at discharge | 100% | 100% | 99% | 99% |
| ***Higher*** *percentages are better* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Effective Heart Failure Care** |  |  |  |  |
| Heart failure patients given discharge instructions | 99% | 100% | 97% | 95% |
| ***Higher*** *percentages are better* |
| Heart failure patients given an evaluation of Left Ventricular Systolic (LVS) function | 100% | 100% | 100% | 99% |
| ***Higher*** *percentages are better* |
| Heart failure patients given ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD) | 100% | 100% | 99% | 97% |
| ***Higher*** *percentages are better* |
| **Effective Pneumonia Care** |  |  |  |  |
| Pneumonia patients given the most appropriate initial antibiotic(s) | 99% | 100% | 98% | 96% |
| ***Higher*** *percentages are better* |
| **Timely Surgical Care** |  |  |  |  |
| Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery) | 97% | 98% | 97% | 98% |
| ***Higher*** *percentages are better* |
| Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection | 100% | 99% | 99% | 99% |
| ***Higher*** *percentages are better* |
| Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) | 100% | 99% | 99% | 98% |
| ***Higher*** *percentages are better* |
| Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery | 100% | 99% | 100% | 99% |
| ***Higher*** *percentages are better* |
| **Effective Surgical Care** |  |  |  |  |
| Outpatients having surgery who got the right kind of antibiotic | 98% | 97% | 98% | 98% |
| ***Higher*** *percentages are better* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Outpatients having surgery who got the right kind of antibiotic | 98% | 97% | 98% | 98% |
| ***Higher*** *percentages are better* |
| Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery | 100% | 98% | 99% | 98% |
| ***Higher*** *percentages are better* |
| Surgery patients who were given the right kind of antibiotic to help prevent infection | 100% | 100% | 100% | 99% |
| ***Higher*** *percentages are better* |
| Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery | Not Available | Not Available | Not Available | Not Available |
| ***Higher*** *percentages are better* |
| Surgery patients whose urinary catheters were removed on the first or second day after surgery | 100% | 100% | 99% | 98% |
| ***Higher*** *percentages are better* |
| Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery | 100% | 100% | 100% | 100% |
| ***Higher*** *percentages are better* |
| **Timely Emergency Department Care** |  |  |  |  |
| Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient | 405 Minutes | 280 Minutes | Not Available | Not Available |
| *A* ***lower*** *number of minutes is better* |
| Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room | 176 Minutes | 140 Minutes | Not Available | Not Available |
| *A* ***lower*** *number of minutes is better* |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Average time patients spent in the emergency department before being sent home | 193 Minutes | 148 Minutes | 119 Minutes | 139 Minutes |
| *A* ***lower*** *number of minutes is better* |
| Average time patients spent in the emergency department before they were seen by a healthcare professional | 46 Minutes | 25 Minutes | Not Available | Not Available |
| *A* ***lower*** *number of minutes is better* |
| Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication | 80 Minutes | 34 Minutes | 48 Minutes | 54 Minutes |
| *A* ***lower*** *number of minutes is better* |
| Percentage of patients who left the emergency department before being seen | 2% | 0% | 1% | 2% |
| ***Lower*** *percentages are better* |
| Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival | Not Available | Not Available | 56% | 63% |
| ***Higher*** *percentages are better* |
| **Preventive Care** |  |  |  |  |
| Patients assessed and given influenza vaccination | 91% | 97% | 96% | 93% |
| ***Higher*** *percentages are better* |
| Healthcare workers given influenza vaccination | 81% | 88% | 84% | 79% |
| ***Higher*** *percentages are better* |
| **Effective Children’s Asthma Care** |  |  |  |  |
| Children who received reliever medication while hospitalized for asthma | Not Available | Not Available | Not Available | 100% |
| ***Higher*** *percentages are better* |
| Children who received systemic corticosteroid medication (oral and IV medication that reduces inflammation and controls symptoms) while hospitalized for asthma | Not Available | Not Available | Not Available | 100% |
| ***Higher*** *percentages are better* |
| Children and their caregivers who received a home management plan of care document while hospitalized for asthma | Not Available | Not Available | Not Available | 90% |
| ***Higher*** *percentages are better* |  |  |  |  |

The results of this patient survey indicate that in most instances both EMMC and Maine Coast have results meeting and/or exceeding State and National averages in effective heart attack and heart failure care, pneumonia care and timely and effective surgical care. An area of weakness for EMMC is timely Emergency Department care. EMMC has several instances of waiting times in excess of State and National averages. This may be in part because this hospital is located in a urban area with a significant population density, which points out the need for less expensive alternatives to emergency department care. It was also noted that EMMC scored lower than State averages in preventive care.

**3.) Readmissions, Complications and Deaths:**

Patients who are admitted to the hospital for treatment of medical problems sometimes get other serious injuries, complications, or conditions, and may even die. Some patients may experience problems soon after they are discharged and need to be admitted to the hospital again. These events can often be prevented if hospitals follow best practices for treating patients.

|  |  |  |
| --- | --- | --- |
| **Measures** | **EMMC** | **Maine Coast** |
| Rate of Readmission for Heart Attack Patients | ND | ND |
| Death Rate for Heart Attack Patients | ND | ND |
| Rate of Readmission for Heart Failure Patients | ND | ND |
| Death Rate for Heart Failure Patients | ND | ND |
| Rate of Readmission for Pneumonia Patients | ND | ND |
| Death Rate for Pneumonia Patients | ND | ND |
| Rate of unplanned readmission after hip/knee surgery | ND | ND |
| Rate of unplanned readmission after discharge from hospital (hospital wide) |  |  |
| Rate of unplanned readmission for chronic obstructive pulmonary disease (COPD) patients | ND | ND |

Note: B = Better than national rate, ND = no different than

National Rate, W= Worse than national rate, NA = not available or too few cases to measure.

The results displayed above show that both EMMC and Maine Coast performed no better or worse than the national rate for readmissions, complications or death.

**State Survey Results**

The results of the most recent surveys for Eastern Maine Medical Center and Mid Coast Hospital are as follows:

**Eastern Maine Medical Center,** an Acute Care Hospital is in compliance with State of Maine 10-144 C.M.R Ch. 112, Rules for the Licensing of Hospitals. All requirements have been met. A State complaint investigation was completed on April 2, 2015.

**Maine Coast Memorial Hospital,** a State licensed hospital is in compliance with 10-144 Ch. 112, Rules for the Licensing of Hospitals. All requirements have been met. A State complaint investigation was completed on January 31, 2015.

### iii. Conclusion

CONU recommends that the Commissioner find that the applicant has met their burden to show that the applicant is fit, willing and able.

# III. Economic Feasibility

## A. From Applicant

**Background**

“The projected MCMH financial statements in Attachment F are intended to be reflective of the overall impact of the Affiliation as currently understood, including the effects on information systems, administration, internal control infrastructure, operational improvements, and other important benefits derived from becoming a member organization of EMHS. Specifically, the projections include revenue cycle improvements and cost savings.”

“Audited financial statements for EMHS and MCMH are included as Attachment G**.”**

“Table 2 below illustrates that MCMH is experiencing growing losses from operations. Consistent with many community-based independent hospitals across the United States, MCMH recognizes the need to gain scale as well as access to capital and information systems upgrades.”

**Table 2: MCMH Historical Financial Results**



“Historical Financial Ratios for MCMH and EMMC for 2009-2013 compared to State and National benchmarks are included in Attachment H**.** following summarizes the percent of time that MCMH has met or exceeded Maine and National means or medians for these ratios over the five year period. “Table **4** following includes similar comparisons for EMMC.”

**Table 3: MCMH % of Time Achieving or Exceeding State and National Average Financial Ratios 2009 – 2013**

|  |  |  |
| --- | --- | --- |
| **MCMH** | **RATIO** | **MAINE NATIONAL** |
| Profitability  Profitability  Profitability | Operating Margin  Net Operating Income  Return on Equity | 40% NAV  40% NAV  40% 40% |
| Liquidity  Liquidity  Liquidity | Current Ratio  Days Cash on Hand  Avg. Payment Period | 100% 20%  80% 80%  60% 0% |
| Capital Structure  Capital Structure  Capital Structure | Debt Service Coverage  Cash Flow to Total Debt  Fixed Asset Financing | 40% 40%  40% 40%  80% 80% |
| Asset Efficiency  Asset Efficiency | Total Asset Turnover  Fixed Asset Turnover | 20% 100%  20% NAV |

*Source: MHDO Website NAV – Not Available*

“MCMH meets or exceeds the Maine and National (where available) median measurements of profitability over the 5-year period an average of 40% of the time. MCMH meets or exceeds Maine median measurements of liquidity an average of 80% of the time and National medians 33% of the time. The facility meets or exceeds Maine and National median measurements of capital structure an average of 53% of the time. MCMH meets or exceeds Maine median measurements of asset efficiency 20% of the time and National median measurements (where available) 100% of the time.”

**“Table 4: EMMC % of Time Achieving or Exceeding State and National Average Financial Ratios 2009 – 2013”**

|  |  |  |
| --- | --- | --- |
| **EMMC** | **RATIO** | **MAINE NATIONAL** |
| Profitability  Profitability  Profitability | Operating Margin  Net Operating Income  Return on Equity | 100% NAV  100% NAV  60% 80% |
| Liquidity  Liquidity  Liquidity | Current Ratio  Days Cash on Hand  Avg. Payment Period | 60% 0%  20% 0%  100% 60% |
| Capital Structure  Capital Structure  Capital Structure | Debt Service Coverage  Cash Flow to Total Debt  Fixed Asset Financing | 100% 100%  80% 20%  80% 80% |
| Asset Efficiency  Asset Efficiency | Total Asset Turnover  Fixed Asset Turnover | 80% 80%  100% NAV |

*Source: MHDO Website NAV- Not Available*

“EMMC meets or exceeds Maine median measurements of profitability over the 5-year period an average of 87% of the time and meets or exceeds National measures of profitability (where available) 80% of the time. EMMC meets or exceeds Maine median measurements of liquidity an average of 60% of the time and National medians 20% of the time. The facility meets or exceeds Maine median measurements of

capital structure an average of 87% of the time and meets or exceeds and National medians 67% of the time. EMMC meets or exceeds Maine median measurements of asset efficiency 90% of the time and National median measurements (where available) 80% of the time.”

“By affiliating with EMHS, MCMH will see an improvement in financial results, as more specifically described below.”

**Management Initiatives**

“Financial Assumptions are described in more detail in Attachment F. The following key initiatives will yield improved financial results:

* Revenue cycle improvement – EMHS has systems and tools needed to improve the yield on MCMH’s billings, to improve collections and reduce denials.
* Health care cost savings – Reduction in employee medical health costs as a result of transitioning MCMH’s employees to EMHS’ self-insured health plan.
* Supply cost savings specific to adding participation in the 340B drug pricing program – MCMH is eligible for this program; EMHS has built the infrastructure needed to optimize the program for member hospitals.
* Professional liability and casualty insurance – MCMH will experience savings by joining EMHS’ successful insurance programs.
* The projections do not assume an increase or decrease in MCMH’s historical cost of shared services expenses (accounting, information technology, et al.) due to the Affiliation. It is EMHS’s intention that any Overhead Cost allocated to MCHC/MCMH for shared services provided by EMHS will not result in an increase in MCHC/MCMH’s expenses for comparable services. The overhead cost implications cannot be reasonably estimated without engaging in transitional shared services planning.”

**Capital**

“The Agreement details the manner in which EMHS will support MCMH for annual capital budget needs as well as assist with the investment needed to upgrade its electronic medical record system and other information technologies. MCMH will be integrated into the Cerner electronic medical record platform in use across EMHS. This system supports population health analytics, decision support care sets, and improved patient care management.”

**Post-Transaction Financial Results**

“The projected consolidated financial statements in

Table **5** below present 12 months of activity for fiscal years 2015 – 2018. Subsequent to the Transaction Date, MCMH will adopt EMHS’ year-end date, which is the last Saturday in September. As such, the projected consolidated financial statements for fiscal year (“FY”) 2015 present a full year of operations of MCMH prior to Affiliation.”

**Table 5: MCMH Projected Financial Results Post-EMHS Affiliation**



**Revenue Cycle Improvements and Expense Reductions Due to Affiliation**

“EMHS will extend its revenue cycle improvement initiative, consultants, and tools to MCMH. Below provides ranges of potential revenue cycle improvements included in the projections as a result of the Affiliation.”

**Table 6: Anticipated Revenue Cycle Improvements**



Table 6 provides details of savings due to new programs included in the projections as a result of the Affiliation:

**Table 6: Projected Cost Savings**

****

**EMHS Results following Affiliation**

“Post-closing, EMHS and MCMH will more fully explore population health strategies and how to build a continuum of care across the entire EMHS system to give patients improved access to services, closer to home and in a more cost-efficient manner.”

**CON Filing Fee**

“The CON filing fee of $9,000 was calculated based on the value of MCMH’s net assets. This table is included in Attachment F, the financial forecast. There is nopurchase price for the transaction.”

**Summary of Financial Feasibility**

“The financial projections in Attachment F and the discussion in this section reflect the financial feasibility of the proposed affiliation. Losses incurred by MCMH over the past few years will be eliminated based on efficient use of shared services, performance improvement efforts, revenue cycle improvement, physician practices service capacity, and participating in population health (accountable care) strategies.”

“The Affiliation will strengthen EMHS’ financial results as well as MCMH’s and support population health throughout the service region and Maine.”

