

**Department of Health and Human Services
Division of Licensing and Regulatory Services
State House Station #11, Augusta, Maine
Preliminary Analysis**

Date: May 16, 2014

Project: Acquisition of Control of Franklin Community Health Network

Proposal by: MaineHealth

Prepared by: Larry Carbonneau, Manager Health Care Oversight
Richard Lawrence, Senior Health Care Financial Analyst

Directly Affected Party: Central Maine Health

Certificate of Need Unit Recommendation: Approval

	Proposed Per Applicant	Approved CON
Estimated Capital Expenditure	\$ 21,936,902	\$ 21,936,902
Maximum Contingency	\$ 0	\$ 0
Total Capital Expenditure with Contingency	\$ 21,936,902	\$ 21,936,902
Pro-Forma Marginal Operating Costs	\$ (375,000)	\$ (375,000)
MaineCare Neutrality Established		Yes

I. Abstract

From Applicant

“Franklin Community Health Network (FCHN) is organized and operated as a nonprofit health care corporation under § 501(c)(3) of the Internal Revenue Code. It is the sole corporate member of Franklin Memorial Hospital (“FMH”). FMH is a nonprofit, §501(c)(3) tax exempt Maine corporation. FMH is organized and operated solely for charitable, educational, scientific and benevolent purposes. Its primary purpose is to promote the provision of needed health care services in the communities in and around Franklin County, Maine, and outlying areas. FCHN and FMH are committed to maximizing community access to quality health care by providing cost effective options for health care services.”

“MaineHealth is a nonprofit integrated healthcare delivery system that is the parent of eight regional health delivery systems and their hospitals, employed physician practices and subsidiary healthcare organizations; a regional home health care organization; and other health care related entities located throughout southern, western and central Maine and eastern New Hampshire. MaineHealth also has strategic affiliation agreements with other local health systems within the same area. MaineHealth is the largest integrated healthcare delivery system in Maine. MaineHealth’s administrative offices are located in Portland, Maine. MaineHealth is organized and operated as a non-profit, tax-exempt healthcare corporation under §501(c)(3) of the Internal Revenue Code.”

“The FCHN Board of Trustees proposes to amend the FCHN Articles of Incorporation and Bylaws so that MaineHealth shall become its sole corporate member thereby making FCHN a subsidiary member of MaineHealth. The scheduled effective membership date is October 1, 2014 (the “Effective Date”), subject to obtaining all required consents and regulatory approvals.”

“As of the Effective Date the sole Member of FCHN will be MaineHealth. The Definitive Agreement between MaineHealth and FCHN reflects all consideration passing between MaineHealth and FCHN (See Exhibit 1-A: Definitive Agreement).”

“As of the Effective Date, FCHN and its subsidiaries, including FMH, shall require MaineHealth approval (the "Reserved Rights") for any of the following:

- Adoption of annual capital and operating budgets;
- Approval of business, marketing and strategic plans;
- Authorization of debt incurred, assumed or guaranteed in excess of \$250,000;
- Authorization of any acquisition, disposition, organization or investment in other corporation, limited liability company or joint venture;
- Authorization for any sale, capitalized lease, assignment, transfer, mortgage or encumbrance or properties or assets in excess of \$250,000;
- Authorization for any merger or consolidation;
- Authorization for institution of bankruptcy;
- Authorization for a capital investment in excess of \$250,000;
- Authorization for developing, implementing or termination of services other than those included in any approved strategic or financial plan;

- Amendment to the Articles of Incorporation of FCHN or its direct subsidiaries;
- Election, evaluation and termination of the FCHN Chief Executive Officer;
- Authorization for the commencement of litigation other than routine collection actions by FCHN or its direct subsidiaries; and
- Adoption and amendment of the FCHN Bylaws.”

“As of and after the Effective Date:”

“FCHN and its subsidiaries will be maintained as healthcare organizations in their current form. FMH will retain its §501(c)(3) tax-exempt, charitable status, hospital license, Medicare/Medicaid provider numbers and contractual relationships. Responsibility for the day-to-day operational control of FCHN and its subsidiaries including FMH will reside with FCHN, subject to ultimate oversight by MaineHealth.”

“As a member of MaineHealth, FCHN, its subsidiaries and providers will participate in the development and implementation of MaineHealth health status improvement, clinical integration, population health management, and quality improvement initiatives, all of which will improve the health care and health status of the greater Franklin County region.”

“All property of FCHN and its subsidiaries pre-closing will remain the property of FCHN and its subsidiaries. FCHN will retain its tax-exempt charitable status. Endowment funds of FCHN, including funds held in trust or otherwise for the benefit of FCHN or its subsidiaries will remain assets of FCHN.”

“As a MaineHealth member, FCHN will have access to shared administrative resources of the MaineHealth system, including purchasing, legal services, audit and compliance services, financial services, strategic planning, program development, information services and human resource management. FCHN will also participate in MaineHealth’s health benefit and workers’ compensation plans, and certain insurance coverage. FCHN will become a member of MaineHealth’s borrowing group. MaineHealth’s guaranty stands behind borrowing by any member of the group, providing access to capital with favorable terms.”

“There is no capital expenditure requiring a Certificate of Need as described in 22 M.R.S.A. § 329 (3) involved in MaineHealth acquiring control of FCHN (Membership). MaineHealth has agreed to make a capital contribution or provide credits to FCHN to support the implementation of an ambulatory electronic medical record for employed members of FMH’s medical staff, such system to be part of the MaineHealth system now under development (SeHR). MaineHealth will provide FCHN financial support of at least \$2.25 Million. MaineHealth and FCHN anticipate that FCHN would transition to SeHR no sooner than Fiscal Year Ending 2018. This commitment is exempt from CON. See, 22 M.R.S.A. § 329(3).”

“There are no incremental third year operating costs associated with this transaction. MaineHealth and FCHN forecast annual cost savings will offset FCHN’s MaineHealth membership dues as a result of the transaction.”

“MaineHealth is Fit, Willing and Able – Since 1996 MaineHealth’s integrated healthcare delivery system has expanded by adding eleven hospitals, two home health agencies and one hospital administrative support services organization into MaineHealth. For each transaction requiring Certificate of Need review and approval DHHS has determined that MaineHealth was fit, willing and able and has granted certificates of need authorizing MaineHealth’s acquisition of control for the nine hospitals located in Maine: Brighton Medical Center (since merged into Maine Medical Center), St. Andrews and Miles Memorial Hospitals (since merged with the surviving entity known as LincolnHealth), Stephens Memorial Hospital, Jackson Brook Institute/Spring Harbor Hospital, Waldo County General Hospital, Southern Maine Medical Center and Henrietta D. Goodall Hospital (since merged with the surviving entity known as Southern Maine Healthcare), and Penobscot Bay Medical Center; and one of the home health agencies: Community Health Services of Cumberland County.”

“MaineHealth has demonstrated that it has the organizational infrastructure and resources in place to ensure the quality of services at FCHN continues to improve and that FCHN maintains all appropriate licenses, certifications and accreditations. Leadership of both organizations anticipates that all key personnel at FCHN and MaineHealth will remain in place.”

“Is Economically Feasible – FCHN’s proposed MaineHealth membership involves no capital expenditure by MaineHealth or FCHN requiring a certificate of need. FCHN, MaineHealth, the State of Maine nor the Maine health care delivery system will incur any increase in operating expenses as a result of the Proposed Transaction. MaineHealth, as evidenced by its Standard and Poors A+ credit rating and its financial statements, has the financial capacity to support the Proposed Transaction.”

“Meets a Public Need – Based on an extensive review and analysis, FCHN’s Board of Trustees, Management and Medical Staff determined that FCHN could best meet its mission of providing high quality health care and improving the health of the communities it serves if it became part of a larger health system, choosing MaineHealth as the organization that best shares its not for profit values and its vision that health care is best delivered as locally as possible. FCHN will secure significant clinical, administrative and economic benefits from its MaineHealth membership, strengthening its ability to serve its communities.”

“FCHN’s MaineHealth membership will positively impact the health status of the greater Franklin County region and FCHN’s quality of care. As a result of the Proposed Transaction FCHN will become a member of a robust integrated healthcare system that is focused on clinical and community health improvement, quality and safety, population health management and administrative excellence. MaineHealth has developed and implemented the most comprehensive array of initiatives focused on population based health and prevention of disease of any organization in Maine and continues redirecting its resources to these initiatives. All MaineHealth members participate in these initiatives, contributing to their development and best practices.”

“Is Consistent with Orderly and Economic Development – FCHN’s membership in MaineHealth, (enabling it to take maximum advantage of the benefits described in this application to improve quality, to expand opportunities for collaborative efforts and to control costs) is consistent with the orderly and economic development of the healthcare delivery system.”

“MaineHealth’s acquisition of control of FCHN should not have any impact on regional and statewide health insurance premiums.”

“Outcomes and Community Impact – MaineHealth’s acquisition of control of FCHN will not negatively affect the quality of care provided by existing providers.”

“MaineHealth’s support and expertise will create additional opportunities for FCHN to improve the quality of care it provides and improve the health of its communities.”

“Service Utilization – Utilization of health care services by residents of the FCHN service area is not affected except to the extent that FCHN implementation of MaineHealth’s evidence-based, best practice health status improvement and clinical integration initiatives reduces utilization in the long term. This is the intent of MaineHealth’s population health management programs, which seek to align the delivery of care with the Triple Aim: improving patient experience, improving quality, and reducing overall cost of care.

FCHN joining MaineHealth will have no adverse impact on the utilization of services by residents of the service area.”

II. Fit, Willing and Able

From Applicant

“In order to determine that an applicant is fit, willing and able to provide the proposed services at the proper standard of care, the Certificate of Need Act states: “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.” (22 MRSA §335 (1) (7 A))”

“MaineHealth and FCHN are fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by the services previously provided by MaineHealth members and FCHN operating entities being consistent with applicable licensing and certification standards.”

“Franklin Community Health Network’s operating entities – Franklin Memorial Hospital, (including Franklin Health physician practices and NorthStar ambulance service) and Evergreen Behavioral Services– have provided health care services for years in a manner that has been consistent with applicable licensing and certification standards. Any “Statements of Deficiencies” and site visit reports from the previous three years for FMH are on file with the Department of Health and Human Services’ Division of Licensing and Regulatory Services. FMH is State Licensed, CMS Certified and fully accredited by the Joint Commission.”

“MaineHealth’s current members’ licenses, certifications and accreditations are numerous. All are State Licensed and CMS Certified; most are Joint Commission accredited. MaineHealth has demonstrated that its members are capable of delivering the proposed services at the proper standard of care. Any “Statements of Deficiencies” and site visit reports from the previous three years for all the Maine-based health care facilities and services in which MaineHealth and its members have been involved are on file with the Maine Department of Health and Human Services’ Division of Licensing and Regulatory Services. MaineHealth member Memorial Hospital is licensed by the New Hampshire Department of Health and Human Services’ Bureau of Health Facilities Administration.”

“MaineHealth members’ current licenses, certifications and accreditations demonstrate that MaineHealth related parties meet industry standards. Please refer to the table on the following page.

MaineHealth Members’ Current Licenses, Certifications and Accreditations

MaineHealth Member	Facility/ Service	State Licensed	CMS Certified	Joint Commission Accredited
Maine Medical Center	Hospital	✓	✓	✓
Maine Mental Health Partners	Hospital	✓	✓	✓
Lincoln County Health Care	Hospital	✓	✓	
	Nursing Home	✓	✓	
	Assisted Living	✓		
Western Maine Health Care	Hospital	✓	✓	
	Nursing Home	✓	✓	
	Assisted Living	✓		
Home Health Visiting Nurses of Southern Maine	Home Health	✓	✓	
NorDx	Lab Services		✓	
Southern Maine Health Care	Hospital	✓	✓	✓
	Nursing Home	✓	✓	
Waldo County Healthcare	Hospital	✓	✓	
	Home Health	✓	✓	
Pen Bay Healthcare	Hospital	✓	✓	✓
	Nursing Home	✓	✓	
	Assisted Living	✓		
	Home Health	✓	✓	
Memorial Hospital, North Conway, NH	Hospital	✓	✓	
	Nursing Home	✓		
Franklin Memorial Hospital (pending)	Hospital	✓	✓	✓

Franklin Community Health Network

111 Franklin Health Commons
Farmington, Maine 04938
<http://www.fchn.org>”

“Franklin Community Health Network, is a nonprofit, § 501(c)(3) tax-exempt, integrated healthcare delivery system formed in 1991. It is the parent entity for a system that includes FMH (including Franklin Health physician practices and NorthStar ambulance service), Evergreen Behavioral Services, and Healthy Community Coalition of Greater Franklin County. FCHN provides accounting and financial oversight, human resources, planning, facilities, maintenance, purchasing, and other administrative supports for all its entities.”

“Mission: **To work cooperatively with other concerned individuals and organizations to achieve the highest level of health and wellness possible for the people of west central Maine.**”

“Vision: To be the best rural healthcare organization in New England by expressing our values of pride, innovation, caring and excellence, and by centering our work on nine basic “Foundation Stones” as the best means to accomplish our mission.”

- “People - Be a healthcare employer of choice in Maine by emphasizing mission and values-based recruitment, employee and physician satisfaction, and leadership development.”
- “Service - Provide compassionate care and service excellence to all customers at a level that is at the highest standard for healthcare in New England.”
- “Quality - Constantly improve the quality, safety, effectiveness, and efficiency of services we provide measured against the highest standards and best practices in the country.”
- “Growth - Increase the scope of services provided, service volumes, and market share to meet the needs of the people and communities we serve, enhance the region’s economy, and preserve our financial health.”
- “Finances - Remain financially strong by consistently operating in a fiscally prudent manner and by careful stewardship of the community resources that are our fiduciary responsibility.”
- “Community - Remain centered on doing what is right for the community we serve. Continue as locally controlled and owned, but seek affiliations that benefit those we serve. Give equal priority to providing outstanding patient care and improving community health. Be accountable to the community through public disclosure of our performance. Build community infrastructure where such efforts are needed, welcomed and can make a difference to the overall health of the community.”
- “Collaboration - Work collaboratively with all individuals and organizations where mutual efforts will best serve the missions and goals of both organizations and the community. Respect the independence of other organizations in the community.”
- “Integration of Care - Integrate best practice clinical services and systems so patients can receive the care they need with maximum continuity, quality and convenience. Use information systems to integrate medical care and public health services so patients obtain optimal care and the communities we serve achieve the highest level of health and wellness possible.”
- “Access - Assure everyone in our service area can obtain the care they need. Reduce barriers to care for all residents, such as lack of insurance, income, transportation and information.”
 - “Values:
 - Pride - To nurture pride and enthusiasm about the mission of FCHN within our organization and the communities we serve by engaging staff and residents through connections to our work, values and vision.
 - Innovation - To create the best means of fulfilling our mission with limited resources by using our creativity and being open to change.
 - Caring - Too consistently show respect for all we serve and the staff and members of Franklin Community Health Network based on the human dignity of every person.
 - Excellence - To become the best we can.”

“Affiliated Entities”

“Franklin Community Health Network (FCHN), a nonprofit integrated network formed in 1991, is the parent entity for a system that includes FMH, Evergreen Behavioral Services and Healthy Community Coalition of Greater Franklin County. FCHN provides accounting and financial oversight, human resources, planning, facilities, maintenance, purchasing, and other administrative supports for all its entities.”

“Franklin Memorial Hospital, a 65-bed JCAHO accredited hospital located in Farmington, Maine, is a progressive, friendly, nonprofit community hospital whose mission is to provide high-quality, cost-effective, patient-centered health care. FMH provides a broad range of medical, surgical, pediatric, women’s care, and diagnostic services. Top quality specialty care is offered including: cardiology, oncology and hematology, orthopedics, urology, ophthalmology, podiatry, occupational health, pain management, pediatric endocrinology, physical rehabilitation, pulmonology, sleep disorders, sports medicine, and wound care.”

“Franklin Health, a Department of FMH, is a provider-based multi-specialty group practice that includes eleven medical and surgical practices; specialties, include internal medicine, family medicine, pediatrics, obstetrics and gynecology, dermatology, general surgery, orthopedics and behavioral health. Practice sites are located at the Mount Blue Health Center located on FMH’s campus in Farmington and at the Androscoggin Valley Medical Arts Center, Livermore Falls.”

“NorthStar, a Department of FMH, is the regional ambulance service established in 2005 that serves 71 communities in Northwestern Maine. NorthStar’s coverage area includes all of Franklin County and parts of Oxford, Somerset, Androscoggin, and Kennebec counties, approximately 2,800 square miles of mostly rural territory (8.3% of Maine’s landmass).”

“Evergreen Behavioral Services, a 24/7 emergency mental health response and community outreach service provider, was formed in 1994 to address a community-identified need for expanded mental health services in Franklin County and surrounding areas.”

“Healthy Community Coalition a/k/a Healthy Community Coalition of Greater Franklin County, founded in 1989, is one of the oldest health coalitions in the country. Its mission is to measurably improve the well-being of all people in Greater Franklin County and neighboring towns using a coordinated public health approach of education, promotion, and outreach. With its qualified staff of public health professionals, Healthy Community Coalition offers health screenings, health information, and programs and events to support healthy lifestyles that prevent disease and improve quality of life. Its community outreach efforts appear in every town and corner of the region.”

“Pine Tree Medical Associates – An inactive §501(c)(3) health care corporation.”

“Please refer to Exhibit 2-A: Franklin Community Health Network’s Current Organizational Chart”

“Please refer to Exhibit 2-B: Franklin Community Health Network’s Proposed Organizational Chart”

“Please refer to Exhibit 2-C: Franklin Community Health Network’s 2013 Annual Report.”

“MaineHealth

465 Congress Street
Suite 600
Portland, Maine 04101”

“<http://www.mainehealth.com>”

“MaineHealth’s vision is: *Working together so our communities are the healthiest in America.*”

“MaineHealth is a non-profit §501(c)(3) health care corporation, with the purpose of developing a broad range of integrated health care services in Maine through member organizations, including hospitals and other health care provider organizations.”

“MaineHealth’s service area is defined in the following manner:

Primary: Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo and York counties in Maine and Carroll County, New Hampshire.

Secondary: Aroostook, Hancock, Penobscot, Piscataquis and Washington counties.”

“MaineHealth Members, Affiliated Entities & Related Parties”

“MaineHealth consists of the following members:

Maine Medical Center – hospital; Maine Medical Partners – physician practices, physician and practice management services; MMC Realty Corp - real estate. Maine Medical Center is involved in the following joint ventures:

- Maine Heart Center – joint venture with cardiologists, cardiac surgeons and anesthesiologists for managed care contracting;
- MMC Physician Hospital Organization (PHO) - a joint venture with Community Physicians of Maine;
- New England Rehabilitation Hospital of Portland - joint venture rehabilitation hospital with HealthSouth;
- MMC/MaineGeneral Medical Center Joint Venture Cath. Lab; and
- Cancer Care Center of York County –MMC/Southern Maine Health Care joint venture radiation therapy center.”

“Maine Mental Health Partners – psychiatric hospital and integrated system of mental health providers serving MaineHealth’s primary service area.”

“Lincoln County Health Care – oversees and coordinates integrated health care services of LincolnHealth, Cove’s Edge and Lincoln County Medical Group.”

- “LincolnHealth – hospital, nursing home and assisted living.”
- “Cove’s Edge - nursing home and assisted living”.
- “Lincoln County Medical Group – physician employment.”

“Western Maine Health Care – hospital (Stephens Memorial Hospital) and physician practices.

Southern Maine Health Care –hospital, physician practices, nursing homes and home health agency.”

“Waldo County Healthcare – hospital, home health agency, hospice and retirement community.

Pen Bay Healthcare – hospital, nursing home, home health agency and retirement community.”

“Memorial Hospital, North Conway, New Hampshire – hospital, physician practice, nursing home.”

“Franklin Community Health Network (Pending) - hospital, physician practice, ambulance service, crisis mental health service, and community health coalition.”

“NorDx, Scarborough, Maine – general and reference lab.”

“Home Health Visiting Nurses of Southern Maine – home health care.”

“Concentra Health – Formerly Occupational Health & Rehabilitation, Inc., joint venture limited liability corporation providing occupational health services.”

“Maine Molecular Imaging – joint venture providing positron emission tomography (PET) scans.

Synernet – business corporation providing medical transcription services, revenue cycle management, group purchasing and consulting services for its member organizations.”

“The rationale for these organizations joining MaineHealth has the following common themes:

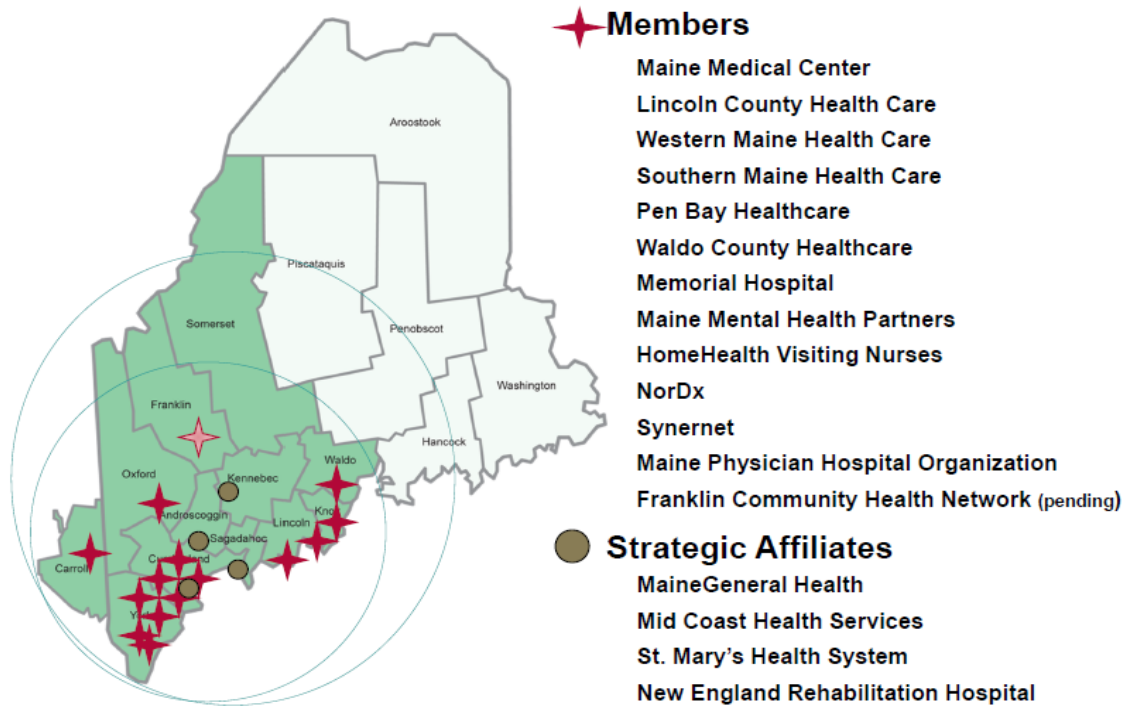
- Achievement of clinical and financial benefits from economies of scale;
- Cost effective access to capital;
- Avoidance of unnecessary duplication of services and improving efficiency, access and quality.