## B. Certificate of Need Unit Discussion

### i. CON Standards

The relevant standards for inclusion in this section are specific to the determination that the economic feasibility of the proposed services is demonstrated in terms of the:

* Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and
* The applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the applicant is deemed to have fulfilled the requirements of this subparagraph if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with applicable licensing and certification standards.

Because this is an application regarding the acquisition of control of a health facility, these additional standards apply:

* the applicant must demonstrate the economic feasibility of the project in light of its impact on the operating budget of the facility and the applicant;
* and the applicant's ability to operate the facility without increases in the facility's rates beyond those that would otherwise occur absent the acquisition.

If the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the applicant is deemed to have fulfilled the requirements. This is allowable if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with applicable licensing and certification standards.

### ii. CON Unit Analysis

In order to assess the financial stability of the applicants, the CONU used financial ratios to measure profitability, liquidity, and capital structure and asset efficiency. Financial data from Maine Coast and EMMC are used in this analysis. CONU utilized Maine Health Data Organization (MHDO) data from 2009 through 2013. Please see MHDO hospital financial information available on MHDO’s website <http://mhdo.maine.gov/imhdo/>.

**PROFITABILITY RATIOS**

CONU used three profitability ratios to measure the applicant’s ability to produce a profit (excess of revenue over expenses). Hospitals cannot be viable in the long term without an excess of revenues over expenditures. Cash flow would not be available to meet normal cash requirements needed to service debt and investment in fixed or current assets. Profitability has a large impact on most other ratios. For example, low profitability may adversely affect liquidity and sharply reduce the ability to pay off debt.

**Operating margin:** The operating margin is the most commonly used financial ratio to measure a hospitals financial performance. This ratio is calculated as follows:

**Operating Income/Total Operating Revenue**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Operating Margin** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 2.33% | 1.64% | 2.58% | 9.18% | 4.58% |
| Maine Coast | 3.57% | (1.83%) | 5.45% | (1.28%) | (.47%) |
| All Maine Hospitals Median | 2.08% | .98% | 2.34% | (.29%) | .07% |
| National Median | NA | NA | NA | NA | NA |

**Net Operating Income (Loss):** Net operating income is calculated by subtracting operating expense from operating revenue. This measure is used to look at how a hospital’s net operating income performed in comparison with last years’ figure and whether or not there is a positive or negative trend in the future.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Net Operating Income** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | $12,657,859 | $9,185,814 | $14,711,174 | $60,107,333 | $29,659,616 |
| Maine Coast | $3,022,216 | ($1,423,347 | $4,667,475 | ($1,024,320 | ($375,470) |
| All Maine Hospitals Median | $1,419,993 | $762,435 | $1,549,111 | ($108,996) | $101,000 |
| National Median | NA | NA | NA | NA | NA |

**Return on Equity**: This ratio defines the amount of excess revenue over expenses and losses earned per dollar of equity investment. Most not-for-profit hospitals received their initial, start-up equity capital from religious, educational, or governmental entities, and today some hospitals continue to receive funding from these sources. However, since the 1970s, these sources have provided a much smaller proportion of hospital funding, forcing not-for-profit hospitals to rely more on excess revenue over expenses and outside contributions. Many analysts consider the Return on Equity measure a primary indication of profitability. A hospital may not be able to obtain equity capital in the future if it fails to maintain a satisfactory value for this ratio. This ratio was calculated as follows:

**Excess of Revenue over Expenses/Fund Balance-Unrestricted**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Return on Equity** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 4.99% | 6.77% | 7.85% | 22.02% | 14.50% |
| Maine Coast | 8.40% | (1.01%) | 11.80% | (1.16%) | .63% |
| All Maine Hospitals Median | 5.01% | 4.51% | 8.28% | 2.05% | 3.97% |
| National Median | 5.5% | 6.30% | 6.40% | 5.70% | 5.50% |

**LIQUIDITY RATIOS**

CONU used three liquidity ratios to measure the applicant’s ability to meet short-term obligations and maintain cash position. A poor liquidity ratio would indicate that the hospital is unable to pay current obligations as the come due.

**Current Ratio**: Current ratio is a liquidity ratio that measures a company’s ability to pay short-term obligations. The ratio is mainly used to determine if the hospital is able to pay back its short-term liabilities (debt and payables with its short-term assets (cash, inventory, receivables). From an evaluation stand point, high values for the Current Ratio imply a high likelihood of being able to pay short term obligations. A ratio under 1 suggests that the hospital would be unable to pay off its obligations if they came due at that point. This ratio is calculated as follows:

**Total Current Assets/Total Current Liabilities**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Current Ratio** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 1.077 | 1.512 | 1.603 | 1.791 | 1.650 |
| Maine Coast | 2.414 | 1.679 | 1.600 | 1.369 | 1.794 |
| All Maine Hospitals Median | 1.65 | 1.68 | 1.60 | 1.37 | 1.65 |
| National Median | 2.11 | 2.19 | 2.11 | 2.15 | 2.03 |

**Days Cash on Hand:** Days cash on hand is a common measure that gives a snapshot of how many days of operating expenses a hospital could pay with its current cash available. High values for this ratio usually imply a greater ability to meet short term obligations and are viewed favorably by creditors. This ratio is calculated as follows:

**Cash & Investments + Current Assets who’s Use is Limited/Total Advertising + Salaries & Benefits +Other Operating Expenses + Interest/365 days**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Days Cash on Hand** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 8.6 | 12.7 | 15.6 | 25.00 | 22.6 |
| Maine Coast | 84.3 | 70.6 | 57.2 | 41.1 | 28.7 |
| All Maine Hospitals Median | 33.3 | 32.5 | 26.2 | 23.7 | 29.6 |
| National Median | 34.8 | 27.3 | 25.6 | 30.5 | 34.5 |

**Average Payment Period:** This ratio provides a measure of the average time that elapses before current liabilities are paid. Creditors regard high values for this ratio as an indication of potential liquidity problems. Decreasing values are favorable. This ratio is calculated as follows:

**Total Current Liabilities/Total Advertising + Salaries & Benefits +Other Operating Expenses + Interest/365**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Average Payment Period** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 59.9 | 36.2 | 39.8 | 43.3 | 52.8 |
| Maine Coast | 54.6 | 72.2 | 62.5 | 68.3 | 76.5 |
| All Maine Hospitals Median | 59.9 | 60.5 | 62.8 | 78.1 | 73.6 |
| National Median | 50.6 | 48.6 | 50.3 | 51.8 | 52.7 |

**CAPITAL STRUCTURE RATIOS**

CONU used three capital structure ratios in order to measure the applicant’s capacity to pay for any debt. The hospital industry has radically increased its percentage of debt financing over the past two decades making this ratio vitally important to creditors who determine if a hospital is able to increase its debt financing. The amount of funding available to a hospital directly impacts its ability to grow.

**Debt Service Coverage:** This ratio measures the amount of cash flow available to meet annual interest and principal payments on debt. A DSCR of less than 1 would mean a negative cash flow. Increasing values are favorable. This ratio is calculated as follows:

**Excess of Revenue over Expenses + Depreciation + Interest/Interest + Previous Years Current LTD**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Debt Service Coverage** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 8.205 | 8.193 | 7.320 | 14.445 | 13.343 |
| Maine Coast | 4.318 | 2.111 | 5.068 | 1.92 | 2.204 |
| All Maine Hospitals Median | 2.91 | 2.68 | 4.11 | 2.76 | 2.90 |
| National Median | 3.1 | 2.61 | 2.96 | 3.02 | 2.63 |

**Cash Flow to Total Debt**: This coverage ratio compares a company’s operating cash flow to its total debt. This ratio provides an indication of a hospitals ability to cover total debt with its yearly cash flow from operations. The retirement of debt principal is not a discretionary decision. It is a contractual obligation that has definite priority in the use of funds. Therefore, a decrease in the value of the Cash Flow to Total Debt ratio may indicate a future debt repayment problem. The higher the percentage ratio, the better the company’s ability to carry its total debt. This ratio is calculated as follows:

**Excess of Revenue over Expenses + Depreciation/Total Current Liabilities + Total Non- Current Liabilities**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cash Flow to Total Debt** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 15.21% | 17.73% | 17.58% | 32.11% | 17.82% |
| Maine Coast | 19.29% | 8.46% | 30.29% | 10.34% | 12.18% |
| All Maine Hospitals Median | 15.00% | 15.14% | 20.51% | 11.86% | 12.28% |
| National Median | 17.4% | 19.6% | 19.00% | 21.70% | 19.80% |

**Fixed Asset Financing**: This ratio defines the proportion of net fixed assets (gross fixed assets less accumulated depreciation) financed with long-term debt. This ratio is used by lenders to provide an index of the security of the loan. Decreasing values are favorable. This ratio is calculated as follows:

**Long Term Debt/Net Plant, Property & Equipment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Fixed Asset Financing** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 18.89% | 38.29% | 38.42% | 33.87% | 103.45% |
| Maine Coast | 54.86% | 45.17% | 44.07% | 41.14% | 38.34% |
| All Maine Hospitals Median | 54.22% | 47.59% | 46.06% | 52.78% | 50.83% |
| National Median | 49.70% | 48.40% | 50.80% | 50.00% | 55.50% |

**ASSET EFFICIENCY RATIOS**

CONU used two asset efficiency ratios. These ratios measure the relationship between revenue and assets.

**Total asset turnover ratio:** Provides an index of the number of revenue dollars generated per dollar of asset investment. Higher values for this ratio imply greater generation of revenue from a limited resource base and are sometimes viewed as a positive indication of efficiency. This ratio is affected by the age of the plant being used by the hospital. Increasing values are favorable. This ratio is calculated as follows:

**Total Operating Revenue + Total non-operating Revenue/Total Unrestricted Assets**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Total Asset Turnover** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 1.437 | 1.379 | 1.325 | 1.211 | .887 |
| Maine Coast | 1.337 | 1.130 | 1.180 | 1.092 | 1.061 |
| All Maine Hospitals Median | 1.23 | 1.21 | 1.21 | 1.14 | 1.14 |
| National Median | 1.07 | 1.05 | 1.07 | 1.00 | 1.00 |

**Fixed Asset Turnover Ratio:** Measures the number of revenue dollars generated per dollar of fixed asset investment. High values for this ratio may imply good generation of revenue from a limited fixed asset base and are usually regarded as a positive indication of operating efficiency. This ratio is calculated as follows:

**Total Operating Revenue/Net Plant, Property, & Equipment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Fixed Asset Turnover** | **2009** | **2010** | **2011** | **2012** | **2013** |
| EMMC | 3.731 | 3.223 | 3.401 | 3.595 | 3.129 |
| Maine Coast | 2.778 | 2.191 | 2.538 | 2.411 | 2.381 |
| All Maine Hospitals Median | 2.72 | 2.63 | 2.96 | 2.84 | 2.80 |
| National Median | NA | NA | NA | NA | NA |

**CONU Summary of Financial Ratios:**

The applicant submitted data measuring both EMMC and Maine Coast’s performance against Maine and National measures of profitability, liquidity, and capital structure and asset efficiency. CONU verified these measures using data from the Maine Health Data Organization for 2009 through 2013. In summary, EMMC exceeds Maine and National measures in most instances while Maine Coast lags behind in several areas. EMMC has outlined several initiatives which will take place post-affiliation which will enhance Maine Coast’s financial position.

Maine Coast has incurred operating losses for several years. This is the result of volume declines due to efforts by insurance companies, large employers and ACO’s to reduce inpatient utilization and revenue cycle deficiencies. Maine Coast lags State and National averages in measures of profitability, capital structure and asset efficiency. The 2012 through 2014 financial results indicate that Maine Coast was experiencing increasing losses from operations. As an independent community based hospital it is difficult to gain economies of scale, access to capital and invest in expensive information systems upgrades. These conditions illustrate the need for Maine Coast to affiliate with a larger health care system. EMHS has the resources necessary to improve Maine Coast’s financial position. As described by the applicant several initiatives are planned post affiliation:

1. Revenue cycle improvements,
2. Health care cost savings,
3. Supply cost savings,
4. Insurance savings,
5. Capital contributions for an upgraded electronic medical record system and other information technologies,
6. Performance improvement efforts,
7. Participation in population health (accountable care) strategies.

These initiatives are projected to result in over $8,000,000 in savings over the next three years.

**Financial Forecast**

CONU reviewed the financial forecasts and underlying assumptions associated with this acquisition of control transaction and finds them reasonable. The highlights of these assumptions follow:

1. Maine Coast and its’ affiliates will become a direct, wholly controlled subsidiary of EMHS as of September 1, 2015.
2. Projected consolidated financial statements are intended to be reflective of the overall impact of the Affiliation, including the effects on information systems, internal control infrastructure, accounting policies and practices, operational improvements and other benefits associated with Maine Coasts’ affiliation with EMHS.
3. Inpatient admissions remain at 2015 levels through the projection period (2015 – 2019).
4. Outpatient volumes will increase approximately 8.9% during this same period.
5. Gross and net patient service revenue projection assumptions include the projected impact of the Affordable Care Act and associated changes in reimbursement.
6. Operating expense projections are based on historical relationships to patient service volumes and historic usage rates where possible.

In order to determine if projected savings materialize, CONU recommends that the applicant report cost savings attributable to the acquisition for a period of three years.

**Condition:**

* The applicant is to report cost savings attributable to the transaction for three years following the commencement of the CON.

### Conclusion

CONU recommends that the Commissioner determine that the applicant has demonstrated that the project is economically feasible.