In addition to bringing these organizations into its corporate structure, MaineHealth has established strategic affiliation agreements with the following organizations. These affiliations seek to improve quality, access and efficiency through cooperative efforts:

- MaineGeneral Health/MaineGeneral Medical Center (1997)
- Mid Coast Health Services/Mid Coast Hospital (1999)
- St. Mary’s Regional Medical Center (2000)”

“Please refer to Exhibit 2-D: MaineHealth’s organizational chart showing MaineHealth members, FCHN as a pending member, strategic affiliates and joint ventures.”

“Locations of MaineHealth Members and Affiliates



MaineHealth members deny no one care, regardless of ability to pay. During Fiscal Year 2012 (October 1, 2011 through September 30, 2012) MaineHealth and its members provided a variety of programs and services without reimbursement or any other compensation. The value of these community benefits in FY 2012 was \$315,288,018.”

“Please refer to Exhibit 2-E: MaineHealth 2012 Community Benefit Report.”

“MaineHealth Management Approach”

“Through definitive agreements, MaineHealth and its members have defined their roles, responsibilities and expectations. MaineHealth’s approach to governance and management can best be described as a “decentralized model.”

“Each member’s board, medical staff and management retain field responsibility for policy, management, fiscal affairs, clinical program development, quality and safety and performance improvement. The CEOs of each member along with the MaineHealth senior staff recommend policy and program development and budget performance targets to the MaineHealth Board of Trustees. The MaineHealth Board reviews and approves members’ budgets, strategic and financial plans, property acquisitions and dispositions, debt financing above a certain level and major capital projects.”

“MaineHealth Commitment to Quality”

“MaineHealth Board vision for quality and safety is that by 2017 MaineHealth will be a nationally recognized leader in health care quality and safe patient and family centered care. MaineHealth is recognized by patients, payers and providers for setting the benchmark for quality and safety, patient and family experience and evidence based use of resources.”

“The MaineHealth Board of Trustees has an active Quality Committee, which monitors MaineHealth’s performance on key measures of quality and reports on a quarterly basis to the full Board. Its reviews center on system and member organization performance on:

- National Quality Forum hospitals measures,
- Home health clinical measures,
- Long term care clinical measures and
- Patient satisfaction measures.”

“MaineHealth has established the MaineHealth Center for Quality and Safety under the direction of Dr. Vance Brown, MaineHealth Chief Medical Officer. The Center focuses on:

- Data management analysis and reporting to support quality and patient safety initiatives
- Education and consultation on improvement science, methodologies, and system redesign
- Program evaluation to assist with the design and implementation of methods to assess effectiveness and value of various MaineHealth programs.”

“From 2007 through 2012 MaineHealth has been named by SDI (formerly Verispan) to its annual lists of the Top 100 Integrated Health Networks (based on an independent assessment of operations, quality, scope of services and efficiency). A 2013 top 100 list was not produced.”

“Under MaineHealth’s leadership, MaineHealth members have been recognized by a wide variety of organizations for the quality of services they provide to their communities. Those organizations include the Leapfrog Group, the Joint Commission, the American Nurses Credentialing Center, US News and World Report and the American Colleges of Surgeons and Radiology among others.”

“Please refer to Section VI: Outcomes and Community Impact for further information.”

“MaineHealth Participation in the High Value Healthcare Collaborative”

“MaineHealth is a member of the High Value Healthcare Collaborative (HVHC), a consortium of 19 healthcare delivery systems and the Dartmouth Institute for Health Policy and Clinical Practice. HVHC Members include Dartmouth Institute for Health Policy and Clinical Practice, Dartmouth-Hitchcock, Denver Health, Intermountain Healthcare, Mayo Clinic, Baylor Health Care System, Beaumont Health System, Beth Israel Deaconess Medical Center, Eastern Maine Health Systems, Hawaii Pacific Health, MaineHealth, North Shore-LIJ, NYU Langone Medical Center, Providence Health & Services, Scott & White Healthcare, Sinai Health System, UCLA Health, University of Iowa Health Care, Virginia Mason Medical Center.”

“HVHC Mission and Goals”

“The mission of the HVHC is to improve healthcare value – defined as quality and outcomes over costs, across time – for its service population, in a sustainable manner, while serving as a model for national healthcare reform.”

“HVHC’s goals are to improve care, improve health, and reduce costs by identifying and accelerating widespread adoption of best-practice care models and innovative value- based payment model.”

“MaineHealth is participating in all of the high-cost, high-variation conditions/ treatments prioritized by the collaborative. These include increasing patient engagement by:

- Implementing shared decision making interventions for preference-sensitive decisions (hip and knee replacement, spine surgery);
- Advancing best practice care models for patients considering hip, knee or spine surgery and for patients with diabetes and congestive heart failure;
- Disseminating best practices to improve care of sepsis patients.”

“MaineHealth emerged as a leader in the HVHC early on because of its experience with shared decision making, complex care management, and surgical quality outcomes. MaineHealth’s diabetes care model is being used nationally by HVHC members. Baseline data in hip and knee surgery demonstrate that Maine Medical Center (a MaineHealth member) has some of the lowest length of stay rates among all members of the collaborative. In addition, there has been a downward trend in discharge rates for patients with heart failure and diabetes who are attributed to MaineHealth’s Accountable Care Organization.”

“For more information please refer to: <http://highvaluehealthcare.org/>”

“MaineHealth Accountable Care Initiatives”

“MaineHealth has defined four fundamental strategies that support the goal of improving the patient experience and health outcomes, while at the same time containing and reducing the overall cost of care. These four strategies are:

- Primary Care Transformation: develop patient centered medical homes for primary care practices;
- Care Coordination: examine and improve Care Coordination practices and capabilities;
- Information at the Point of Care: leverage the investment in a Shared Electronic Health Record (SeHR) and the Northern New England Accountable Care Collaborative (NNEAC) to inform the delivery of care;
- Transparency: advance a policy of transparency and pro-active review of the quality and efficiency care provided patients served by Participants in the MaineHealth Accountable Care Organization”

“Important progress has been made in each of these areas as MaineHealth has oriented its clinical and administrative communities to the demands and opportunities of accountable care. At the same time, MaineHealth and the Maine Medical Center Physician Hospital Organization (MMC PHO) have engaged in deliberate, planned efforts with major payer organizations – MaineCare, Anthem, Aetna, and Medicare - in efforts to re-design the contracts that underpin healthcare delivery. Each of these efforts has involved collaborative discussions regarding implementation of payment reform, programs that will generate long term reductions in the cost of health care for local employers and citizens and lasting improvements in the quality of care and engagement of patients. In presentations to the Maine Health Management Coalition and other groups, MaineHealth has outlined plans to follow a deliberate, a transitional approach to global budgets, and many stakeholders have acknowledged that a good place to start in this effort is with primary care.”

“MaineHealth and Maine Medical Center Physician Hospital Organization Capabilities”

“Long before the formation of the MaineHealth Accountable Care Organization (MHACO), MaineHealth developed a track record for ensuring patient access to the full continuum of care and care options. In 2010, MaineHealth ranked 26th among the nation’s top 100 integrated health networks for excellence in contractual capabilities, services and access, integration, and other features. Our Care Partners and Med Access Programs for uninsured and/or low-income adults (supported by the Maine Health Access Foundation) and the charity care provided by our members, all demonstrate our commitment to improving access.”

“MMC PHO supports practices to make changes that improve care quality and patient satisfaction while decreasing the cost of care. MMC PHO collaborated with MaineHealth to develop and implement a web-based Clinical Improvement Registry in 2003, and to provide practices with highly trained RN care managers, transitional care coordinators, and practice coaches whose work is helping to achieve the Triple Aim. MMC PHO administers pay-for-performance programs that provide primary and specialty care practices with financial incentives for changes that improve care quality and patient satisfaction.”

“MaineHealth Participation in National and State Accountable Care Programs”

“Medicare Shared Savings Program (MSSP)”

“In July of 2012, the MaineHealth Accountable Care Organization (MHACO) was designated one of 89 new Accountable Care Organizations (ACO) in MSSP. MaineHealth was previously offered a spot in the more advanced Pioneer ACO program, which after careful deliberation, we elected not to pursue.”

“The high quality performance of MHACO is demonstrated by the results published in Medicare’s ACO 2012 Quality Performance Report, the first for MHACO’s participation in MSSP. The 2013 reports have not been released. In comparison to 406 other ACOs nationally, MHACO performed above the median on 28 of the 33 measures and scored above the 90th percentile level on four.”

“Please see Exhibit 2-F: MaineHealth ACO 2012 Quality Performance Report.”

“Medicare Imaging Demonstration”

“In 2010, MMC PHO was one of five conveners selected nationally by the Centers for Medicare and Medicaid (CMS) to participate in the Medicare Imaging Demonstration, testing how use of decision support improves quality of care and efficiency and reduces unnecessary radiation exposure, by promoting appropriate ordering of advanced imaging services. Over 900 attending physicians, residents, and advance practice practitioners are participating. CMS officials have commented that clinicians in the MaineHealth/MMC PHO program demonstrate significantly broader uptake and compliance with programmatic objectives that other nationally recognized project conveners.”

“Community Care Transitions Program (CCTP)”

“In November 2011, MaineHealth and the MMC PHO, under a partnership led by the Southern Maine Agency on Aging, were selected by Center for Medicare and Medicaid Innovation as one of seven first-wave organizations to participate in CCTP. This program augments the existing RN Care Management program operated by the PHO.”

“Dedicated to providing assistance to high risk patients, RN Care Managers are embedded in physician practices, supporting patients, their families, and practice teams. In 2013, the Care Management Program achieved a 31% reduction in admission rates for patients enrolled in Care Management vs. those who declined enrollment. The program achieved a 30% reduction in dangerous blood sugar levels for patients with diabetes, and a 13% improvement in blood pressure for patients with coronary artery disease. These outcomes have a tremendous impact on the lives of patients served and result in a significant decrease in the cost of their care.”

“Commercial Accountable Care Programs”

“The MaineHealth ACO is among the very few ACOs nationally who have Agreements in place with both government and commercial payers. Over 25,000 commercially-insured patients are covered under MaineHealth ACO Agreements with three different payers, with whom MaineHealth has agreed to manage the cost of care to meet a specific medical cost target and to hit a range of specific quality benchmarks. Strong performance on the quality benchmarks determines any eligibility for gain sharing under these contracts.”

“MaineHealth’s Patient Centered Medical Home Learning Collaborative”

“The Patient Centered Medical Home (PCMH) Collaborative is a MaineHealth strategic initiative that supports our members’ strategies for creating a strong primary care network within each hospital service area. The PCMH has emerged as a priority and its importance continues to be underscored as MaineHealth repositions itself as a leader in accountable care through the redesign of our care delivery and financing systems. MaineHealth also recognizes that the communities served benefit from a common strategy across employed and independent practices.”

“MaineHealth and MMC PHO have partnered to develop the PCMH Collaborative to support both employed and independent practices transform to a Patient Centered Medical Home. The goal of the PCMH Learning Collaborative is to provide the knowledge, skills and tools necessary for practice teams to optimize care through a patient centered, coordinated approach.”

“The teams receive support as they move through the transformation process and have access to improvement coaching and technical assistance. Teams have access to a range of learning opportunities and support services that are tailored to meet individual practice needs. MaineHealth and MMC PHO partner with each practice to assess strengths and opportunities for transformation based on the National Center for Quality Assurance’s Patient Centered Medical Home Standards and Guidelines. These assessments are used to plan for future practice and system needs.”

“MaineHealth and FCHN Key Personnel”

“The following are the key senior managers involved in this proposal. Leadership of both organizations anticipates that all will continue in their respective positions following FCHN becoming a member of MaineHealth.”