# IV. Public Need

## A. From Applicant

**Needs of the Community**

“MCMH is a vital healthcare and economic resource to the people of Hancock and Western Washington Counties. MCMH actively participates in key district health efforts to coordinate the right care with public needs.”

“As an EMHS affiliate, MCMH will directly benefit from EMHS' participation in the Maine Shared Health Needs Assessment & Planning Process (“SHNAPP”) project, which is comprised of EMHS, MaineHealth (“MH”), MaineGeneral Health (“MGH”), Central Maine Health Care (“CMHC”), and Maine CDC. The SHNAPP is a statewide effort to conduct a community health needs assessment (“SHNA”) that addresses community benefit reporting needs of hospitals, supports state and local public health accreditation efforts, and provides valuable population health assessment data for a wide variety of organizations concerned with the health of Maine’s communities. It is the intent of EMHS to utilize the SHNA to advance health services planning and integration in MCMH’s service area. SHNAPP is currently a routine agenda item at the State Coordinating Committee (“SCC”) meetings.”

“In 2010, OneMaine (a prior collaboration of EMHS, MG and MH) contracted with the Muskie School and University of New England to conduct a Community Health Needs Assessment (“CHNA”) study with a resulting extensive report that documents the health status, barriers to care, and other demographic and social issues affecting people and organizations throughout Maine. The study highlighted health status issues and needs by county.”

“The 2013-2017 State Health Improvement Plan (“SHIP”) reflects the public health priorities of the Maine CDC and Maine DHHS, with significant input from our public health partners. The SHIP focuses on six health priorities:

* Increase youth and adult immunizations
* Reduce youth and adult obesity
* Reduce substance abuse and improve mental health
* Reduce tobacco use and exposure to tobacco smoke
* Increase the community’s awareness of public health
* Increase the community’s active involvement in public health”

“MCMH lists 12 initiatives in their most recent community benefit plan (Attachment I): MCMH Community Benefit Work). Many of the initiatives mirror those outlined in the 2010 OneMaine’s CHNA, which identified several key issues for Hancock County (which represents MCMH’s primary service population) including:

* Prevention
* Substance Abuse
* Asthma
* Cancer
* Unemployment
* Uninsured (Access to Care)”

Table **7** summarizes MCMH’s nearly $12 million in community benefit expenditures in FY2013.

**Table 7: MCMH’s FY2013 Community Benefit Expenditures**



“MCMH is aware of the requirements for service area needs assessments and community engagement as outlined by the Affordable Care Act. MCMH maintains community benefit reporting which will be further integrated into EMHS’ statewide community health programs.”

**Collaborating for Community Health Improvement**

“Healthy Acadia is the local Healthy Maine Partnership in DHHS Downeast District 7 (Hancock and Washington Counties). As a member of the Advisory Council, MCMH is working toward common goals to increase physical activity in the daily lives of community members, create sustainable local food options, and connect people of all ages with quality, affordable healthcare. For example, the MCMH Food Service Department has partnered with Healthy Acadia to develop a pilot program to look at food waste. The proposed tracking system will reduce food waste and cut costs. They are also partnered to build a small greenhouse of herbs on-site to encourage healthy, locally-sourced food consumption. A support letter from Healthy Acadia is included in Attachment E.”

“In 2014, EMHS was awarded a major grant from the Federal Centers for Disease Control under the Partnerships to Improve Community Health. A three-year cooperative agreement, Northern Maine Rural Collaborative for Healthy Communities (“NMRC”) is focused on bringing community agencies, public health, health care providers, and a range of stakeholders together to address identified needs targeting seven contiguous counties of northern, central, and eastern Maine: Aroostook, Hancock, Penobscot, Piscataquis, Somerset, Waldo, and Washington. NMRC will identify and implement evidence-based, multi-sector interventions to address underlying health issues by improving access to nutritious food; increasing physical activity; increasing opportunities to prevent and manage the risks of chronic disease; and informing, educating, and empowering people to lead healthier lives. MCMH will be working closely with stakeholders in Hancock County and EMHS project coordinators to establish infrastructure that will alleviate the target health issues in the long run.”

“MCMH also collaborates with local healthcare organizations to address health service needs. Selected collaborations are set forth in Table 17 of this application.”

“In summary, MCMH is committed to working with public health and others to improve community health and to identifying high priority issues that impact health status.”

**Description of Maine Coast Memorial Hospital (MCMH)**

MCMH

50 Union Street,

Ellsworth, Maine 04605

<http://www.mcmhospital.org>

**Mission and Vision**

“Maine Coast Memorial Hospital is dedicated to providing exceptional medical care with the personal touch and convenience only a community hospital can offer. MCMH has a strong and clear Mission: *Improving our communities with excellence in health care.”*

“Vision: *Maine Coast Memorial Hospital will be the preferred community healthcare provider by delivering high-quality, coordinated, and accessible care.”*

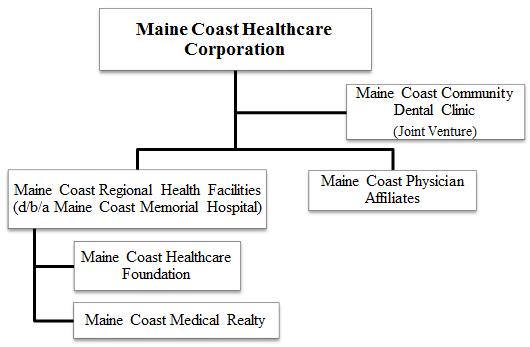
**Background**

“Figure 3 below describes the organization of MCHC, a Maine nonprofit 501c3 tax-exempt corporation, which is the sole member MCMH. MCMH is the sole member of Maine Coast Healthcare Foundation (the Foundation) and Maine Coast Medical Realty (Realty Corp). In accordance with the agreement, post- Affiliation, the parties intend to merge the Foundation will into Eastern Maine Foundation. Realty Corp. holds title to a medical office building located at 50 Union St. in Ellsworth and a few smaller houses used as interim housing.”

“Maine Coast Physician Affiliates is currently not operating. Prior to the physicians being employed by MCMH, there was a multi-specialty provider group which operated out of this organization. Provider employment transitioned to the hospital in 1999.”

“The Maine Coast Community Dental Clinic provides access to much needed oral health services in Ellsworth.Maine Coast Medical Reality holds the title to the Medical Office Building located on the MCMH campus, providing office space to physicians and other care providers.”

**Figure 3: Maine Coast Healthcare Corporation Organizational Chart**

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“Located in Ellsworth, MCMH is a 64-bed, full-service hospital serving Hancock and Western Washington Counties. Opened in 1956, the comprehensive healthcare facility provides emergency, primary and specialty care, as well as acute inpatient, diagnostic, and surgical services. MCMH employs 525 full time equivalents and is a major economic driver in Hancock County.”

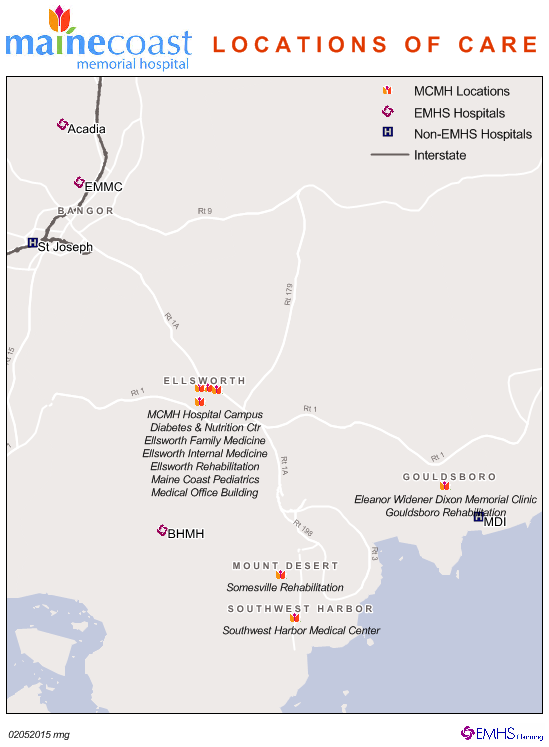
“MCMH is accredited by The Joint Commission, reflecting its commitment to meeting the highest performance standards for patient safety and quality, and has received both national and state recognition for patient safety, outcomes, and patient satisfaction levels.”

“MCMH seeks to improve the health of the communities it serves by delivering a broad range of services to meet the individual needs of patients and their families. These services include:

* An emergency center, with 24-hour physician coverage and an adjacent helipad used for emergency air transport for the most critical patients. A tele-psych program allows for patient consults with Acadia Hospital.
* A primary care network with locations in Ellsworth, Gouldsboro, and Southwest Harbor.
* Full rehabilitation services located in Ellsworth, Gouldsboro, and Somesville that include physical and occupational therapy, speech language pathology, nutritional counseling, and diabetes management.
* Inpatient and outpatient surgical services including: orthopedics, gynecology, urology, general surgery, otolaryngology, podiatry and endoscopy. MCMH has an endoscopy suite to meet the increased demand for painless colon and gastrointestinal screenings.
* Specialty physicians and services provide care in the fields of rheumatology, gastroenterology, oncology, dermatology, cardiology and neurology.
* Imaging capabilities include a 64-slice computed tomography (“CT”) scanner, digital mammography, 3 and 4 dimensional ultrasound machines, and digital diagnostic equipment all networked to a Picture Archiving Communication System (“PACS”) used to communicate with other health care facilities.
* Complete care for women is provided by both OB/GYNs and Certified Nurse Midwives.
* A Wound Center for treatment of acute and chronic hard-to-heal wounds.
* Cancer treatments at the MCMH’s Mary Dow Cancer Center.
* Cardiac and pulmonary diagnostic testing, rehabilitation programs and sleep center.”

“MCMH services are offered at a variety of locations throughout Hancock and Western Washington Counties, with sites of care shown in Figure 4 and described in

**Figure 4: MCMH Health System Service Locations**



“below includes service locations that are consistent with MCMH’s Maine Hospital license, included as Attachment J.”

**Table 8: MCMH Service Location Descriptions**

| **Location** | **Description** |
| --- | --- |
| **Maine Coast Memorial Hospital**  50 Union Street  Ellsworth, ME 04605 | Main Hospital Facility |
| **The Mary Dow Center**  50 Union Street  Ellsworth, ME 04605 | Outpatient services including;   * Oncology * Cardiology * Rheumatology * Wound Care * Osteoporosis |
| **Southwest Harbor Medical Center**  45 Herrick Road  Southwest Harbor, ME, 04679 | Primary Care, laboratory services, and limited imaging services. |
| **Eleanor Widener Dixon Memorial Clinic**  37 Clinic Road  Gouldsboro, ME 04607 | Primary Care, laboratory services, and limited imaging services. |
| **Eleanor Widener Dixon Memorial Clinic Physical/Rehabilitation Facility**  37 Clinic Road  Gouldsboro, ME 04607 | Outpatient therapy services including physical, occupational, and speech therapy. Eleanor Widener Dixon Memorial Clinic Medicine holds a level 2 certification as a Patient Centered Medical Home from the National Committee for Quality Assurance (NCQA). |
| **Ellsworth Family Practice**  32 Resort Way  Ellsworth, ME, 04605 | Primary Care and laboratory services. |
| **Maine Coast Pediatrics**  32 Resort Way  Ellsworth, ME, 04605 | Primary Care and laboratory services. |
| **Ellsworth Internal Medicine**  32 Resort Way  Ellsworth, ME, 04605 | Primary Care and laboratory services.   * Ellsworth Internal Medicine received level 1 certification as a Patient Centered Medical Home from the National Committee for Quality Assurance (NCQA). |
| **Medical Office Building**  50 Union Street | * Down East Dermatology * Maine Coast General Surgery * Maine Coast Women Care * Frenchman Bay Orthopedics * Maine Coast Hand & Shoulder * Maine Coast Otolaryngology * Maine Coast Urology |
| **Medical Office Building**  50 Union Street  (Continued) | * The Breast Clinic * Cardiac and Pulmonary Rehab Services * Maine Coast Diabetes and Nutrition: Outpatient Nutrition, Diabetes Self-Management Education, Pre-diabetes Classes, Diabetes Support Group, Cardiac Rehab Nutrition Classes, Community Outreach, Corporate Wellness and Cancer Rehabilitation program. * Maine Coast EEG Lab and Maine Coast Sleep Lab |
| **Disease Management Services**  306 Main St.  Ellsworth, ME, 04605 | The Disease Management Services group assists patients with Medicare Buy-Ins, ACA enrollment, Meals on Wheels, fuel assistance and prescription assistance. |
| **MCMH Rehab Services**  65 Church Street  Ellsworth, ME 04605 | Outpatient therapy services including physical, occupational, and speech therapy. |
| **MCMH Rehab Services**  1049 Maine Street  Mt Desert, ME 04605 | Outpatient therapy services including physical, occupational, and speech therapy. |

**Medical Staff**

“MCMH medical staff includes a range of primary care and specialty care providers to serve the service area. The medical staff will work closely with providers at EMMC and other EMHS members to assure continuing access to patient care and to build on the services currently in place. Table 9 highlights the range of providers in MCMH who will join their colleagues within EMHS to improve regional care delivery.”