“William Caron, President & Chief Executive Officer, MaineHealth. Prior to his current position, Mr. Caron was Executive Vice President and Treasurer at MaineHealth and Vice President and Treasurer at Maine Medical Center in Portland, Maine. He previously was a Partner with Ernst & Young and headed their East Region healthcare consulting practice in Philadelphia, Pennsylvania.”

“Frank McGinty, Executive Vice President & Treasurer, MaineHealth. Prior to his current position, Mr. McGinty was a senior executive of Blue Cross and Blue Shield of Maine as Senior Vice President for External Affairs and Senior Vice President & Treasurer. Mr. McGinty also worked in the public sector as the Maine Department of Human Services' Deputy Commissioner for Health & Medical Services and as Executive Director of the Maine Health Care Finance Commission.”

“Vance Brown, MD, Chief Medical Officer, MaineHealth. Prior to joining MaineHealth, Dr. Brown was Chairman of Family Practice of the Cleveland Clinic. He is Board Certified in both Internal Medicine and Family Practice. . Dr. Brown holds a B.A. from Stanford University and an M.D. from the Yale University School of Medicine.”

“Rebecca Arsenault, President and Chief Executive Officer, FCHN. Prior becoming FCHN’s President and CEO in 2009, Mrs. Arsenault served in various health care chief operating officer and chief executive officer positions with Intermountain Healthcare in Utah, Providence Health Services in Washington and California and Universal Health Services in Texas. Mrs. Arsenault received her bachelor’s degree in nursing from the University of Southern Maine and her master’s degree in community health nursing from Boston University. She is currently a doctoral candidate in health care administration at Capella University.”

“Wayne Bennett, Vice President and CFO, FCHN. Prior to his current position, Mr. Bennett was CFO at Mercy Hospital in Portland, ME; Vice President of Finance at Central Maine Healthcare in Lewiston, ME; and CFO at Mt. Ascutney Hospital in Windsor, VT. Mr. Bennett earned an MBA/MHA from Georgia State University and a BS from Bates College.”

Certificate of Need Unit Discussion

i. CON Standards

Relevant standards for inclusion in this section are 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

ii. CON Unit Analysis

MaineHealth was established to lead a community care network which provides a broad range of health care services for Maine and Northern New England. MaineHealth’s subsidiaries and affiliated organizations provide services along the full continuum of care in order to improve the health status of the population it serves. MaineHealth is the organizational parent of Maine Medical Center (MMC). MMC is the state’s largest medical center. It is licensed for 637 beds and employs more than 6,000 people.

In order to determine if the applicant is fit, willing and able CONU evaluated three measures of quality for Maine Medical Center (the largest hospital in the MaineHealth healthcare system) and for Franklin Memorial Hospital. These three measures of quality were:

- **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>. Data collected was from April 1, 2012 through March 31, 2013. (Data was downloaded from website – April 1, 2014.)

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 Maine Medical Center and Franklin Memorial Hospital and compares them to the Maine and national averages.

SURVEY OF PATIENTS' EXPERIENCES	FRANKLIN MEMORIAL HOSPITAL	MAINE MEDICAL	MAINE AVERAGE	NATIONAL AVERAGE
Patients who reported that their nurses "Always" communicated well	78%	81%	82%	78%
Patients who reported that their doctors "Always" communicated well	80%	82%	83%	81%
Patients who reported that they "Always" received help as soon as they wanted	66%	64%	71%	67%
Patients who reported that their pain was "Always" well controlled	67%	71%	74%	71%
Patients who reported that staff "Always" explained about medicines before giving it to them	63%	64%	69%	64%
Patients who reported that their room and bathroom were "Always" clean	74%	72%	79%	73%
Patients who reported that the area around their room was "Always" quiet at night	49%	51%	57%	61%
Patients who reported that YES, they were given information about what to do during their recovery at home	88%	86%	89%	85%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	67%	75%	74%	70%
Patients who reported YES, they would definitely recommend the hospital	67%	80%	77%	71%

The data shown in Exhibit 1: Patient Survey Results indicates that Franklin Memorial Hospital scores below National averages in 7 out of 10 categories and below State averages in 10 out of 10 categories. Maine Medical scores above national averages in 7 out of 10 categories and below State averages in 9 out of 10 categories.

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.

	Franklin Memorial	Maine Medical	Maine Average	National Average
Timely Heart Attack Care				
Average number of minutes before outpatients with chest pain or possible heart attack got an ECG A lower number of minutes is better	13 min.	Not Available	6 min.	7 min.
Outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival Higher percentages are better	96%	Not Available	100%	61%
Heart attack patients given PCI within 90 minutes of arrival Higher percentages are better	Not Available	99%	96%	95%
Effective heart attack care				
Heart attack patients given aspirin at discharge Higher percentages are better	100%	100%	100%	99%
Heart attack patients given a prescription for a statin at discharge Higher percentages are better	87%	99%	99%	98%
Heart failure care				
Heart failure patients given discharge instructions Higher percentages are better	98%	98%	97%	94%
Heart failure patients given an evaluation of left ventricular systolic (LVS) function Higher percentages are better	100%	100%	100%	99%

Heart failure patients given ACE inhibitor or ARB for left ventricular systolic dysfunction (LVSD) Higher percentages are better	92%	100%	98%	97%
Pneumonia care				
Pneumonia patients whose initial emergency room blood culture was performed prior to the administration of the first hospital dose of antibiotics Higher percentages are better	96%	99%	98%	98%
Pneumonia patients given the most appropriate initial antibiotic (s) Higher percentages are better	96%	100%	97%	95%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time (within one hour before surgery) Higher percentages are better	100%	96%	96%	97%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection. Higher percentages are better	100%	97%	99%	99%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery) Higher percentages are better	99%	98%	99%	98%
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 Higher percentages are better	100%	100%	99%	98%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic Higher percentages are better	100%	98%	97%	97%

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 Higher percentages are better	100%	100%	99%	97%
Surgery patients who were given the right kind of antibiotic to help prevent infection Higher percentages are better	100%	99%	99%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery Higher percentages are better	Not available	100%	98%	96%
Surgery patients whose urinary catheters were removed on the first or second day after surgery Higher percentages are better	97%	100%	98%	97%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery Higher percentages are better	100%	100%	100%	100%
Timely emergency dept. care				
Average time patients spent in the emergency department, before they were admitted to the hospital as an inpatient A lower number is better	259 min.	381 min.	290 min.	275 min.
Average 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 A lower number is better	115 min.	188 min.	110 min.	97 min.

Average time patients spent in the emergency department before being sent home A lower number is better	104 min.	216 min.	121 min.	137 min.
Average time patients spent in the emergency department before they were seen by a healthcare professional A lower number is better	25 min.	29 min.	28 min.	27 min.
Average time patients who came to the emergency dept. with broken bones had to wait before receiving pain medication A lower number is better	50 min.	73 min.	55 min.	59 min.
Percentage of patients who left the emergency department before being seen Lower percentages are better	1%	2%	Not available	Not available
Percentage of patients who came to the emergency dept. with stroke symptoms who received brain scan results within 45 min. of arrival Higher percentages are better	Not available	5%	40%	51%
Preventive Care				
Patients assessed and given influenza vaccination Higher percentages are better	100%	85%	93%	90%
Patients assessed and given pneumonia vaccination Higher percentages are better	99%	89%	93%	90%
Effective children's asthma care				
Children who received reliever medication while hospitalized for asthma Higher percentages are better	Not Available	Not Available	Not Available	100%

Children who received systemic corticosteroid medication (oral and IV medication that reduces inflammation and controls symptoms) while hospitalized for asthma Higher percentages are better	Not Available	Not Available	Not Available	100%
Children and their caregivers who received a home management plan of care while hospitalized for asthma Higher percentages are better	Not Available	Not Available	Not Available	87%

The results of this patient survey indicate that in most instances both Franklin Memorial and Maine Medical meet and or exceed 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 Maine Medical is timely emergency department care. This may be in part because Maine Medical is located in an urban area with a significant population density. It was also noted that Maine Medical scored lower than State and national 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	Franklin Memorial	Maine Medical
Rate of Readmission for Heart Attack Patients	ND	B
Death Rate for Heart Attack Patients	ND	ND
Rate of Readmission for Heart Failure Patients	ND	B
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 Readmission after Hip/Knee Surgery	ND	B
Rate of Readmission after Discharge from Hospital	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 Franklin Memorial performed no better or worse than the national rate for readmissions, complications or death. Maine Medical performed better than the national average in several instances.

State Survey Results

The results of the most recent surveys for Franklin Memorial and Maine Medical are as follows:

Franklin Memorial Hospital is in compliance with the State of Maine Rules for the Licensing of Hospitals. There were no deficiencies cited during the recent onsite State complaint investigations completed on October 16, 2013

Maine Medical Center is in compliance with the State of Maine Rules for the Licensing of Hospitals. There were no deficiencies cited during the recent onsite State complaint investigations completed on February 24, 2014.

iii. Conclusion

CON RECOMMENDATION: CONU recommends that the Commissioner find 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.

III. Economic Feasibility

From Applicant

A. “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.”

“Please refer to Exhibit 3-A: Franklin Community Health Network’s audited financial statements. These documents demonstrate FCHN’s ability to govern and manage its subsidiaries, including FMH.”

“All MaineHealth members pay MaineHealth dues to support MaineHealth’s operations. Currently, those dues are calculated on the basis of 0.5% of a member’s net operating revenue. In the case of FCHN, those dues are estimated to be approximately \$375,000 for FY 2015. MaineHealth does not anticipate there will be a significant increase in the dues percentage over the next three years. The Applicants anticipate FCHN will experience cost savings and avoidances from participation in MaineHealth programs which will offset those dues. Since there will be no net increase in FCHN’s operating expenses resulting from membership in MaineHealth, membership will require no price increase for FCHN services.”

“MaineHealth, as evidenced by its Standard and Poors A+ credit rating and its financial statements, has the financial capacity to support this transaction. These documents demonstrate MaineHealth’s ability to govern and manage its subsidiaries.”

“Please refer to Exhibit 3-B: MaineHealth’s audited financial statements.”

“The CON Unit Financial Forecast Module is attached as Exhibit 3-C.”

“The module was completed based on instructions provided to the Applicants by CON Unit staff.”

“MMC financials are used as a proxy for MaineHealth, as directed by DHHS staff.”

“FCHN’s annual Maine Health dues of \$375,000 will be offset through savings in:

- \$200,000 annual savings in lab contracted services,
- \$100,000 annual savings in insurance premiums and
- \$75,000 annual savings in legal fees.”

“The CON Financial Module does NOT include the \$2.25 million commitment from MaineHealth to fund conversion of the Ambulatory EHR, because FCHN is assuming conversion will not happen until after FYE 2017, which is the third year of the Proposed Transaction.”

“The CON Financial Module excludes from Net Book Value the costs of physician practice office space and all IT capital costs. This results in a CON filing fee of \$22,000.”

“Computing the Certificate of Need Filing Fee”

“There is no capital expenditure associated with this transaction. Nowhere in the application or in the information supplied to the CON Unit in completing the Financial Module is evidence of a “payment” to Franklin Community Health Network by MaineHealth for assets or other considerations that would

constitute a “capital expenditure” (as defined by the CON Act, DHHS CON rules or generally accepted accounting principles) as part of the Proposed Transaction for which a CON is sought.”

“The Applicants are paying an application filing fee of \$22,000 in this matter under protest.”

“Contrary to the express language of the CON Act, 22 M.R.S. § 338(3) and the Department's *Certificate of Need Manual*, 10-144 Chapter 503, (the "CON Rules") ch.3, §7, the Department has created an accounting fiction by asserting that the fair market value of a hospital's non-CON exempt assets over which MaineHealth acquires control, is a "capital expenditure" for purposes of CON. The Department has adopted this reasoning since 2008 when, in a CON proceeding involving MaineHealth's acquisition of control of Waldo County Healthcare and Waldo County General Hospital ("WCGH"), it refused to process the CON application unless a filing fee, based on the value of WCGH's non-CON exempt assets, was remitted. MaineHealth continues to take issue with the Department's position and request that the Department acknowledge that the lawful filing fee for the Proposed Transaction, which involves no reviewable capital expenditure, is the minimum \$5,000 fee prescribed by CON Rules, ch. 6, § 8.B.”

“Accordingly, the Applicants request that the Department reconsider its earlier interpretation of the CON Act and Rules and return to MaineHealth \$17,000, the amount of the filing fee remitted with this application that exceeds \$5,000.”

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

“In order to determine that an applicant’s ability to establish and operate the project in accordance with existing and anticipated rules, the Certificate of Need Act states:

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.”

“22 MRSA §335 (1) (7 B)”

“MaineHealth members and FCHN operating entities including FMH have been providing substantially similar health care services to those services being reviewed for years in a manner that has been consistent with applicable licensing and certification standards.”

“As of the Effective Date, MaineHealth will become the sole member of Franklin Community Health Network. Franklin Community Health Network will, in turn, retain the same sole membership interest in FMH that it currently holds. FMH intends to notify the Maine DHHS, Division of Licensing and Regulatory Services, that MaineHealth will become the sole member of FMH's parent, FCHN, as of the Effective Date. It is not clear whether this will result in an amendment to FMH's license. FMH also intends to file a Medicare “change of information” with respect to the information currently contained in its CMS Forms 855A and 855B noting MaineHealth's status as sole member of its parent, FCHN, as of the Effective Date. FMH understands that MaineHealth's sole membership in FCHN as contemplated by the Proposed Transaction is not a change of ownership (CHOW) for purposes of Medicare participation and that providing the change of information notification to CMS complies with Medicare’s enrollment requirements. FMH will retain its current Medicare/MaineCare provider numbers on and after the Effective Date.”

“Hart-Scott-Rodino Act”

“Hart-Scott-Rodino (“HSR”) pre-merger notification is only required for transactions meeting each of two financial thresholds based on the size of the parties; and the size of the transaction. The current HSR thresholds became effective February 24, 2014. Under these current HSR thresholds the size of the parties threshold is met if one party to the transaction has \$151.7 million or more in annual sales or total assets and the other has \$15.2 million or more in annual sales or total assets.”

“The Proposed Transaction exceeds the size of parties threshold, because MaineHealth has annual net service revenues in excess of \$151.7 million and FCHN has annual net service revenues in excess of \$15.2 million.”

“For the size of transaction threshold to be crossed, the fair market value (not book value) of FCHN’s assets, less cash and cash equivalents, must be determined to be at least \$75.9 million by MaineHealth, the acquiring entity, as of a date within sixty (60) calendar days prior to filing, if filing is required, or within sixty (60) days prior to closing, if filing is not required.”

“MaineHealth has not yet determined whether the fair market value of FCHN’s assets, less cash and cash equivalents, equals or exceeds this size-of-transaction threshold, and for HSR reporting purposes cannot do so until the parties are within sixty (60) days of a closing on the Proposed Transaction.”

“Within sixty (60) days prior to the closing on the Proposed Transaction, MaineHealth will determine whether it will be necessary to file an HSR notice-and-report with the Federal Trade Commission. Such notice, if required, must, and will, be submitted at least 30 days prior to the closing of the Proposed Transaction.”

“If a notice is required and, if the thirty (30) day notice period expires without further action by the FTC or DOJ, the parties will be free to close on the Proposed Transaction. If during the thirty (30) day notice period either the FTC or DOJ formally requests more information, the waiting period before closing will be extended until thirty (30) days following substantial compliance with the additional information request. The FTC and DOJ have the discretion, in individual cases, to terminate the waiting period before the 30 days expires.”

“Consistent with conditions incorporated by DHHS into CON’s previously issued to MaineHealth in connection with similar CON applications, MaineHealth proposes reporting to the DHHS the following Hart-Scott-Rodino Act activities:

- MaineHealth will notify DHHS whether it intends to make a Notice and Report filing with the Federal Trade Commission under the HSR Act.
- If MaineHealth makes a Notice and Report HSR filing, MaineHealth will
 - Provide to DHHS any letter from the Federal Trade Commission acknowledging the filling of the Notice and Report.
 - Notify DHHS if the Federal Trade Commission or Department of Justice has granted a request for early termination of 30-day waiting period requirement; or if the Federal Trade Commission or Department of Justice has made a formal request for additional information that would extend the 30 day waiting period.
 - Notify DHHS if the Federal Trade Commission or Department of Justice has allowed the waiting period and any subsequent extension to lapse without taking further action, thereby allowing the transaction to occur.”

Certificate of Need Unit Discussion

i. CON Standards

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.

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.

ii. CON Unit Analysis

In order to assess the financial stability of Maine Medical Center and Franklin Memorial Hospital, the CONU used financial ratios to measure profitability, liquidity, capital structure and asset efficiency. Financial ratios were obtained from the Maine Health Data organization Hospital Financial Information Part II and Maine Health Data Organization Hospital Financial Data Definitions available on MHDO's website <http://mhdo.maine.gov/imhdo/>. National trend and forecast information through 2010 was obtained from the 2012 Almanac of Hospital Financial and Operating Indicators.

PROFITABILITY RATIOS

CONU determined that it was necessary to evaluate the financial fitness of the two hospitals by investigating commonly used 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 hospital's financial performance.

This ratio is calculated as follows:

Operating Income/Total Operating Revenue

Operating Margin	2007	2008	2009	2010	2011
Franklin Memorial	3.87%	4.78%	2.11%	2.98%	1.82%
Maine Medical Center	7.94%	6.48%	7.34%	6.25%	5.95%
All Maine Hospital Median	2.37%	1.61%	2.08%	0.98%	2.34%
National Median	NAV	NAV	NAV	NAV	NAV

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 (Loss)	2007	2008	2009	2010	2011
Franklin Memorial	\$2,691,721	\$3,658,425	\$1,677,248	\$2,439,324	\$1,549,111
Maine Medical Center	\$46,578,000	\$40,740,000	\$50,754,000	\$45,012,000	\$49,442,185
All Maine Hospital Median	\$1,354,376	\$720,298	\$1,419,993	\$762,435	\$1,549,111
National Median	NAV	NAV	NAV	NAV	NAV

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	2007	2008	2009	2010	2011
Franklin Memorial	9.09%	14.92%	5.18%	7.21%	3.05%
Maine Medical Center	12.74%	10.18%	13.90%	10.76%	13.29%
All Maine Hospital Median	9.16%	7.12%	5.01%	4.51%	8.28%
National Median	8.30%	4.60%	5.50%	6.20%	6.40%

Trends for Return on Equity: Return on Equity saw continued improvement in 2010 nationally. Larger hospitals continue to out-perform smaller ones. Hospitals with a lower operating margin show lower overall values as lower total margin and less financial leverage combine to reduce Return on Equity.

Forecast: Return on Equity values should show a slight increase in the short term. Continued improvement will only be possible if hospitals can realize increased asset efficiency, especially in the area of fixed assets.

LIQUIDITY RATIOS

CONU used three liquidity ratios to measure the main operating units’ ability to meet short-term obligations and maintain cash position. This is a substitute for measuring the combined unit’s financial ability. A poor liquidity ratio would indicate that a hospital is unable to pay current obligations as they 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	2007	2008	2009	2010	2011
Franklin Memorial	4.805	1.943	2.371	2.475	2.914
Maine Medical Center	2.419	2.740	3.019	2.530	2.540
All Maine Hospital Median	1.88	1.49	1.65	1.68	1.6
National Median	2.13	2.05	2.11	2.19	2.1

*Without Board Designated/Undesignated Investments

Current Ratio Trends: Northeast hospitals have values for the Current Ratio that has been consistently lower than those of other regions. This is a direct result of relatively weak operating profitability. Continued erosion of margins in this region may impair the short-term liquidity positions of the weakest hospitals and may force some defaults.

Forecast: Little change in current ratios is expected over the next five years. Values will continue to fluctuate around 2.0.

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 (Current)	2007	2008	2009	2010	2011
Franklin Memorial	75.0	26.1	39.8	53.2	45.2
Maine Medical Center	224.6	161.7	162.9	160.2	113.6
All Maine Hospital Median	26.7	15.9	33.3	32.5	26.2
National Median	26.8	24.6	34.7	26.7	25.4

Trends for Days Cash on Hand: Values for Days Cash on Hand (Current) continue to increase because of hospitals caution with their cash positions. A reasonable norm for most hospitals would be 20 days of cash on hand for short-term working capital purposes.

Forecast: Days Cash on hand should remain steady or slightly increase as hospitals solidify their cash positions. The majority of hospitals should not expect any difficulty in maintaining short-term liquidity positions.

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.

This ratio is calculated as follows: *Total Current Liabilities/total Advertising + Salaries & Benefits + Other Operating Expenses + Interest/365*

Average Payment Period*	2007	2008	2009	2010	2011
Franklin Memorial	37.1	43.9	42.5	44.7	35.7
Maine Medical Center	117.0	76.9	68.1	82.2	62.1
All Maine Hospital Median	50.8	54.3	59.9	60.5	62.8
National Median	49.8	51.2	50.5	48.6	50.2

*Current Liabilities

Trends for Avg. Payment Period: Median values in Average payment Period continued to decrease in 2010. Northeast hospitals have the highest values for Average Payment Period, which is consistent with their relatively low values for the Current Ratio.

Forecast: Overall Average Payment Period values should remain unchanged in the short term.

CAPITAL STRUCTURE RATIOS

CONU used three capital structure ratios in order to measure the individual hospital's capacity to pay for any debt. By evaluating the individual hospitals capacity it can provide information as to how the combined entity may operate. 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. This ratio is calculated as follows: *Excess of Revenue over Expenses + Depreciation + Interest/Interest + Previous Years Current LTD*

Debt Service Coverage	2007	2008	2009	2010	2011
Franklin Memorial	4.829	8.188	4.087	4.377	3.708
Maine Medical Center	13.539	8.635	6.520	6.291	7.622
All Maine Hospital Median	3.82	3.43	2.92	2.68	4.11
National Median	3.82	2.86	3.1	2.8	3.18

Trends for Debt Service Coverage: Debt Service coverage fell again in 2010 after 2009’s decrease. Some of the changes on a regional basis are more striking and variable indicating that local economic experience is more variable. The Northeast showed an increase while all other regions showed a decrease.

Forecast: Debt Service Coverage should stabilize or increase somewhat over the next few years. Values are predicted to remain between 2.8 and 3.0.

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	2007	2008	2009	2010	2011
Franklin Memorial	23.41%	25.52%	18.32%	23.00%	20.09%
Maine Medical Center	28.39%	26.47%	24.51%	20.78%	22.93%
All Maine Hospital Median	22.54%	17.06%	15.00%	15.14%	20.51%
National Median	22.70%	15.70%	17.40%	19.50%	19.00%

Trends for Cash Flow to Total Debt: Median Cash Flow to Total Debt continued to increase in 2010 although values still remain under 2007. Northeast hospitals continue to have the lowest median cash flow to total debt of any region. This results from both lower profitability and higher indebtedness as compared with other regions.

Forecast: Cash Flow to Total Debt should continue to have modest gains during the next few years.

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	2007	2008	2009	2010	2011
Franklin Memorial	85.03%	63.11%	62.35%	62.77%	61.45%
Maine Medical Center	40.85%	33.64%	30.14%	28.17%	26.06%
All Maine Hospital Median	49.49%	52.37%	54.22%	47.59%	46.06%
National Median	52.50%	60.30%	49.80%	48.20%	50.80%

Trends in Fixed Asset Financing: Median values for the Fixed Asset Financing Ratio continued to decrease in 2010 after a five year 2008 high.