**Table 9: MCMH Medical Staff Composition**

| **Dept. Type** | **# Practices** | **# Employed Providers** | **# Private Practice Providers** | **Total Providers** | **% Employed** |
| --- | --- | --- | --- | --- | --- |
| Anesthesia | 1 | 6 | 1 | 7 | 86% |
| Cardiology | 1 | 0 | 1 | 1 | 0% |
| Dermatology | 1 | 2 | 0 | 2 | 100% |
| Emergency Medicine | 1 | 8 | 0 | 8 | 100% |
| Family Medicine | 3 | 20 | 0 | 20 | 100% |
| Gastroenterology | 1 | 0 | 1 | 1 | 0% |
| General Surgery | 2 | 2 | 2 | 4 | 50% |
| Hematology/Oncology | 1 | 0 | 1 | 1 | 0% |
| Hospitalist | 1 | 7 | 0 | 7 | 100% |
| Infectious Disease | 1 | 1 | 0 | 1 | 100% |
| Internal Medicine | 1 | 7 | 0 | 7 | 100% |
| Neurology | 1 | 0 | 2 | 2 | 0% |
| Neurosurgery | 0 | 0 | 1 | 1 | 0% |
| Obstetrics/Gynecology | 2 | 6 | 5 | 11 | 55% |
| Ophthalmology | 5 | 0 | 6 | 6 | 0% |
| Oral & Maxillofacial Surgery | 0 | 0 | 2 | 2 | 0% |
| Orthopedic Surgery | 1 | 3 | 1 | 4 | 75% |
| Otolaryngology | 1 | 1 | 0 | 1 | 100% |
| Pathology | 1 | 0 | 1 | 1 | 0% |
| Pediatrics | 1 | 6 | 0 | 6 | 100% |
| Podiatric Medicine | 1 | 0 | 1 | 1 | 0% |
| Psychiatry | 1 | 1 | 0 | 1 | 100% |
| Radiology | 1 | 0 | 1 | 1 | 0% |
| Rheumatology | 1 | 0 | 1 | 1 | 0% |
| Urology | 1 | 2 | 0 | 2 | 100% |
| **Total** | **31** | **72** | **27** | **99** | **73%** |

“Source: MCMH Credentialing Staff; Information is of 2/17/15

Notes: Includes active and consulting staff. Nurse Practitioners and Physician Assistants are included. The table does not include telemedicine contractors or covering providers.”

**MCMH Key Personnel**

“MCMH has a strong governance and management team working with EMHS leaders on affiliation transitional issues. A brief summary of the MCMH Board Chair and management team and their areas of expertise follow. Resumes of key staff are included in Attachment B.”

**MCMH Board Chair: Adin M. Tooker**

“Mr. Tooker of Brooksville graduated from Middlebury College with a degree in English Literature. He served in the US Army as Artillery, second lieutenant and was deployed to Vietnam for a year. After active duty, Mr. Tooker joined IBM as a marketing representative, selling computers to banks and insurance companies in the northeast. Following his career at IBM, he became a banker, rising to the position of senior vice president and director of marketing. After a decade in the banking field, he joined The Travelers Insurance Company securities unit and assisted banks with developing their brokerage business and personal lines insurance for bank customers. Following this work, he joined a subsidiary of General Reinsurance – serving as chief marketing officer, operations officer, and chief technology officer. Mr. Tooker retired and moved to Maine in 2000.”

**MCMH President & Chief Executive Officer: Charles Therrien**

“Mr. Therrien, a resident of Lamoine, has been President and CEO of Maine Coast Memorial Hospital since 2010.  Mr. Therrien is responsible for the overall strategic and operational performance of the hospital. Prior to joining Maine Coast Memorial Hospital he served in multiple roles over a nine year period at Sharon Hospital including President & CEO. Mr. Therrien has worked in healthcare for over 30 years in areas including physician practice management, business development, business turnarounds, and all levels of operational management. He has a degree in Finance and Quantitative Methods from Babson College in Wellesley, MA.”

**MCMH Chief Financial Officer: Chris Frauenhofer**

“Mr. Frauenhofer has been Chief Financial Officer of Maine Coast Memorial Hospital since May of 2013. Mr. Frauenhofer lives in Ellsworth. Prior to joining Maine Coast Memorial Hospital, Mr. Frauenhofer served as CFO for Alice Hyde Medical Center in Malone, N.Y. He provided financial and operational leadership to the 76-bed community hospital. Mr. Frauenhofer also served as CFO at Niagara Falls Memorial Medical Center in Niagara Falls, N.Y. Mr. Frauenhofer has a master’s degree in Business Administration from Niagara University and a bachelor’s degree in Business Administration from State University of New York at Buffalo.”

**MCMH Chief Medical Officer: Sheena Whittaker, MD**

“Dr. Whittaker has been a pediatrician for 11 years, has been with Maine Coast Memorial Hospital since 2004, and is a resident of Blue Hill. Dr. Whittaker earned her undergraduate degree in Psychology from Barnard College of Columbia University, NY; before completing her Medical Degree at George Washington Medical School in Washington D.C. and a residency at St. Christopher’s Hospital for Children in Philadelphia, PA. Dr. Whittaker served as Medical Staff President at MCMH for three years and as chair of several committees before accepting the position of Chief Medical Officer in June of 2014. Dr. Whittaker is also the current Clinical Director of Maine Coast Pediatrics and Medical Director of Maternal Child Health for the hospital.”

**MCMH Chief Nursing Officer and Vice President of Patient Care Services: Ardelle C. Bigos, RN, MSN, CMSRN**

“Ms. Bigos has been CNO and VP of Patient Care Services at Maine Coast Memorial Hospital in Ellsworth, Maine since September of 2014. She is a resident of Ellsworth. Prior to her work at MCMH, Mrs. Bigos was most recently the CNO and Chief Experience Officer at Newton Medical Center, part of the Atlantic Health System, in Newton New Jersey. In her role there Mrs. Bigos was accountable for providing senior management leadership and direction for the Division of Patient Care Services and for ensuring adherence to local, state, and national regulatory standards. Before her position as CNO, she served as Director of Acute Care Operations; Director of Quality Resources; and Director of Supervision & Medical-Surgical Services at the Medical Center. She also has prior experience as a Clinical Educator and Intensive Care Unit Clinical Coordinator, as well as Staff Nurse. Following graduation from Trenton State College in 1983 with a B.S. in Nursing, Ms. Bigos obtained her Master of Science Degree in Nursing (MSN) and her Medical-Surgical certification (CMSRN).”

**Board of Directors**

“EMHS and MCHC/ MCMH are committed to community advised governance. Subject to the contingencies in the Agreement, their Governing Boards have approved the Affiliation. Directors include a broad range of skills and background. Complete Board listings are included as Attachment C.”

**Quality Programs**

**Most Recent State Survey**

“On August 7, 2014 MCMH was surveyed by the Maine Department of Health and Human Services (DHHS) based upon an allegation of noncompliance with EMTALA regulations. The survey and subsequent reviewed determined that MCMH was not in compliance with certain EMTALA regulations and with certain CMS Conditions of Participation relative to Patient Rights and Emergency Services. A Plan of Correction (PoC) was submitted to CMS on September 10, 2014 relative to the EMTALA issues. The PoC was accepted by CMS. A PoC was submitted to Maine DHHS on September 12, 2014 relative to the Patient Rights and Emergency Services issues. The PoC was accepted by Maine DHHS. MCMH is following the PoC’s as submitted.”

**Medicare Hospital Compare**

“The Medicare Hospital Compare website provides a broad range of clinical, operational, experience and cost comparison information specific to Medicare patients. A report was generated which includes MCMH, EMMC and BHMH, along with Maine and National Averages and is included as Attachment D. MCMH results were better than or equal to State and National averages for most indicators. One area noted for improvement involves the following indicator for the emergency department.”

*“Average time (in minutes) patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room”*

|  |  |  |  |
| --- | --- | --- | --- |
| Maine Coast | EMMC | Maine State | National |
| 142 (1) | 200 (1) | 109 | 97 |

“MCMH’s time of 142 minutes is higher than State and National averages but not as high as the regional referral center. While this indicator at EMMC is related to bed availability as well as efficient practices, at MCMH, the staff is working on increasing efficiencies in moving the patient from the ED to the floor. This is not an indicator of bed capacity constraint at MCMH.”

“Although MCMH is already recognized as a high value, high quality provider in Maine as per the CMS Hospital Compare results, this desirable position will be difficult to maintain as the cost of operations inevitably continues to rise (e.g., salaries, physician recruitment, information technology, supplies, equipment, insurance, bad debt, charity care, etc.). Hospitals affiliate with health systems in order to take advantage of scale and scope. For example, the electronic medical record system is in need of replacement and must be able to support state-of-the-art clinical delivery systems. As noted in the application, EMHS will assist MCMH in that endeavor both financially and operationally.”

**Rationale for MCMH to Seek Affiliation with EMHS**

“In today’s challenging economic environment, consumers, employers, and government are looking for ways to improve healthcare access and outcomes (quality) while lowering costs. In order to better serve the patients and members of the community, MCMH determined it needed to affiliate with another hospital or health system. EMHS is the logical choice because of its long-standing referral relationship with MCMH, its existing collaborative arrangements with MCMH and EMHS’ demonstrated capability and competence in providing the resources necessary to address MCMH’s needs. MCMH’s rational for affiliating with EMHS include:

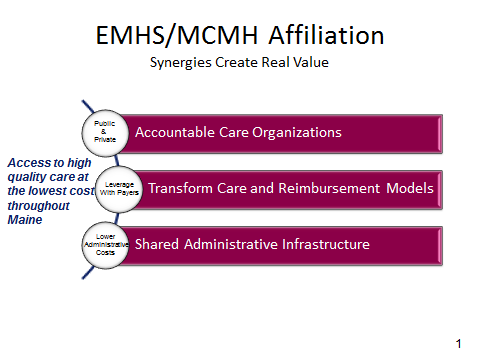
* **Financial constraints**
  + Recent annual operating losses
  + Further cost reductions could only be achieved through affiliation with a larger system, which creates the ability to lower overhead and eliminate costly redundancies
* **Need to Sustain Access to Regional specialty services**
  + The Affiliation will support and sustain the current range of services through linkages to EMHS specialists. The Affiliation supports regional medical staff planning and provider recruitment and retention.
  + Leaders will conduct strategic service line planning involving physicians and other stakeholders to assume access to a continuum of services.
  + Residents of and visitors to Hancock and Western Washington Counties will continue to have access to a continuum of care as close to home as feasible.
* **Minimum Viable Scale**
  + MCMH’s census is relatively low and lacks the scale necessary for long-term financial success. As a part of a larger system, with shared clinical and administrative services, MCMH leaders are assuring continued access to specialty services in the service region.
* **Transition to value based payment from governmental and commercial payors**
  + Population health focused health care delivery and payment requires a range of new skills and resources not historically utilized by hospitals, including wellness training, risk-based contracting, provider network development, predictive health analytics and state of the art care management in a range of settings. Standalone facilities are unlikely to have the capacity to develop these skills on their own.”

“The proximity to and compatibility with EMHS state-wide, and with EMMC and Blue Hill hospitals regionally, makes EMHS the right choice for MCMH.”

**Affiliation Synergies**

“Figure 5 below was used in the Mercy Hospital Affiliation documents and is also applicable to the EMHS/MCMH affiliation. By aligning patient care and regional support services, and with a mind towards the Triple Aim of Improved Care, Experience and Lower Costs, EMHS and MCMH will focus on improved population health.”

**Figure 5: EMHS/MCMH Affiliation**

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“EMHS is committed to care close to home. The synergies illustrated above will position EMHS and MCMH to improve economies of scale, transform the delivery system and assure access to care for patients and families in the Hancock and Western Washington Counties.”

“By becoming part of the EMHS family, MCMH and the community will benefit from:

* Cost and operating efficiencies related to scale;
* population health management expertise which will enable MCMH to offer local (connected to statewide) choice regarding an entire care system; and complementary coordinated patient care and wellness services MCMH takes pride in its historical high value proposition to patients, employers and payors.  MCMH recognizes the need to continue to evolve as a member of EMHS in the communities it serves with respect to price, quality and service.”

“Letters of support for the proposed affiliation are included in Attachment E.”

**Rationale for EMHS to Affiliate with MCMH**

“EMHS’ vision for 2020 is to be a national model for healthcare delivery. This includes transforming the full spectrum of care delivery systems with a defined goal of providing the “right care at the right time in the right place.” As a strategic initiative, EMHS’ goal is to reduce total cost for patients and payors by accepting accountability for costs, quality and experience. Additionally, as a statewide healthcare system, EMHS serves as the backbone for sustainable, locally distributed care delivery as referring hospitals come under increasing economic pressure in the national healthcare reform market.”

“The EMHS response to changing market dynamics is to develop a range of strategic partnership options for collaborating. Partnership models include clinical relationships, accountable care arrangements, medical transport, purchasing cooperation, comprehensive population health management, as well as a path to full corporate membership. For example, a significant number of non-EMHS hospitals and Federally Qualified Health Centers (“FQHCs”) have aligned with EMHS to participate in EMHS’ value based population initiatives. Nearly every hospital in the EMHS northern, eastern and central regions has one or more tele-medical support systems connected 24 hours a day and 7 days a week to EMMC. Most rural emergency departments have tele-trauma systems connected to the surgical trauma and pediatric intensivists at EMHS for real time consultation. Most of these rural hospitals are connected to EMHS Picture Archiving and Communication System (“PACS”) radiology imaging system supporting state-of-the-art consultations. Nearly all of the rural hospitals and FQHCs have remote access to EMHS inpatient electronic medical records so that they can review the status of patients transferred to an EMHS hospital.”