Forecast: Fixed Asset Financing Ratios are expected to remain stable during the next five years as hospitals curtail their growth in new capital expenditures and reduce their reliance on long-term debt.

ASSET EFFICIENCY RATIOS

CONU used two asset efficiency ratios. These efficiency ratios for the individual hospitals can elucidate the efficiency of the combined entity. Since the two applicants are operating the same two hospital groups, this evaluation can be transferred to both applicants. 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	2007	2008	2009	2010	2011
Franklin Memorial	0.950	1.200	1.188	1.183	1.232
Maine Medical Center	0.682	0.741	0.770	0.740	0.846
All Maine Hospital Median	1.17	1.2	1.23	1.21	1.21
National Median	1.08	1.08	1.07	1.05	1.07

Trends in Total Asset Turnover: Total Asset Turnover values have remained generally constant over the past five years with a slight decline in 2010.

Forecast: Total Asset Turnover should improve over the next five years.

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	2007	2008	2009	2010	2011
Franklin Memorial	2.399	1.977	2.122	2.289	2.397
Maine Medical Center	1.671	1.568	1.617	1.680	1.933
All Maine Hospital Median	2.9	2.78	2.72	2.63	2.96
National Median	1.97	1.87	1.95	1.96	NAV

Trends in Fixed Asset Turnover: Fixed Asset Turnover is relatively unchanged in 2010, declining slightly.

Forecast: Fixed Asset Turnover ratios should remain stable during most of the next few years.

CONU Summary of Financial Ratios: Below are charts summarizing the percentage of time Franklin Memorial and Maine Medical Center meets or exceeds Maine or National medians:

FRANKLIN MEMORIAL	RATIO	MAINE	NATIONAL
Profitability	Operating Margin	80.00%	NAV
Profitability	Net Operating Income	100.00%	NAV
Profitability	Return on Equity	60.00%	100.00%
Liquidity	Current Ratio	100.00%	80.00%
Liquidity	Days Cash on Hand	100.00%	100.00%
Liquidity	Avg. Payment Period	100.00%	100.00%
Capital Structure	Debt Service Coverage	100.00%	100.00%
Capital Structure	Cash Flow to Total Debt	80.00%	100.00%
Capital Structure	Fixed Asset Financing	0.00%	0.00%
Asset Efficiency	Total Asset Turnover	40.00%	80.00%
Asset Efficiency	Fixed Asset Turnover	0.00%	80.00%

NAV-Not available

Franklin Memorial meets or exceeds Maine median measurements of profitability an average of 80% of the time and National medians (where available) 100% of the time. Franklin Memorial meets or exceeds Maine median measurements of liquidity an average of 100% of the time and National medians 93.3% of the time. The facility meets or exceeds Maine and National median measurements of capital structure an average of 60% of the time and meets or exceeds Maine and median measurements of asset efficiency 20% of the time and National median measurements an average of 80% of the time.

MAINE MEDICAL CENTER	RATIO	MAINE	NATIONAL
Profitability	Operating Margin	100.00%	NAV
Profitability	Net Operating Income	100.00%	NAV
Profitability	Return on Equity	100.00%	100.00%
Liquidity	Current Ratio	100.00%	100.00%
Liquidity	Days Cash on Hand	100.00%	100.00%
Liquidity	Avg. Payment Period	0.00%	0.00%
Capital Structure	Debt Service Coverage	100.00%	100.00%
Capital Structure	Cash Flow to Total Debt	100.00%	100.00%
Capital Structure	Fixed Asset Financing	100.00%	100.00%
Asset Efficiency	Total Asset Turnover	0.00%	0.00%
Asset Efficiency	Fixed Asset Turnover	0.00%	0.00%

NAV-Not available

Maine Medical Center meets or exceeds Maine median measurements of profitability an average of 100% of the time and National medians (where available) 100% of the time. Maine Medical Center meets or exceeds Maine and National median measurements of liquidity an average of 66% of the time. The facility meets or exceeds Maine and National median measurements of capital structure an average of 100.0% of the time. Maine Medical meets or exceeds Maine and National median measurements of asset efficiency an average of 0% of the time.

The applicant addressed this section by referring to the CON financial module submitted with the application. The applicant projects a positive operating surplus for years one through three of the project with a total operating surplus of \$31,821,432 in 2017. MaineHealth provided a copy of their September 30, 2013 audited financial statements prepared by Deloitte and Touche LLP. The balance sheet shows cash and cash equivalents of \$108,746,000 and investments of \$285,855,000. The applicant has sufficient resources to utilize in the event that the expected results of operations do not materialize.

Subsequent Event:

The applicants audited June 30, 2013 financial statements prepared by BerryDunn indicate an operating loss of \$7,583,498 million for the fiscal year ended June 30, 2013. Unfortunately rural hospitals are heavily reliant on MaineCare and Medicare which only pay a fraction of actual costs. These funding sources account for approximately 63% of the hospital's gross patient service revenues. Further complicating this situation is the likelihood of State and Federal cutbacks in these programs. In order to capture economies of scale, avoid duplication of services and gain access to capital at favorable rates the FCHN Board believes that affiliating with a larger organization such as MaineHealth is of vital importance in improving the financial position of Franklin Memorial Hospital..

iii. Conclusion

CON RECOMMENDATION: CONU recommends that the Commissioner determine that the applicant has met their burden to demonstrate: (1) 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 (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.

IV. Public Need

From Applicant

“Applicants are required to demonstrate the need for the project which is typically a new service or the expansion of an existing service requiring a capital expenditure that exceeds the threshold for CON review. In this application, the “project” is the Proposed Transaction by which MaineHealth acquires control of FCHN, including its subsidiary FMH. It is the acquisition of control of FMH which requires CON review and approval. As a result, this application addresses the need in the context of the need and benefits of MaineHealth’s acquisition of control of FCHN.”

“FCHN Board of Directors’ Decision-making Process”

“The changing landscape of government reimbursement, challenges to maintain access to providers and services, increasing costs to deliver healthcare and a drive to improve quality are paving the way for many small hospitals to seek membership in larger systems.”

“In April 2013, the Franklin Community Health Network (FCHN) Board of Directors met to discuss strategic options for the organization. CEOs of various integrated healthcare delivery networks were invited to Farmington to share their observations with the Board about the rapidly changing healthcare environment and their respective organization’s responses to it. Following these presentations, Board members discussed possible next steps with a stated intent of finalizing a clear strategic direction for FCHN by the end of calendar year 2013.”

“During the late summer and fall of 2013, the Board released a Request for Information about a possible affiliation arrangement, resulting in responses from a number of integrated healthcare delivery networks. The responses were reviewed and analyzed by three FCHN multi-disciplinary, Board-appointed teams comprised of 35 participants (physicians, nurses, technicians, Board members, department managers and senior leaders). In late October, the Board reviewed feedback and recommendations from these teams. This comprehensive review led the Board to narrow its analysis to MaineHealth. FCHN Board members then made site visits to four MaineHealth hospitals to conduct further due diligence.”

“Throughout this process, information was openly shared with key stakeholders throughout the organization and the community about the Board’s due diligence process and timeframes.”

“In December 2013, the Board adopted a resolution to seek membership in MaineHealth. The primary reasons for seeking membership included:

- Strategic positioning for an evolving accountable care delivery system;
- Access to actionable data for population health management and quality management initiatives;
- Access to sub-specialty medical services locally;
- Cost-savings opportunities in the area of administrative overhead;
- Financial, operational and strategic considerations;
- Governance and mission objectives; and
- The interests of FCHN/FMH key constituencies.”

“The Board’s overarching goal for the organization throughout this process has been to develop a long-term strategy for success that would assure access to health for the next generation in the greater Franklin County region.”

“FCHN MaineHealth Membership Benefits”

“FCHN’s membership in the MaineHealth system will allow FCHN to strategically partner with MaineHealth and its members to improve healthcare in the greater Franklin County region. Membership will help Franklin Community Health Network maximize its delivery of care to patients, realize efficiencies and cost savings and ensure healthcare remains available in the region.”

“By coordinating resources and collaborating on healthcare delivery, FCHN will be able to deploy resources more efficiently and effectively and better serve its community today and well into the future.”

“Membership provides a number of opportunities to work together to improve the health of the communities in the greater Franklin County region; strengthening the ability to provide high quality, safe patient care to the local communities, while striving to increase access to tertiary services and lowering healthcare costs.”

“FMH has a history of collaborating with other members and affiliates of the MaineHealth system for well over a decade; including Maine Medical Center for cardiology and cardiovascular care, neonatal care at the Barbara Bush Children’s Hospital at Maine Medical Center and MaineGeneral Health for oncology services.”

“Because MaineHealth is committed to improving the health of all of the communities throughout its service area, it welcomes the opportunity to demonstrate to FCHN how by joining MaineHealth, the two organizations will make significant progress in achieving this vision.”

“FCHN will experience the following benefits from joining MaineHealth:

- **Full Participation in MaineHealth’s Quality, Health Status Improvement, Population Health Management and Clinical Integration Programs.** As a member of the MaineHealth system, FCHN will participate, as all members do, in the development and implementation of quality improvement programs, as well as educational/networking clinical support.

Please refer to Section VII. Service Utilization for further information on these MaineHealth initiatives.

- **Access to MaineHealth’s Shared Administrative Programs.** As a member of the MaineHealth system, FCHN will have access to shared administrative resources including but not limited to: legal, audit and compliance, financial, strategic planning, program development, marketing, information services and human resources.
- **Access to MaineHealth’s Administrative Integration Programs.** As a member of the MaineHealth system, FCHN will have complete access to MaineHealth’s health plan, workers compensation trust, purchasing program and vendor contracts, physician practice management services, professional liability trust, laundry services, investment advisory and banking services and audit services.
- **Access to MaineHealth’s Borrowing Group.** FCHN will become a member of MaineHealth’s borrowing group, which includes Maine Medical Center. Because MaineHealth’s guaranty stands behind borrowing by any member of the group, FCHN will have greater access to capital and access with favorable terms.”

“As a result, MaineHealth membership will significantly enhance FCHN’s ability to meet community needs, to improve the community’s health, to continue to provide access to services regardless of ability to pay and to continue to improve the quality of services.”

“Community Health Needs: The project will substantially address specific health problems as measured by health needs in the area to be served by the project.”

“FCHN is addressing Chronic Disease Management, Obesity and Colorectal Cancer as priority concerns based on its most recent Community Health Needs Assessment.”

“Please refer to Exhibit 4-A Franklin Community Health Network’s 2013 Community Health Needs Assessment.”

“FCHN provides a broad array of necessary services to the greater Franklin County region, a sparsely populated, 2,800 square mile region of Maine.”

“Franklin Memorial Hospital is a CMS-designated Sole Community Hospital. Sole Community Hospitals are deemed essential safety net providers as the sole source of hospital services available in a wide geographic area. The Sole Community Hospital program was established in 1983 by Congress to maintain access to needed health services for Medicare beneficiaries in isolated (mostly rural) communities.”

“Franklin Health, a Department of Franklin Memorial Hospital, is a provider-based multispecialty group practice that includes eleven medical and surgical practices that provide residents and visitors to the region with access to needed physician services.”

“NorthStar, a Department of Franklin Memorial Hospital established in 2005, is the greater Franklin County region’s ambulance service providing pre-hospital emergency services to 71 communities in the service area.”

“Healthy Community Coalition, founded in 1989, is one of the country’s oldest health coalitions. The Coalition uses a coordinated public health approach to improve the well-being of local residents throughout the service area. The Coalition provides needed public health services for the greater Franklin County region that otherwise would not be available since Maine does not have county health departments.”

“Evergreen Behavioral Services provides crisis mental health services for the service area.”

“Access to Care: The services affected by the project will be accessible to all residents of the area proposed to be served.”

“All services currently provided by Franklin Community Health Network, its subsidiaries and providers prior to acquisition of control by MaineHealth will be accessible to all residents and visitors of Franklin County and surrounding communities after the Proposed Transaction. Nothing will change as a result of the Proposed Transaction.”

“Quality of Care: The project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.”

“FCHN its subsidiaries and providers will participate in MaineHealth clinical integration, population health management and quality improvement initiatives designed to improve care quality and outcomes.”

“Please refer to Section VII. Service Utilization.”

“Health Status: The project will have a positive impact on the health status indicators of the population to be served.”

“MaineHealth is leading the development of health status improvement and clinical integration initiatives in Maine. Management of populations with chronic diseases has become a major focus of MaineHealth’s clinical integration initiatives. FCHN will participate in MaineHealth’s health status improvement, clinical integration, population health management and quality improvement initiatives, which should over time impact the community’s health status indicators positively.”

“The MaineHealth Health Index Initiative has identified seven priority areas for improving the health of the communities that are served by MaineHealth. MaineHealth, its members and its partners are taking actions to address these priorities in community settings, clinical settings and the policy arena.”

“The Initiative’s priority areas are:

- Increasing childhood immunizations,
- Decreasing tobacco use,
- Decreasing obesity,
- Decreasing preventable hospitalizations,
- Decreasing cardiovascular deaths,
- Decreasing cancer deaths and
- Decreasing prescription drug abuse and addiction.”

“Please refer to Exhibit 4-B: MaineHealth Health Index 2013 Report.”

“Greater Franklin County Region”

“FCHN serves the greater Franklin County region, a sparsely populated 2,800 square mile area of Maine that includes the following communities, plantations, townships and unorganized territories:

Androscoggin County: Livermore Falls

Franklin County: Alder Stream Township, Avon, Beattie Township, Carrabassett Valley, Carthage, Chain of Ponds Township, Chesterville, Coplin Plantation, Coburn Gore, Dallas Plantation, Davis Township, East Central Franklin Unorganized Territory, Eustis, Farmington, Freeman Township, Gorham Gore, Industry, Jay, Jim Pond Township, Kibby Township, Kingfield, Lang Township, Lowelltown Township, Madrid Township, Massachusetts Gore, Merrill Strip Township, Mount Abram Township, New Sharon, New Vineyard, North Franklin Unorganized Territory, Perkins Township, Phillips, Rangeley, Rangeley Plantation, Redington Township, Salem Township, Sandy River Plantation, Seven Ponds Township, Skinner Township, Southern Franklin Unorganized Territory, Stratton, Stetsontown Township, Strong, Temple, Tim Pond Township, Township D, Township E, Township 6 North of Weld, Washington Township, Weld, Wilton, Wyman Township, Wyman Unorganized Territory

Kennebec County: Kent’s Hill, Mount Vernon New Portland, Vienna

Somerset County: Appleton Township, Attean Township, Bigelow Township, Bowtown Township, Bradstreet Township, Carrying Place Town Township, Carrying Place Township, Dead River Township, Flagstaff Township, Forsyth Township, Highland Plantation, Hobbstown Township, Holeb Township, Johnson Mountain Township, King & Bartlett Township, Lower Enchanted Township, Pierce Pond Township, Upper Enchanted Township, T3 R4 BKP WKR, T3 R5 BKP WKR, T5 R6 BKP WKR, T5 R7 BKP WKR”

“Service Area Population”

“There are seventy-one communities within this service area. The majority of the population resides in 29 towns. In 2010 the population density for the region was 12.9 persons per square mile; this extremely low population density demonstrates that the region is mostly rural and frontier in nature with a number of small, remote communities. The following table presents 2010 Census population and population projections for 2015 and 2020:

**Greater Franklin County Region Population:
2010 Census and Projections for 2015 and 2020**

Town	2010	2015	2020
Livermore Falls	3,187	3,178	3,159
Avon	461	425	389
Carrabassett Valley	776	827	923
Carthage	560	564	566
Chesterville	1,352	1,405	1,452
Coplin plantation	165	171	179
Dallas plantation	305	324	342
East Central Franklin UT	806	841	872
Eustis	617	628	611
Farmington	7,751	7,700	7,622
Industry	923	962	997
Jay	4,838	4,675	4,477
Kingfield	995	961	903
New Sharon	1,404	1,418	1,426
New Vineyard	756	748	737
North Franklin UT	61	70	78
Phillips	1,026	1,014	998
Rangeley	1,173	1,155	1,151
Rangeley plantation	189	200	217
Sandy River plantation	133	147	161
South Franklin UT	69	66	64
Strong	1,211	1,202	1,169
Temple	526	516	492
Weld	418	414	408
Wilton	4,108	3,977	3,834
Wyman UT	88	90	93
Mount Vernon	1,640	1,653	1,666
Vienna	569	575	581
Highland plantation	<u>73</u>	<u>80</u>	<u>87</u>
Total	36,180	35,986	35,655

Data Source: Maine State Office of Policy and Management”

“Service Area Inpatient Hospital Use”

“Franklin Memorial Hospital is a community hospital that serves approximately 60% of the region’s need for inpatient hospital care. (Note: This analysis focuses on the Farmington Hospital Service Area, which is the core of the greater Franklin County region.) FMH meets approximately 80% of the region’s need for the community hospital level of services that FMH provides. This further supports FMH’s designation as a Sole Community Hospital by CMS. The following table presents information on the region’s discharges for the 33 DRGs for which FMH had more than twenty discharges in CY 2011. This group of DRGs provides a reasonable representation of FMH’s usual and customary inpatient services.”

**“Farmington Hospital Service Area Discharges by Maine Hospitals
Calendar Years 2009 to 2011 for FMH’s Usual & Customary Services
(excluding newborns)”**

Facility	2009		2010		2011	
Franklin Memorial Hospital	1,219	81.3%	1,061	79.1%	1,216	78.7%
Central Maine Medical Center	107	7.1%	119	8.9%	125	8.1%
Maine Medical Center ^A	58	3.9%	64	4.8%	89	5.8%
St Mary’s Regional Medical Center	52	3.5%	41	3.1%	34	2.2%
Maine General Medical Center	27	1.8%	19	1.4%	33	2.1%
All Other Maine Hospitals	<u>36</u>	2.4%	<u>38</u>	2.8%	<u>49</u>	3.2%
TOTAL	1,499		1,342		1,546	

“Data Source: Maine Health Data Organization Hospital Inpatient Databases CY 2009 – 2011.”

“A: Thirty-one percent (31%) of 89 discharges from MMC in 2011 were for a single DRG: major joint replacement or re-attachment of lower extremity.”

“Franklin Memorial Hospital”

“Franklin Memorial Hospital is a community hospital with most of its inpatient admissions from the Farmington Hospital Service Area or communities in the bordering Hospital Service Areas.”

**“Franklin Memorial Hospital Patient Origin
Calendar Years 2009 to 2011
(excluding newborns)”**

Hospital Service Area	2009	2010	2011
Farmington	2,388	2,254	2,285
Lewiston	103	105	114
Rumford	105	87	100
Skowhegan	69	63	52
Augusta	47	41	48
Out of State/Unknown	49	35	46
Other Maine	16	23	35
Waterville	<u>9</u>	<u>14</u>	<u>11</u>
TOTAL	2,786	2,622	2,691”

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 Analysis

The goal of Franklin Community Health Network (FCHN) Board of Directors is to “develop a long-term strategy for success that would assure access to health for the next generation in the greater Franklin County region.” The increasing complexities of health care delivery, financing and reimbursement make it difficult, if not impossible, for a small organization to meet community needs as an independent organization. Nationally over 50% of community hospitals are in health care systems. In Maine 60% of hospitals are part of a system. As stated previously, FCHN’s rationale for establishing a formal affiliation with MaineHealth is to achieve financial and clinical economies of scale, avoid duplication of services while improving efficiency, access and quality, and gaining access to capital at favorable rates.

The applicant identified their service area as greater Franklin County, Maine and the adjoining towns of Livermore and Livermore Falls. Franklin County is a rural county with a population of 30,495 according to the latest 2013 population estimate on the U.S. census website. The population density is approximately 18 persons per square mile. The applicant states that Franklin Memorial Hospital (FMH) provides approximately 60% of the regions need for inpatient hospital care and approximately 80% of the regions need for the community hospital level of service for usual and customary services. For example in 2011 FMH had 1,216, or 78.7% of the discharges for usual and customary services out of a total of 1,546 discharges for the Farmington service area. For all 2011 inpatients 2,285 out of 2,691 inpatients or approximately 85% were from the Farmington area.

CONU expanded the analysis of inpatient utilization by utilizing Maine Health Data Organization hospital inpatient data from 2009 through 2011 for all services. CONU used data from the 29 towns the applicant identified as having the majority of the population in the service area in order to provide a clear picture of where patients in this area receive services. The results of this analysis are provided in the table below:

Table 1: FCHN Hospital Service Area Inpatient Discharges

Hospital	Location	2009 FY	2009 %	2010 FY	2010 %	2011 FY	2011 %	3 year Avg. %
Franklin Memorial	Farmington	3067	41%	2750	39%	2786	40%	40%
Central Maine Medical	Lewiston	1282	17%	1293	18%	1294	19%	18%
Rumford	Rumford	689	9%	813	12%	1077	15%	12%
Maine Medical Center	Portland	670	9%	637	9%	676	10%	9%
St. Mary's	Lewiston	420	6%	395	6%	388	6%	6%
MaineGeneral	Augusta	500	7%	475	7%	319	5%	6%
All Other	Various	916	12%	678	10%	454	6%	9%
TOTAL		7544	100%	7041	100%	6994	100%	100%

This table reveals that an average of 40% of service area residents receive services at Franklin Memorial Hospital while 30% receive services at Central Maine Medical and related facilities (Rumford). 9% receive services at Maine Medical in Portland. The effect of a change in ownership on current referral patterns will be discussed in the Outcomes and Community Impact section of this analysis.

The above trends show that there is a shift in services from rural to urban areas due to a wider array of services offered in urban centers. This is consistent with national trends. In addition larger hospitals are able to charge less for services due to a more favorable payor mix. Urban areas have more large employers that offer private insurance and fewer elderly as a percentage of population. Rural hospitals rely heavily on MaineCare and Medicare which only pay a percentage of actual cost and are at risk of State and Federal cutbacks.

The increasing complexities of health care delivery, financing and reimbursement make it difficult for a small hospital to meet the needs of the community as an independent organization. Many community hospitals establish formal affiliations with larger hospital systems in order to achieve financial and clinical economies of scale, avoid duplication of services, and access capital at favorable rates.

This project will substantially address specific health problems as measured by health needs in the area to be served by the project. The applicant provided a copy of FCHN's Community Health Needs Assessment which identifies three priority concerns in their service area:

1. Chronic Disease Management
2. Obesity
3. Colorectal Cancer

Other community health needs include dental care, domestic violence, fatal motor vehicle deaths, suicide and substance abuse. A review of MaineHealth's 2013 Health Index report shows that MaineHealth has identified many of the same needs. By coordinating resources and collaborating on healthcare delivery FCHN will be able to utilize resources more efficiently and better serve its community on an ongoing basis. FCHN will be better positioned to continue its broad array of services which includes a sole community hospital, a multi-specialty group practice providing physician services, an ambulance service, public health services and behavioral health services.

The health status indicators of the population living in FCHN's service area will be positively impacted by participating in MaineHealth's health status improvement, clinical integration, population health management and quality improvement initiatives.