“EMHS’ goal is to be a statewide system for clinically integrated and distributed specialty care. As such, EMHS member organizations would collectively serve as the regional core for these clinically integrated and locally distributed service lines. EMHS ambulatory strategy will ensure that every community served will have access to specialty and primary care services that otherwise would not be available in communities with standalone small hospitals. Through partnerships and/or by stepping in to ensure access to ambulatory services, EMHS is committed to improving population health.”

“The Affiliation will allow EMHS to continue its commitment of collaboration with healthcare providers across Maine. MCMH has developed a very strong local care network that connects patients in both Hancock and Western Washington Counties to needed services. Linking EMHS and MCMH will create a level of collaboration that is not possible without the Affiliation. MCHC is joining EMHS as a full corporate member; this will allow for the most efficient combining of infrastructures into a single care delivery platform that capitalizes on shared learning and economies of scale. Together in one system, EMHS and MCMH can pool resources and share expertise, knowledge, and relationships necessary for effective care coordination.”

“EMHS recognizes MCMH as an excellent affiliation partner with a similar mission-driven culture, a strong primary care network needed for population health management and a leadership team who will add to EMHS’ expertise. EMHS works with member organizations to improve quality, service and cost-effectiveness. Best practices are shared within the system and incorporated into standard system-wide processes.”

“MCMH will support EMHS’ strategy to develop a stronger ambulatory care system with its strong and growing provider network. MCMH’s 72 employed physicians and additional nurse practitioners, physician assistants, behavioral health experts, and other clinicians will be welcome participants in efforts towards value-based consumer-directed plan designs and delivery models for commercial- and government-insured populations.”

“The proposed affiliation will strengthen EMHS’ corporate infrastructure by dispersing administrative costs over a larger system, thereby reducing overhead costs for other EMHS members. This will result in more cost-effective and streamlined services throughout the EMHS system.”

“As EMHS develops a care model that succeeds under risk sharing population health payment models, MCMH’s attributed patients already provide additional numbers that support the growing Pioneer ACO demonstration sites and the infrastructure needed to improve health.”

**Accountable Care and Population Health**

“In 2010, EMHS was awarded $12.8 million as one of 17 grantees of the Federal Office of the National Coordinator. Funds supported the development of exemplary healthcare communities with strong health information technology ties, chronic care managers, and community wide collaboration. The collaborations and systems built as part of this three year program formed the basis for the development of EMHS’ Accountable Care organization, Beacon Health LLC.”

“During the past several years, Beacon has developed significant expertise in population health management. The following key statistics about the organization:

* 72 employees including 55 RNs
* 55 RN Care Coordinators
* 100,000 covered lives
* CMS Pioneer Quality Score in the top 5 and >90%
* 5 Risk Bearing contracts
* Preferred provider network with 600 providers statewide”

**Medicare Pioneer Demonstration: A Statewide Population Management Network**

“EMHS was proud to be one of the original 32 organizations across the United States invited to become a Pioneer Accountable Care Organization (ACO) through a Medicare demonstration project administered by the Centers for Medicare and Medicaid Innovation (CMMI). EMHS has been a participant in the Medicare Pioneer shared risk demonstration since January 1, 2012. During year 1, CMS limited the program to PPS hospitals; in year 2, critical access hospitals and FQHCs were added to the model. In year 1, approximately half of the 32 Pioneer ACOs achieved shared savings; EMHS realized 2.5%+ in savings. In years 2 and 3, the Beacon Pioneer has experienced shared losses as the network was expanded to other providers with different base costs. Beacon is now investing in predictive risk models which identify patients at risk for using high cost settings or services.”

“The Medicare Pioneer Program provides substantial public benefits. It requires ACOs to: (a) be accountable for Medicare beneficiaries, (b) improve the coordination of fee-for-service items and services, and (c) invest in infrastructure and redesigned care processes that promote high quality, efficient service delivery, and “demonstrate a dedication and focus toward patient centered care.” Participating ACOs have the opportunity to earn shared savings payments by reducing Medicare expenditure growth for their assigned beneficiaries below specified targets while at the same time meeting quality performance measures.”

“The Secretary of DHHS announced this year an ambitious goal of tying 30% of payments to quality and value through alternative payment models by 2016 and 50% by 2018. Organizations participating in the Pioneer demonstration are consulted in the development of other CMS initiatives, including the recently announced “Next Generation ACO Model.” EMHS is at the forefront of linking services to value based payments.”

**Accountable Care beyond Medicare**

“Beacon Health LLC, participates in risk-based arrangements with employers, payors and other governmental agencies such as MaineCare. Beacon’s strong management team is contracting with non-member regional hospitals and FQHCs in addition to EMHS members to bring a focus on population health to communities throughout Maine.”

“EMHS is partnering with Geisinger Health System, a renowned rural health system based in Danville, Pennsylvania. By implementing an innovative primary care delivery model which results in improved quality and value, Geisinger Health System and Geisinger Health Plan, the insurance member of the system, are viewed across the country as a model for ACO design and primary care excellence.”

**MCMH and Beacon Health**

“MCMH joined the Beacon Health Network in January 2014.  Beacon Health provides the leadership, structure and expertise to support a statewide network of partners in standardizing high quality care through collaboration performance improvement powered by real time data and teamwork.”

“The 34 providers caring for patients in the five primary care, internal medicine, and pediatric practices of MCMH are collectively improving the lives of 3,164 Pioneer Medicare patients as well as nearly 3,500 patients in commercial contract arrangements.  Patients in the Beacon Health network report that they are feeling healthier. Providers convey they are able to deliver more personalized care and that care standard is improving the quality of their patients’ lives.”

“In addition to benefiting the residents of the MCMH Service Area, MCMH’s participation broadens the base and benefits for those already participating in the ACO and living in northern, central, and eastern Maine. MCMH has a strong primary care and regional specialty network. MCMH’s primary care network provides services to over 27,000 active patients currently. MCMH’s patients are among the 100,000 covered lives currently managed by Beacon Health. EMHS and MCMH recognize the value in adding covered lives to a shared accountable care strategy.”

**MCMH Service Areas and Market Overview**

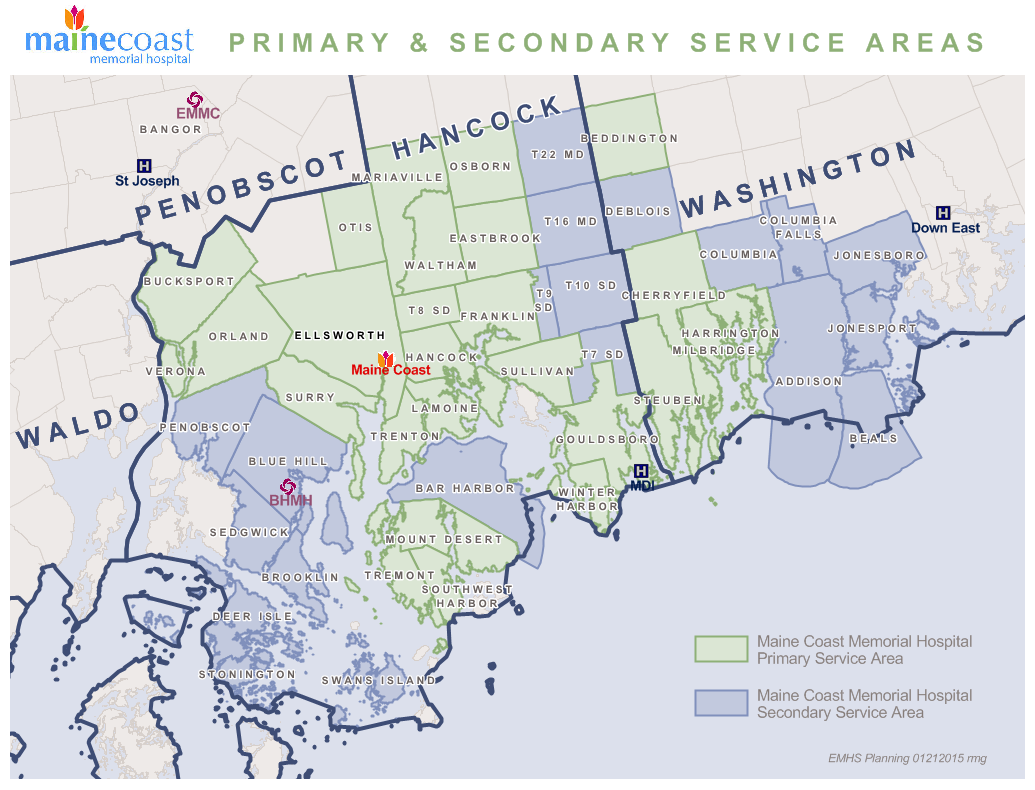
“For analysis purposes, the MCMH Primary Service Area (PSA) is defined to include sufficient contiguous towns to capture 75-80% of MCMH’s admissions. Residents of these 27 communities accounted for 1,943 admissions to MCMH in 2012, 76% of MCMH’s total. The Secondary Service Area (SSA) was defined to represent an additional 10-15% of MCMH’s admissions. These 15 towns adjacent to the PSA accounted for 363 admissions to MCMH in 2012, 14% of the total. Data source is the Maine Health Data Organization inpatient hospital dataset**.** See **Table 10**.”

**Table 10: MCMH Patient Origin by Town – CY 2012 Admissions**

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“MCMH’s Total Service Area (Primary plus Secondary) covers virtually all of Hancock and Western Washington counties. See Figure 6 below.”

**Figure 6: MCMH PSA and SSA**



**Rural Federally Designated Shortage Areas**

“MCMH’s primary service area includes all or part of the Ellsworth, Bucksport, Sullivan and Milbridge Primary Care Analysis Areas (PCAA). These PCAAs have received the following federal designations of shortage areas:

* The Gouldsboro/Milbridge PCAA is a Primary Care Health Professional Shortage Area.
* The Milbridge and Bucksport PCAA’s are designated as Medically Underserved Areas. As are the Blue Hill and Mt Desert Island areas which are part of MCMH’s Secondary Service Area.
* The Ellsworth, Milbridge/Gouldsboro and Bucksport PCAA’s are Dental Health Professional Shortage Areas. The Blue Hill and Mt Desert Island PCAA’s also have this designation.
* MDI and Blue Hill PCAAs are designated as medically underserved areas.”

“The Affiliation will support healthcare work force development opportunities to maintain access to care in rural Hancock and Western Washington Counties.”

**Socioeconomic and Market Share Information for the Service Area**

**Population and Age Characteristics**

“MCMH serves Hancock and Western Washington Counties. As noted in Table 11 below, the total population is expected to remain relatively unchanged. Consistent with other areas in the State, the population of residents aged 65+ is expected to grow most rapidly over the next five years, while the numbers of younger residents are expected to decline.”

“Per the 2010 U.S. Census, 29% of the Ellsworth PCAA residents are at or below 200% of the federal poverty level.”

**Table 11: MCMH Hospital Service Area Population Trends to 2019**



“Hancock County has one of the highest unemployment rates in Maine. The Maine Bureau of Labor reported the February 2015 unemployment rate for Hancock County was 9.4% and a rate of 6.0% for Maine overall (not seasonally adjusted).”

“As shown in Table 12, Hancock and Washington Counties have a lower 2014 estimated average household income than the average Maine household. The service area is projected to continue to have a steadily lower household income through 2019 than Maine as a whole. The health care sector is important to preserve as an economic engine, to support visitor and seasonal population, as well as year-round residents.”

“Income trends in Hancock and Washington Counties are unfavorable. Average household income is projected to decline and will be significantly below the Maine average by 2019*.”*

**Table 12: Hancock and Washington County Household Income Trends to 2019**



*Source: Nielsen PopFacts Premier 2014*

“The service area for MCMH will not change as a result of the Affiliation. Non-MCMH providers in the service areas will see no adverse impact on the range of services they offered.”

“Market share is shown in Table 13 below. MCMH has a 40% historical inpatient market share of the PSA and 15% of the SSA.”

**Table 13: MCMH Historical Inpatient Market Share - PSA/SSA**

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*(\*) Please refer to Table 10 for definitions.*

*Source: MHDO Inpatient Database, Calendar Year 2012*

“In addition to MCMH, there are three other hospitals in Hancock and Western Washington Counties (see Table 15 below) which are all critical access hospitals. For example, there are many services at MCMH which are not offered at BHMH; these include acute rehabilitation, inpatient obstetrics, gynecology and newborn care, as well as intensive care. The geography and road conditions may create travel challenges and often result in increased travel times.”

**Table 14: Hospitals in MCMH Primary and Secondary Service Areas and Distance from MCMH**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MCMH Service Area** | **Hospital** | **CAH1** | **Location** | **Distance (mi)** |
| Secondary | Down East Community Hospital | CAH | Machias | 57 |
| Secondary | Mount Desert Island Hospital | CAH | Bar Harbor | 21 |
| Secondary | Blue Hill Memorial Hospital | CAH | Blue Hill | 14 |
| *1CAH= Critical Access Hospital* | | | | |

**MCMH Historical and Forecasted Service Statistics**

“The aging of the population in Hancock County will somewhat offset declining age-specific admission rates so that there will be minimal change in the county’s number of admissions and patient days. MCMH’s inpatient admissions are projected to remain at the 2015 level through 2019. Consistent with industry trends and considering regional demographic, overall hospital outpatient visits, primary care visits and emergency department visits will increase. These trends were incorporated into the volume projections were used to develop the financial forecast in Attachment F and discussed in Section III.”

“The volume forecast in Table 16 was developed using market estimator tools from the Advisory Board Company, a national research and consulting firm. Their forecast for Hancock County is consistent with other forecast models. Residents of Hancock County are projected to have a small decrease in the utilization of inpatient services and a small increase in utilization of outpatient services. The majority of MCMH’s admissions come from the immediate Ellsworth area, admissions from these zip codes are projected to decline only 0.08% over the projection period, virtually flat as shown in Table 17.”

**Table 15: Hancock County Volume Forecast**



“Table 16 includes a summary of historical and projected utilization data for MCMH Hospital for fiscal years 2014 and projected through 2018.”

**Table 16: MCMH Historical and Projected Inpatient and Outpatient Volume**



**EMHS Member Hospital Service Area in Relation to MCMH Service Area**

“The Affiliation will enhance EMHS’ and MCMH's efforts to meet healthcare needs of residents Hancock and Western Washington Counties. As one example, MCMH has been contracting with Acadia Hospital for several years to provide tele-psych evaluations in the emergency department. In the future, MCMH and Acadia will have the opportunity to work more closely together to offer integrated behavioral and medical services in the primary care and other settings.”

“As discussed previously, there is little or no overlap between the service areas in the region. This is reviewed in more detail in Section V. EMHS’ vision is to provide care as close to home as possible. No market share changes are assumed in the financial analysis.”

“The Affiliation will not adversely affect competition or have any significant effect on other providers in Hancock or Western Washington Counties. The primary purpose of the Affiliation is to lower costs and improve quality of care by improving access to the most appropriate care for all residents of the region.”

**Summary of Public Need**

“The needs of the health care needs of community will be addressed by the Affiliation. EMHS will strengthen MCMH’s current role as a community based care provider by managing to lower cost status, preserving local choice, and enhancing the patient centered medical home model in primary care; this support includes access to affordable capital.”

“The Affiliation will ensure that MCMH remain an integral primary and specialty care provider to residents of Hancock and Western Washington counties. MCMH will benefit from the cost savings related to economies of scale and continue to be a low cost provider to the community. The projected savings are included in the financial analysis report included within this application.”

“The MCMH service area will not change as a result of the Affiliation. MCMH's 39.7% market share of inpatient admissions from its Primary Service Area and 15.3% share of its Secondary Service Area will not change materially as a result of the Affiliation, see Table 10.”

“Participation in EMHS quality improvement programs will allow MCMH to work with new colleagues on continuous improvement, care integration and benchmark results among EMHS hospitals.”

“In summary, the Affiliation will improve quality outcomes, address identified community needs, engage MCMH providers in the accountable care transformation of service delivery and payment models while maintaining consumer choice in the Ellsworth area.”

**B. Certificate of Need Unit Discussion**

### i. CON Standards

The relevant standard for inclusion in this section are specific to the determination there is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

* Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;
* Whether the project will have a positive impact on the health status indicators of the population to be served;
* Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and
* Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

### ii. CON Unit Analysis

In order to determine whether, and to the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project CONU analyzed the strategic vision of both EMHS and Mid Coast.

**EMHS:**

**EMHS Mission is “EMHS partners with individuals and communities to improve health and well-being by providing high quality, cost effective services.”**

EMHS was a participant in the OneMaine Health Collaborative which includes EMHS, MaineGeneral Health and MaineHealth. The purpose of the OneMaine Health Collaborative was to advance health services planning and integration following the tenets of the Triple Aim which is described below.

Both the healthcare industry and consumers recognize that healthcare costs are growing at an unsustainable pace. Healthcare costs in the U.S. are higher than other countries and result in poorer overall population health. The Institute for Healthcare Improvement (IHI) developed the “Triple Aim” approach which has three crucial objectives:

1. Improve the health of the defined population

2. Enhance the patient care experience (including quality, access and reliability).

3. Reduce, or at least control, the per capita cost of care.

Some methods of accomplishing the Triple Aim include:

1. A focus on individuals and families;

2. Redesign of primary care services and structures;

3. Population health management;

4. A cost-control platform;

5. System integration and execution.

The OneMaine Health Collaborative sponsored a report entitled Community Health Needs Assessment 2010. The report identifies health status, barriers to care, and other demographic and social issues affecting Maine healthcare consumers. Among the relevant findings:

**Access to care** as measured by several health use indicators is a significant issue in most of the state. Maine residents as a whole and in many counties have high rates of emergency department (ED) and preventable hospitalizations. The 2010 CHNA data provides a disturbing view of high ED and hospital use by patients with symptoms and conditions that could be prevented or controlled with care provided in primary care settings.

**Access to, and availability of, high quality primary care**, especially for those with chronic health conditions, is a continuing challenge in Maine. This is an issue in many Maine counties and may be due to inadequate availability of providers, lack of health insurance, or lack of patient self- management, among other patient, health system or population issues.

**Care for Chronic Conditions**: Approximately 90 million Americans are living with at least one chronic disease which contributes to over 70% of deaths in the U.S. each year. Despite the relatively low cost and proven effectiveness of treatments for these common and preventable – but potentially deadly – conditions, many Americans are not getting better. Changes need to address core competencies around how to deliver patient centered care; how to partner with patients, providers and the community; and how to improve medication management and adherence. Use of community care teams that include patients in treatment decisions, and continued quality improvement using evidenced based guidelines, coupled with changes in reimbursement policies may be required.

**Substance Abuse and Mental health Services:** Mental health problems affect a large portion of Maine’s population, and are frequently seen in populations with physical health issues and substance abuse (SA) problems. In order to address these issues a broad based, collaborative prevention programs at the community level need to be implemented. Primary care providers (PCPs) and ED providers need education programs related to substance abuse diagnosis, treatment tools, and protocols. Strategies should be implemented to coordinate the delivery of substance abuse services at the local level. Access to expanded referrals and consultative resources for PCP’s needs to be provided.

EMHS envisions transforming the full spectrum of care delivery systems with a defined goal of providing the “right care at the right time in the right place.” EMHS has a goal of reducing total cost for patients and payers and being a leader and driving force in establishing sustainable, locally distributed care delivery.

EMHS, along with Central Maine Healthcare Corporation, MaineGeneral Health, MaineHealth, and the Maine Center for Disease Control and Prevention, are currently participating in the Shared Health Needs Assessment & Planning Process (SHNAPP) Project. This collaborative is seeking to identify a vendor to conduct a Statewide Community Needs Assessment. According to the SHNAPP request for proposal the goal of the SHNAPP is to “create a framework and approach for a coordinated statewide community health needs assessment (CHNA) that could address community benefit reporting and CHNA needs of hospitals, support state and local public health accreditation efforts, and provide valuable population health assessment data for a wide variety of organizations concerned with the health of Maines’s communities and citizens. SHNAPP leaders are committed to an on-going single statewide assessment which will provide up-to-date data about county and state health status and offer recommendations for improvement.” This includes using existing data from a number of sources, including Maine CDC, such as the Behavioral Risk Factor Surveillance System, the Maine Integrated Youth Health Survey, the Maine Cancer Registry, and MCDC Vital Records to name several common surveillance mechanisms of annual data.”

EMHS participated in the 2013-2017 State Health Improvement Plan which outlines the public health priorities of the Maine CDC and Maine DHHS. According to the Maine State Health Improvement Plans executive summary, “The State Health Improvement Plan (SHIP) is designed to improve the health of all Maine people. It focuses on six health priorities (Immunizations, obesity, substance abuse and mental health, tobacco use, mobilizing community partnerships and informing, educating and empowering the public) with goals, objectives, and strategies for achieving measurable success over the next three years.”

**Maine Coast**

Maine Coast’s mission is “Improving our communities with excellence in health care.”

As stated by the applicant, Maine Coast has outlined 12 risk factors and initiatives to deal with them in their most recent community benefit plan (on file at CONU). In many cases these initiatives mirror what EMHS is striving for. These initiatives are based on the 2010 Community Health Needs Assessment that EMHS co-sponsored. Maine Coast has demonstrated a strong commitment to identifying and addressing the health needs in its service area. Maine Coast spent almost $12 million dollars on community benefit expenditures in FY 2013.

As outlined by the applicant Maine Coast delivers a wide range of services to meet the needs of both patients and their families. These services are offered at a variety of locations throughout Hancock and Western Washington Counties. Maine Coast’s medical staff includes a range of primary care and specialty care providers to serve the service area. Maine Coast is accredited by The Joint Commission and has received state and national recognition for patient safety, outcomes and patient satisfaction.

This project will have a positive impact on the health status indicators of the population to be served. As costs of services continue to rise at Maine Coast, affiliation with EMHS will allow it to take advantage of EMHS’s scale and scope. Cost reductions can be achieved through affiliation with a larger system. Affiliation creates the ability to eliminate duplication of effort and lower overhead. Maine Coast’s small service area and relatively low census will hinder its long run viability. Affiliation with a larger system will allow it to share clinical and administrative services while allowing continued access to specialty services. The transition to value based payment from governmental and commercial payors will require a new skill set and resources not historically utilized by hospitals. As outlined by the applicant these skills include wellness training, risk-based contracting, provider network development, predictive health analytics and state of the art care management in a range of settings. A standalone community hospital would have difficulty developing these skills on their own.

The services affected by this project will be accessible to all residents of the area proposed to be served. The proximity of Maine Coast to EMMC and Blue Hill regionally will be beneficial to current patients of Maine Coast. The goal of this affiliation is to create access to high quality care at the lowest cost throughout Maine.

This project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project. As stated by the applicant, EMHS’s goal is to be a “statewide system for clinically integrated and distributed specialty care.” Maine Coast has developed a strong local network in its’ service area of Hancock and western Washington County. Affiliating with EMHS will allow Maine Coast to pool resources and share knowledge in order to coordinate care. EMHS ambulatory strategy will ensure that the communities in Maine Coast’s service area will have access to specialty and primary care services that would not be available if Maine Coast remained a standalone community hospital. This will improve population health. Maine Coast and EMHS share a vision of maintaining a strong primary care network which is so crucial for population health management. EMHS will work with Maine Coast to improve quality, service and cost-effectiveness. Best practices will be shared and standard system-wide processes will be developed. EMHS received a $12.8 million grant from the Federal Office of the National Coordinator. This grant formed the basis for the formation of Beacon Health, EMHS accountable care organization. Beacon Health has acquired expertise in population health management and has developed a preferred provider network with 600 providers statewide. Maine Coast joined this Beacon in January 2014. As a result Maine Coast has been able to deliver more personalized care and improve the quality of life for their patients.

Accountable Care Organizations ACO) were designed to coordinate high quality care for Medicare patients with the goal of avoiding duplication and medical errors. Any Medicare savings will be shared among members of the ACO. EMHS has built on this model and strives to extend this philosophy to commercial and other government-insured populations. EMHS has partnered with Geisinger Health Systems, a well-known rural health system to implement an innovative primary care delivery model which results in improved quality and value.

### iii. Conclusion

CONU recommends that the Commissioner find that the applicant has met their burden to show that there is a public need for the proposed project.

# V. Orderly and Economic Development

1. **From Applicant**

**Benefits of MCMH and EMHS Affiliation**

“As the result of an extensive Board and management planning process, MCMH determined to affiliate with EMHS in order to facilitate improved access to capital, gain information technology expertise, and create the scale needed to be successful under population health and value-based payment systems. Initially, MCMH’s identified goals in pursuing an affiliation in order to position MCMH for longer term success in a dynamically changing healthcare environment:

* Establishing infrastructure for delivering accountable care
* Right–sizing care delivery network/continuum
* Growing covered lives and patient population
* Increasing scale to improve operating efficiency
* Gaining improved access to capital”

“MCMH concluded that, properly structured, forming a strategic partnership would enable MCMH to:

* Achieve greater scale, consolidate activities, and improve operational efficiencies
* Elevate information technology, especially electronic medical record platform
* Improve cost management of specialty care
* Offer ties to a statewide provider network
* Engage in risk sharing for value based pricing for covered population
* Develop medical homes
* Form a clinically integrated network (CIN)
* Integrate accountable care competencies with respect to:
  + Care management
  + Risk sharing
  + Predictive Health analytics
  + Provider network development and management”

“MCMH conducted a thoughtful thorough process when considering affiliation options. MCMH chose to partner with EMHS because EMHS was the choice that best enabled MCMH to achieve the goals identified during its strategic planning process. Additionally, there is a cultural congruity between both organizations’ commitment to designing the healthcare of the future – keeping populations healthy, rather than focusing primarily on the treatment of patients after they become ill. EMHS will benefit from its new relationship with MCMH, with its strong provider network, resulting in economics of scale, and the opportunity to build on a statewide accountable care organization.”

“All of the benefits and savings related to the Affiliation have not yet been fully quantified; however, the following positive results are expected. Expected benefits of the Affiliation include quality improvements, efficiencies, and cost savings including, but not limited to:

* 340b program savings: EMHS has developed core expertise in optimizing the Federal 340b program which is targeted to providers serving a disproportionate number of low income patients. MCMH will be eligible for the expanded 340b savings for outpatients; EMHS staff will assist in 340b program optimization.
* Administrative function integration: EMHS supports member organizations by providing a range of administrative services, including patient billing, information technology, accounting, planning, human resource and employee benefits, compliance and revenue cycle. By adding MCMH, EMHS will be able to be more efficient with administrative overhead to be spread among all members. Will some cost savings are anticipated, they are not quantified in the financial projections submitted.
* Health information technology – EMHS is a national leader in health information technology. Sharing best practices with MCMH is expected to not only improve clinical outcomes but reduce duplicate tests and re-admissions as the shared clinical data becomes available to providers statewide. As set forth in the Agreement, EMHS has committed to investing in MCMH’s clinical information platform.
* Clinical quality – EMHS has long-standing committees comprised of physician, clinical and IT experts who develop care path protocols based on evidence based medicine which are integrated into the electronic medical record system and clinical policies. For example, patients at risk of stroke or infections are screened upon admission; in the outpatient setting, all patients diagnosed with chronic diseases are identified for standardized treatment services. As Medicare and other payors continue to move towards value based payments, EMHS and MCMH will be better positioned to provide evidence based care to more Maine residents.
* Population Management and Contracting – EMHS is one of the original health systems selected to participate in the CMS Pioneer risk sharing Medicare demonstration. To succeed in health population payment systems, an infrastructure is being developed to manage multiple contracts with employers, and governmental and commercial payors. This includes contracting, legal, care management, analytical and population health expertise. MCMH has a strong primary care network, as do the EMHS member hospitals. Adding MCMH’s covered lives to EMHS’ Accountable Care Organization (ACO) helped spread the infrastructure investment and allow the System and Maine to move more quickly to a patient centered medical home payment system.
* Service line footprint development – EMHS is working to develop system wide service lines to assure access to a full range of services in a cost effective way. MCMH will participate in creating the service line footprint.
* Workforce development – Having a larger employee base will support a broader range of training and engagement opportunities and reduce employee benefit costs.”

“The EMHS-MCMH relationship is based on the principle that patients prefer their local providers and hospital choice. MCMH is recognized for developing an excellent primary and specialty care team.”

“EMHS is a leader in managing the health of the communities it serves and using leading edge health information technology to improve the quality and safety of care. Both systems are known for providing high-quality, safe care in a continuum of care settings.”

**Quality Improvement**

“As noted in Section IV, Attachment D is a report was generated using CMS data to compare results for MCMH and EMMC to Maine state and National Averages. MCMH results were better than or equal to State and National averages for most indicators. One area noted for improvement involved time waiting in the emergency department after the patient has been identified for admission.”

“This process indicator, along with multiple process and clinical outcome indicators, will be monitored and addressed by MCMH and will be aided by the resources of the larger EMHS quality team. MCMH leaders will be participating in System work related to implementing best practices and measuring in a standardized way.”

**MCMH Collaborations**

“The residents of Hancock County and the surrounding region will continue to benefit from a choice in healthcare providers. Competing health systems often find ways to work together for the benefit of patients, as the hospitals in eastern Maine have done for many years.”

“Table 17 outlines selected collaborative activities among MCMH, EMHS and other Hancock County providers.”

“MCMH currently contracts with EMHS members and other regional providers in a number of services. The Affiliation will build on this foundation.”

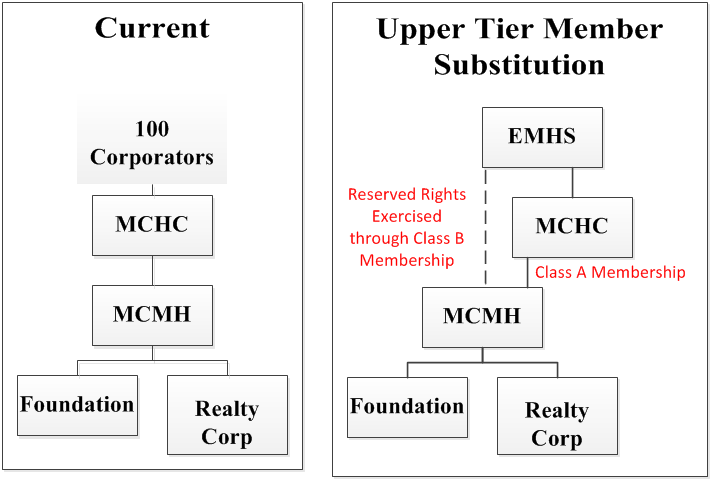
**Table 17: MCMH Selected Collaborations and Contracts**

|  |  |
| --- | --- |
| **Collaborator** | **Services contracted to MCMH or provided in collaboration with MCMH** |
| Acadia Hospital | Telepsych consults in the Emergency Department |
| Eastern Maine Medical Center | Specialist Services:   * Cardiology * Neurology * Oncology * Pharmacy Management   Non clinical: Biomedical/ Clinical Engineering  Future integration: Regional Picture Archiving and Communications Systems (PACS) |
| Affiliated Lab | Regional referral lab |
| Affiliated Materiel | Purchasing contracts |
| Mt. Desert Island Hospital | JV to provide dental services to residents of Hancock and Washington Counties.  Specialists shared for dermatology and general surgery. |
| Blue Hill Memorial Hospital | Obstetrical services coordinated such that pre-and post-natal is provided for Blue Hill residents at BHMH; birthing services are provided at MCMH. |

**Governance Post-Affiliation**

“A local board will continue to be involved in the oversight of MCMH after it becomes a member of EMHS. Both organizations believe in strong local governance that ensures the voices of the community are at the table when decisions are made about their healthcare needs. Section 2 of the Agreement (Attachment A) describes the governance impact of the transaction.”

**Figure 7: Pre- and Post-Affiliation Governance Structure**

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“According to the Agreement, the following steps will be taken:

* EMHS becomes sole corporate member of MCHC
* EMHS becomes the Class B voting member of MCMH
* Hospital is sole corporate member of Foundation
* Foundation will be merged into EMHS Foundation post-closing
* Hospital is sole corporate member of Realty”

“Attachment K provides a more thorough summary of the division of governance and control between EMHS, as MCMH’s Class B. Member, and MCMH’s Board of Trustees and Management.”

**Alternatives**

“During its strategic planning process, MCMH considered a complete array of alternatives before concluding that the EMHS affiliation presented the best possible alternative for MCMH and the communities it serves. MCMH’s strategic partnership process began in the summer of 2013. The Board of Trustees undertook a formal strategic planning process that focused on the current and future situational assessment for MCMH. This planning process led to the decision to explore affiliation relationships, with the goal of ensuring that the people of Hancock and Western Washington County have access to high quality, coordinated and affordable health care services. During its strategic planning process, MCMH considered a complete array of alternatives before concluding that the EMHS affiliation presented the best possible alternative for MCMH and the communities it serves.  Discussions between MCMH and EMHS began in the summer of 2014.”

“EMHS and MCHC/MCMH are well suited to affiliate.  Early analysis indicates that the transaction will have no negative effect upon competition in the relevant market and is in fact expected to maintain MCMH’s position as a healthy, viable provider within its market over the long term.  Additionally, EMHS brings to MCMH all of the financial, operational and strategic resources that were identified in MCMH’s strategic review process.  The discussions between the two organizations revealed a close alignment regarding governance and mission.  Ultimately, this affiliation presented the best alternative for key constituencies including medical staff, employees, volunteers, payors, employers and healthcare consumers.”

**Summary of Alternatives Considered**

* **Remain independent**

“This option was fully evaluated but was determined to be less likely to meet the needs of the community and the strategic goals of the organization.”

* **Work with other independent hospitals**

“MCMH participated in the early stages of a collaboration effort of independent Northern Maine Hospitals. When this model was compared to EMHS it was determined that EMHS more clearly met the strategic goals of MCMH.”

* **Affiliate with another Maine system**

“MCMH considered affiliation with other Maine based multi-hospital systems.  After consideration, it was determined that an affiliation with EMHS was best suited to assuring the continuation of excellent and sustainable health service access in Hancock and Western Washington Counties.”

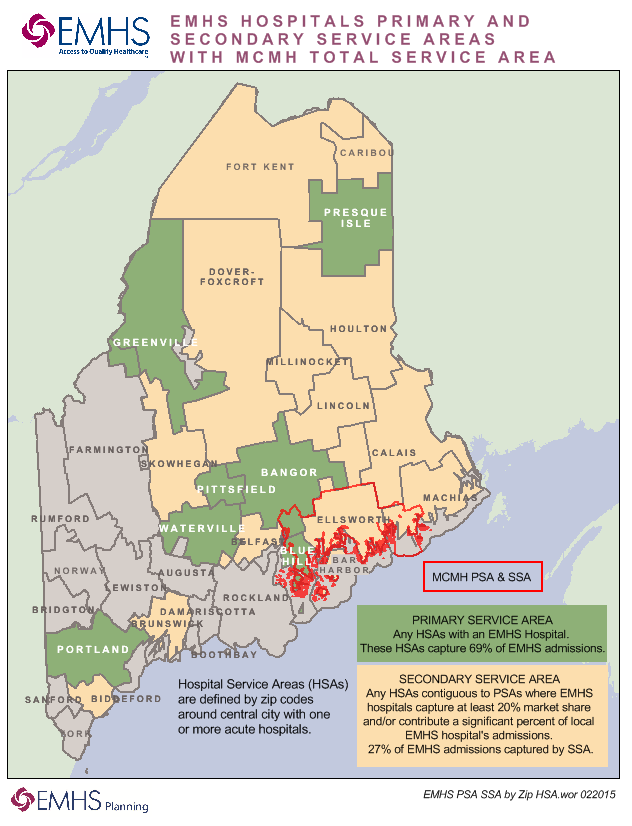
**Minimal Overlap between Service Regions**

**Market Impact Assessment:**

“EMHS and legal counsel have determined that a Hart-Scott-Rodino pre-merger notification to the Federal Trade Commission / Department of Justice is unnecessary. The Hart-Scott-Rodino statute and regulations employ a “size- of-transaction” test which is only met if the value of the non-exempt assets to be acquired or held as a result of the Affiliation would exceed $75.9 million as of the closing date. It has been preliminarily determined that the Affiliation will not meet the “size-of-transaction” test. EMHS has been informally working with the Maine Attorney General’s Office keeping them apprised of these issues.”

**Figure 8** illustrates the lack of overlap of the two systems’ service areas.

**Figure 8: EMHS and MCMH Service Areas**



“EMHS’ current service area is defined using the Maine Health Data Organization’s (MHDO’s) definitions of Hospital Service Areas (HSAs). The Primary Service Area includes the HSAs that contain the eight (8) EMHS hospitals and selected adjacent HSAs that contribute a high number of EMHS’ patients. In 2012 these areas accounted for 69% of EMHS’ admissions. EMHS’ Secondary Service Area (SSA) includes eleven (11) additional HSA’s that contributed another 27% of EMHS’ 2011 admissions. The proposed affiliation does not change EMHS’ total service area; the Ellsworth Hospital Service Area is already included in EMHS’ secondary service area. This service area definition methodology is consistent with that used for MCMH as described in Section IV.”

**CMS notification**

“MCMH has commenced a detailed analysis of the Centers for Medicare and Medicaid Services (CMS) Form 855 requirements necessary to effect a change under a member substitution.”

**Payor Mix Assumptions**

Table 18 and Attachment F include the revenue assumptions by payor mix incorporated into the projected financial statements in Attachment F. Payor mix recognizes the commencement of the insurance exchanges, or marketplaces, designed by the Affordable Care Act. Patients who are self-pay currently will have the opportunity to move to the Exchange payor mix classification. Medicare and Medicaid will comprise 58% of patient revenues over time. The assumptions surrounding price increases and reimbursement increases are consistent with each party’s existing managed care contracts and are not impacted by the Project. The reimbursement assumptions take into consideration Federal health payment reform, insurance marketplaces, and changing demographics.”

**Table 18: Payor Mix Assumptions**



**Summary of Orderly and Economic Development**

“The proposed affiliation is consistent with the orderly and economic development of Maine’s healthcare system as demonstrated by:

* The Affiliation will facilitate EMHS’ and its affiliates’ success under population health payment models by integrating the population health network throughout Maine
* The Affiliation will add to the scale needed to streamline administrative costs and provide access to affordable capital.
* Community health will be improved through collaboration and community benefit activities.
* No providers or payors in the region will be adversely affected.
* After extensive review, MCMH is certain an affiliation with EMHS is the alternative that most effectively provides enhanced access to services, improves population health, and reduces costs.
* EMHS has demonstrated success in assisting Maine hospitals through its previous affiliations and cooperative initiatives. See the information about Mercy Hospital’s integration below.”

“EMHS will provide MCMH with access to affordable capital, revenue cycle improvement, and to a statewide accountable care network.”

**Mercy Integration – A Case Study**

“EMHS has experience integrating other hospitals into its system. Most recently, Mercy joined EMHS, effective October 1, 2013. By working closely together on cost management and by supporting Mercy’s growth initiatives, already underway at the time of its affiliation with EMHS, Mercy has seen significantly improved financial results, as shown in **Table 19**. First year results indicated that over $2 million was saved as a product of its EMHS affiliation. EMHS will apply similar process improvement techniques working with MCMH leadership.”

**Table 19: Mercy Health System of Maine - Financial Improvement Post Affiliation**



“Mercy has been closely integrated into EMHS since the affiliation commenced. The financial turnaround is credited to revenue cycle improvements, streamlined administrative services, use of shared care management expertise as part of Beacon Health LLC, and upgraded information systems technology which links patient clinical information across sites of care. Mercy’s leadership team is advising on integration processes to improve the process in the future.”

## B. Certificate of Need Unit Discussion

### i. CON Standards

The relevant standard for inclusion in this section are specific to the determination that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

* The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;
* The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and
* The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available.

### ii. CON Unit Analysis

This project should result in a net decrease in overall health care expenditures. Previous sections of this application thoroughly describe the synergies and corresponding reduction in overhead and redundancies achieved through this transaction. $6.1 million dollars in projected cost savings are planned by the third year of this project from reductions in employee health care costs, supply costs and transaction costs. Improvements in the revenue cycle should also improve the bottom line of Maine Coast. An analysis of EMHS and Maine Coasts primary and secondary service areas shows very little overlap between the two service areas. Maine Coasts total service area covers almost all of Hancock and western Washington County. This is primarily a rural area and parts of the service area are considered medically underserved with shortages of both Primary Care and Dental Health Professional shortage areas. EMHS primary service area includes the health service areas that contain eight EMHS hospitals and surrounding areas that contribute 69% of EMHS hospital admissions. Their secondary service area includes eleven additional health service areas which contribute an additional 27% of EMHS hospital admissions. Neither service area will change as a result of this affiliation. Since EMHS and Maine Coast operate in separate and distinct service areas the impact on competing providers within Maine Coast’s primary and secondary service areas will be minimal.

State funds should not be materially impacted by this transaction. There should not be any increased utilization of these services because of this proposed transaction.

**Anti-Trust Determination**

Hart-Scott-Rodino

The Hart-Scott-Rodino Act established the federal premerger notification program, which provides the FTC and the Department of Justice with information about large mergers and acquisitions before they occur. The parties to certain proposed transactions must submit premerger notification to the FTC and DOJ. Premerger notification involves completing and HSR Form, also called a “Notification and Report Form for Certain Mergers and Acquisitions”, with information about each company’s business. The parties may not close their deal until the waiting period outlined in the HSR Act has passed, or the government has granted early termination of the waiting period.

The Hart-Scott-Rodino act employs a size of transaction test which is only met if the value of the non-exempt assets to be acquired or held as a result of the affiliation would be in excess of $75.9 million dollars at the closing date. EMHS and legal counsel have determined that this transaction does not meet the size of transaction test. The applicant states that it has been keeping the Maine Attorney General’s Office informed about this issue.

Maine Coast explored other alternatives to affiliating with EMHS:

1. Remain independent;
2. Work with other independent hospitals; and
3. Affiliate with another Maine system.

After careful consideration it was determined that EMHS brings all of the financial, operational and strategic resources necessary for the future success of Maine Coast. In addition there was a close alignment between the two organizations in the areas of overall mission and management philosophy. Affiliating with EMHS was considered the best alternative for all stakeholders. Based on this information it is unlikely that more effective, more accessible or less costly alternative technologies or methods of service delivery will become available.

### iii. Conclusion

CONU recommends that the Commissioner find that the applicant has met their burden to demonstrate that the proposed project is consistent with the orderly and economic development of health facilities and health resources for the State.

# Outcomes and Community Impact

1. **From Applicant**

“EMHS has an established record in the pursuit of quality care. Its clinical leaders for years have focused on “Zero Defects” in clinical care delivery. EMHS’ vision is *to become a nationally recognized model of healthcare delivery system.*  EMHS has a Board Quality Committee and is addressing quality inclusive of clinical outcomes of individuals and populations, patient experience, employee engagement, and reduction in care variation. EMHS’ approach is to encourage transparency and to promote the Triple Aim “plus one” – improved care, improved health, lower costs, and engaged staff.”

“MCMH also focuses significant efforts on achieving quality outcomes. EMHS quality programs will link MCMH to quality and performance improvement initiatives including the following: improving care transitions; medication safety; chronic disease management and hospital acquired infection reduction. By transitioning from Meditech, its current electronic medical record system to Cerner, EMHS’s system of choice, MCMH can hard wire reporting systems that not only meet the needs of required state and federal intermediary reporting, but also include local payor initiatives such as the Maine State Medical Home Pilot, the Maine State Employees health plan, and regional payors (e.g. Maine Community Health Options).”

“EMHS and MCMH are committed to assuring patients, payors and providers of their commitment to provide the highest quality and safety in all aspects of care. Both systems share a commitment to enhancing patient and family experiences with the use of evidence based design, quality monitoring systems and other resources. Both organizations strive for the achievement of the Triple Aim: improved healthcare for individuals, improved health of populations and reduced cost of care.”

“This affiliation will enhance the effort of EMHS in addressing critical issues related to population health. Efforts to reduce chronic disease will be enhanced to be a cohesive state-wide approach. MCMH will participate in these initiatives, among others:

* Patient Centered Medical Homes (PCMH) - EMHS has a mature network of Tier 3 PCMHs. Their expertise in care coordination will assist MCMH in further enhancing these services in southern Maine. Additionally, EMHS has a full spectrum of behavioral health services which have been integrated into these practices.
* Maine Care Value Based Purchasing (VBP) initiative - EMHS has provided feedback to Maine DHHS as MaineCare uses the SIM grant to develop value based purchasing pilots. MCMH and EMHS will work together on MaineCare services.
* Beacon Health LLC – While MCMH practices are involved with Beacon Health, joining EMHS will accelerate the application of care management and the use of population health analytics. EMHS is now using predictive risk modeling to identify and manage patients at risk for acute episodes, use of emergency services, and hospital admissions. EMHS, and now MCMH, has access to population health analytics developed by HealthInfoNet and by the Northern New England Accountable Care Collaborative (NNEACC)
* Chronic conditions such as Diabetes, Heart Disease, COPD, Obesity and Smoking will be able to be addressed through these efforts. This links to MCMH’s community health focus areas, as described in Section IV.”

“The Boards of EMHS and MCMH review quality performance measures at least quarterly. These metrics include:

* National Quality Forum Measures.
* CMS Core Measures.
* Patient Satisfaction Data.
* Other publically reported data.
* VNA publically reported data.”

“MCMH will participate in all EMHS sponsored clinical integration programs. These include:

* CMS and Joint Commission data submissions regarding process and outcomes of care.
* EMHS Zero Defect Monitoring Program
* Patient satisfaction data.
* Participation in the Annual Leapfrog Group patient safety survey.
* Active participation in Maine Health Management Coalition that includes data displayed on their site: *Get Better Maine*.
* Statewide Hand Hygiene Monitoring Program
* High Value Health Collaborative – EMHS”

“Results of these activities are published on public sites. [MCMH](http://www.google.com/search?q=mercy&sourceid=ie7&rls=com.microsoft:en-us:IE-SearchBox&ie=&oe=&safe=active#hl=en&gs_rn=7&gs_ri=psy-ab&pq=mercy&cp=9&gs_id=n&xhr=t&q=mercy+hospital+portland+maine&es_nrs=true&pf=p&safe=active&rls=com.microsoft:en-us%3AIE-SearchBox&sclient=psy-ab&oq=mercy+hos&gs_l=&pbx=1&bav=on.2,or.r_qf.&bvm=bv.44442042,d.dmg&fp=407c7b6da5609c4c&) will publish results in the same manner and to the same extent as other hospital members of [EMHS](http://www.google.com/search?q=mercy&sourceid=ie7&rls=com.microsoft:en-us:IE-SearchBox&ie=&oe=&safe=active#hl=en&gs_rn=7&gs_ri=psy-ab&pq=mercy&cp=9&gs_id=n&xhr=t&q=mercy+hospital+portland+maine&es_nrs=true&pf=p&safe=active&rls=com.microsoft:en-us%3AIE-SearchBox&sclient=psy-ab&oq=mercy+hos&gs_l=&pbx=1&bav=on.2,or.r_qf.&bvm=bv.44442042,d.dmg&fp=407c7b6da5609c4c&). Quality and patient experience measures are consistently monitored to assess opportunities for improvement.”

“The Affiliation will support the public’s demand for access, choice and cost efficient care in MCMH’s primary and secondary service areas.  MCMH will become part of a fully aligned healthcare system, focused on Maine-based clinical and quality improvement initiatives and programs.  This will allow MCMH to shift resources, standardize process improvement and simplify reporting structures.  The combined resources of the quality and clinical teams of MCMH and EMHS will enable the creation and implementation of care plans across Maine to the benefit of patients, employers and payors.”

**Region’s Capacity for Services**

“The proposed affiliation will not result in any adverse change in the range or level of services MCMH or EMHS offer in the region. This proposal is not expected to change existing capacity or affect other providers in the MCMH’s Primary or Secondary Service Area. The methodology for defining these service areas was reviewed in Section IV. As discussed in other sections of this application, with MCMH’s participation in the EMHS ACO, access to care will be improved.”

## B. Certificate of Need Unit Discussion

### i. CON Standards

The relevant standard for inclusion in this section are specific to the determination that the project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.

### ii. CON Unit Analysis

Maine Coast’s clinical outcomes will be enhanced from participation in EMHS’s population health status improvement initiatives, clinical integration and quality improvements initiatives and programs. Both EMHS and Maine Coast review quality measures quarterly.

The applicants provided a significant amount of demographic and statistical information regarding both EMHS and Maine Coasts primary and secondary service areas and the services provided in these areas. As stated in previous sections there is little overlap in primary service areas between EMHS and Maine Coast. Maine Coast’s affiliation with EMHS will result in no new health services being added in the area. As a result, the project will not negatively affect the quality of care delivered by existing service providers.

In order to ensure that anticipated improvements in quality and outcome measures occur, CONU recommends that EMHS and Maine Coast report improvements in quality and outcome measures for a period of three years from the affiliation date.

**Condition:**

* The applicant is to report improvements in quality and outcome measures for three years following the commencement of the CON.

### iii. Conclusion

CONU recommends that the Commissioner find that the applicant has met their burden to demonstrate that this project will ensure high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers.

# Service Utilization

## From Applicant

“The residents of Hancock and Western Washington Counties will benefit from the Affiliation including access to a larger growing primary care network and integrated specialty service lines. EMHS’ intention is to provide care close to home whenever possible, the right care in the right place.”

**Summary of Service Utilization**

“The historical and projected utilization of MCMH is reviewed in Section IV. Table 16 shows anticipated volume changes, which are incorporated into the financial projections in

Attachment F. A summary of key assumptions is as follows:

* Inpatient volumes in the region are projected to decrease slightly over the next five years. The upward pressure on utilization rates from an aging population will be offset by population health management strategies from EMHS and others.MCMH inpatient admissions are projected to remain at essentially current levels
* Outpatient volume is projected to increase.
* Emergency department visits will increase moderately.
* As patients get care in lower-cost settings and as chronic disease management and primary and secondary prevention programs expand, outpatient visits will grow modestly both in the region and at MCMH, Table 15 and Table 16.”

## B. Certificate of Need Unit Discussion

### i. CON Standards

The relevant standard for inclusion in this section are specific to the determination that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum as established in Title 24-A, section 6951, when the principles adopted by the Maine Quality Forum are directly applicable to the application.

### ii. CON Unit Analysis

This application involves the affiliation of Maine Cost with EMHS and does not result in the addition of new health services or the expansion of existing services. This affiliation will improve quality outcomes, address identified community needs, encourage clinical integration and improve the health status of the population in Maine Coast’s service area. As discussed earlier in the application the joint Maine Coast/EMHS focus on community centered primary care will decrease inappropriate and unnecessary hospitalizations and Emergency Department utilization. This will have a positive impact on patient care.

### iii. Conclusion

CONU recommends that the Commissioner find that the applicant has met their burden to demonstrate that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum.

# VIII. Timeline

## A. From Applicant

“EMHS and MCMH will comply with notification timelines required by CON regulations. Key dates to date are as follows:

* February 11, 2015: Letter of intent/reviewability sent.
* March 2, 2015: Technical Assistance meeting with Healthcare Oversight staff and representatives of MCMH and EMHS.
* April 22, 2015: Application filed and declared complete”

## Certificate of Need Unit Discussion

**Activity Date**

Letter of Intent Received 02/09/2015

Subject to CON Letter Issued 02/12/2015

Technical Assistance Meeting Held 03/18/2015

Application Filed 04/24/2015

Public Information Meeting Waived

Public Hearing (PH) 06/01/2015

Pre Release Technical Assistance Meeting 06/30/2015

Close of Public Record (PH) 07/01/2015

Release of Preliminary Analysis 07/10/2015

Close of Comment Period 07/31/2015

# IX. CON Findings and Recommendations

Based on the preceding analysis, including information contained in the record, the CONU recommends that the Commissioner make the following findings and recommendations subject to the conditions below:

A. That the applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant’s control meets industry standards.

B. The economic feasibility of the proposed services is demonstrated in terms of the:

1. Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and

2. The applicant’s ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.

C. The applicant has demonstrated that there is a public need for the proposed services as demonstrated by certain factors, including, but not limited to:

1. The extent to which the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

2. The project has demonstrated that it will have a positive impact on the health status indicators of the population to be served;

3. The project will be accessible to all residents of the area proposed to be served; and

4. The project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

D. The applicant has demonstrated that the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

1. The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;

2. The availability of State funds to cover any increase in state costs associated with utilization of the project’s services; and

3. The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available was demonstrated by the applicant.

In making a determination under this subsection, the commissioner shall use data available in the state health plan under Title 2, section 103, data from the Maine Health Data Organization established in chapter 1683 and other information available to the commissioner. Particular weight must be given to information that indicates that the proposed health services are innovations in high quality health care delivery, that the proposed health services are not reasonably available in the proposed area and that the facility proposing the new health services is designed to provide excellent quality health care.

E. The applicant hasdemonstrated that the project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers; and

F. The applicant has demonstrated that the project does not result in inappropriate increases in service utilization, according to the principles of evidence-based medicine adopted by the Maine Quality Forum.

**Conditions:**

* The applicant is to report cost savings attributable to the transaction for three years following the commencement of the CON.
* The applicant is to report improvements in quality and outcome measures for three years following the commencement of the CON.