The services affected by the project will be accessible to all residents of the area proposed to be served. No changes to the services currently provided by FCHN are expected.

MaineHealth has many members who participate in a comprehensive array of initiatives focused on population based health and prevention of disease. The intent of MaineHealth's population health management is to align delivery of care with improving patient experience, improving quality and reducing cost. FCHN and MaineHealth have each focused on community health initiatives, preventive care and population health. Partnering on these initiatives will encourage best practices and contribute to demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

As stated above, FCHN identified specific concerns regarding chronic disease management, obesity, colorectal cancer, dental care, domestic violence, fatal motor vehicle deaths, suicide and substance abuse in its service area. These health issues require ongoing monitoring. The following condition is necessary to ensure that the impact of community programs instituted to reduce these health issues will be as effective as forecast by the applicant.

Condition: The applicant is to report improvements in quality and outcome measures related to the community services instituted to reduce chronic disease, obesity, colorectal cancer, dental care, domestic violence, fatal motor vehicle deaths, suicide and substance abuse. This report will be required on an annual basis within 90 days of its fiscal year end beginning with the time period when the Certificate of Need was approved until a full three years have elapsed since the date of the project commencement.

iii. Conclusion

The Certificate of Need Unit recommends that the Commissioner find that the applicants have met their burden to show that there is a public need for the proposed project.

V. Orderly and Economic Development

From Applicant

“Impact on Health Care Expenditures: Project’s Benefit and Potential Impact on Other Providers’ Costs”

“The anticipated benefits of the Proposed Transaction are described throughout this Certificate of Need Application. The Proposed Transaction primarily involves the day-to-day operation of FCHN.”

“There is no addition to any facilities or services as a result of the Proposed Transaction. The services that had been offered by FCHN currently will be offered by FCHN after the Effective Date.”

“There is no CON-reviewable capital expenditure and no increase in operating expenses for the health care delivery system in Maine, for the State of Maine, for MaineHealth or for FCHN as a result of the Proposed Transaction.”

“The Proposed Transaction should have no impact on other providers’ volume of services, quality of care or costs. Historical referral patterns for patients requiring care outside the FCHN/FMH system are unchanged by the Proposed Transaction. All referrals will continue to be based on an assessment of the patient’s needs, the resources available and reasonably accessible by the patient, and the patient’s preference after the Effective Date.”

“Availability of State Funds: Impact on MaineCare”

“Approval of this transaction has no impact on MaineCare.”

“Alternatives: Potential of More Effective, More Accessible or Less Costly Technologies or Methods”

“FCHN performed a thorough analysis of various strategic alternatives including affiliation with a number of integrated healthcare delivery systems, including MaineHealth, and remaining independent. FCHN determined that MaineHealth membership was the best option to achieve its purposes. Please see Section IV. Public Need.”

“FCHN, its physicians, providers and patients will benefit from participation in MaineHealth clinical integration and chronic disease management programs.”

“FCHN will benefit from participation in MaineHealth’s employee health plan, workers compensation trust, Supply Chain purchasing program and vendor contracts, Maine Medical Partners physician practice management services, professional liability trust, laundry services, investment advisory and banking services and audit services.”

“MaineHealth also offers participation in its administrative integration programs (those with potential for significant economic benefit and savings) and its obligated group for access to capital only to member organizations (not its affiliates).”

“MaineHealth’s economies of scale enable its members to access goods and services that they individually would not be able to consider. Simply put, MaineHealth’s purchasing power adds value for its members. A prime example of this is the MaineHealth Shared Electronic Health Record (SeHR). MaineHealth’s size enabled its members to select Epic System, one of the premier national EMR developers, as the software partner, a selection that would not have been feasible for many MaineHealth individual members if they were independent.”

Certificate of Need Unit Discussion

i. CON Standards

Relevant criteria 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 Analysis

Based on the financial module submitted by the applicant projected 3rd year incremental operating costs are projected to show a savings, therefore no projected increase in MaineCare funds will be needed to fund this project through the 3rd year of operation (2017). Further, this project does not result in the development of any new health services, involve the acquisition of any major medical equipment, involve a change in the licensed bed complement of Franklin Memorial Hospital or require any major capital expenditures.

The applicants list a variety of potential savings which could occur as a result of this transaction. As stated by the applicant FCHN will benefit from participation in MaineHealth's employee health plan, workers compensation trust, purchasing programs, vendor contracts, Maine Medical Partners physician practice management, laundry services and an array of financial services. Access to capital is enhanced for member organizations. MaineHealth's economies of scale enable its' members to purchase goods and services at reduced prices. Based on the financial module submitted by the applicant operating costs are projected to decline by \$522,941 between year 1 and year 3 of the project. FCHN's membership fee of \$375,000 will be offset by immediate savings of \$200,000 in lab contracted services, \$100,000 in insurance premiums and \$75,000 in legal fees.

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 an 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.

This notification is required for certain transactions where one party has annual net service revenues in excess of the \$151.7 million size of parties threshold and the other party has annual net service revenues in excess of the \$15.2 million size of parties threshold. This transaction exceeds the size of parties' thresholds.

Within 60 days of closing MaineHealth will need to determine if FCHN's book value exceeds the size-of-transaction threshold of \$75.9 million.

The Board of FCHN considered several strategic alternatives to becoming a member of MaineHealth. These alternatives included affiliating with a number of other integrated healthcare delivery systems and remaining independent. The benefits of becoming a member of MaineHealth made it the best alternative. These benefits are described throughout this application.

The CONU will need to monitor the status of the Hart-Scott-Rodino process and will require the following condition:

Condition: MaineHealth will notify DHHS whether it intends to make a Notice and Report filing with the Federal Trade Commission under the HSR Act.

If MaineHealth makes a Notice and Report HSR filing, MaineHealth will:

- Provide to DHHS any letter from the Federal Trade Commission acknowledging the filing of the Notice and report.
- Notify DHHS if the Federal Trade Commission or Department of Justice has granted a request for early termination of 30-day waiting period requirement; or if the Federal Trade Commission or Department of Justice has made a formal request for additional information that would extend the 30 day waiting period.
- Notify DHHS if the Federal Trade Commission or Department of Justice has allowed the waiting period ad any subsequent extension to lapse without taking further action, thereby allowing the transaction to occur.

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.

VI. Outcomes and Community Impact

From Applicant

FCHN, especially its principal subsidiary FMH, and MaineHealth are committed to providing and are recognized for high quality, patient centered, affordable care.”

“FMH High Quality Outcomes”

“The mission of FMH is to provide high-quality, cost-effective, patient-centered health care to our west central Maine community. To achieve this mission FMH implements a rigorous Quality Management Process. The process is two-fold: **quality assurance** and **performance improvement**.”

“**Quality assurance** is a monitoring activity performed by knowledgeable people who review patient data on a regular basis. Quality assurance activities include identifying, measuring, analyzing, tracking, and reporting key indicators related to safety, health outcomes, and the quality of patient care.”

“**Performance improvement** is the process that takes place when quality assurance monitoring indicates a need. Performance improvement activities include defining the problem, charting processes, evaluating systems, and making improvements.”

“Quality Management involves all hospital departments and services, and focuses on improved health outcomes and the prevention and reduction of medical errors. All quality assurance and performance improvement activities are based upon the following principles: Safety; Effectiveness; Patient-centered care; Timeliness; Efficiency; and Equity.”

“Please refer to Exhibit 6-A: Franklin Memorial Hospital’s Quality Management Plan.”

“FMH Award Winning Care”

“FMH has received more national distinctions than any other hospital in Maine. Though proud of the awards, it is not the awards themselves that matter. It is what they testify to: FMH’s commitment to serving the community with the very best care.”

“Among the nation’s more than 5,000 hospital systems, FMH is one of only a handful that have been recognized with no fewer than five separate awards from the American Hospital Association: twice a finalist award for the Foster G. McGaw Prize, once a finalist award for the NOVA Award for innovation, once recipient of the Hospital Award for Volunteer Excellence and once the sole recipient of the Carolyn Boone Lewis Living the Vision Award.”

“FMH and its leaders have also earned unprecedented statewide attention, with dozens of awards such as the Governor’s Award in Technology, the Dr. Dan Hanley Leadership Award, the Ruth Shaper Award and the Maine Public Health Association Program Excellence Award.”

“Recent recognition of FMH includes the following:

2013 "A" Grade by the Leapfrog Group FMH was honored with an “A” grade in the fall 2013 update to the Hospital Safety Score, which rates how well hospitals protect patients from accidents, errors, injuries and infections. The Hospital Safety Score is compiled under the guidance of the nation’s leading experts on patient safety and is administered by The Leapfrog Group (Leapfrog), an independent industry watchdog.

2013 Top Performer on Key Quality Measures® by The Joint Commission Franklin Memorial Hospital was recognized by The Joint Commission for exemplary performance in using evidence-based clinical processes that are shown to improve care for certain conditions. FMH was recognized for its achievement on the following measure sets: acute myocardial infarction (heart attack), heart failure, pneumonia, outpatient services, and the surgical care improvement project.

2013 Most Wired Recipient FMH was named as one of 289 of the nation's most wired hospitals according to the results of the 2013 Most Wired Survey Benchmarking Study released in the July issue of Hospitals & Health Networks, the journal of the American Hospital Association (AHA).

2012 Most Wired Recipient FMH was named as one of 154 of the nation's most wired hospitals according to the results of the 2012 Most Wired Survey Benchmarking Study.

2011 Where to Work: Best Hospital IT Departments The Information Technology (IT) department at FMH has been named among the nation's first-ever "Where to Work: Best Hospital IT Departments" according to Healthcare IT News' December 7 issue, a publication of MedTech Media. The FMH department was ranked third in the small hospital category and was the only Maine hospital selected.

2011 Most Wired Recipient FMH was named among the nation's most wired hospitals according to the results of the 2011 Most Wired Survey Benchmarking Study released in the July issue of Hospitals & Health Networks, the journal of the American Hospital Association.

2009 Most Wired Hospital Recipient FMH was named among the nation's most wired hospitals in the "Top 25 Most Improved" category, according to the results of the 2009 Most Wired Survey Benchmarking Study released in the July 2009 issue of Hospitals & Health Networks, the journal of the American Hospital Association. Out of over 5,700 hospitals across the country, more than 1,300 were considered for the award. Franklin Memorial was one of just two hospitals in Maine to be recognized by the "Most Wired" organization this year."

"MaineHealth High Quality Outcomes"

"The MaineHealth Center for Quality & Safety (CQS) provides system-wide direction in the identification, prioritization, implementation, measurement, and communication of quality and safety initiatives. CQS supports MaineHealth members and affiliates and also provides support for internal programs. CQS focuses on the following areas:

- Data management, analysis and reporting to support quality and patient safety initiatives;
- Education and consultation on improvement science, methodologies, and system redesign;
- Program evaluation to assist with the design and implementation of methods to assess effectiveness and value of various MaineHealth programs."

MaineHealth's quality and safety goal is to increase optimum outcomes for patients by providing timely data to measure the delivery of the right care in the right way at the right time. In 2010 MaineHealth CQS, in collaboration with internal and external stakeholders (e.g. Maine Health Management Coalition, MaineHealth Board and staff, patients and patient advocates, payors, and quality improvement specialists from all MaineHealth organizations) developed a series of 19 clinical quality metrics that are central to payment reform and revised all reporting tools to reflect these new metrics."

"CQS developed a set of 10 criteria to guide the selection of these measures. Each measure was assessed on how strongly it aligns with requirements set forth by local, state and national organizations, and needed to meet MaineHealth's goals of promoting coordinated care, effective engagement, and improved outcomes. We achieved system-wide consensus on measures that cross multiple healthcare settings, reinforcing patient experience, care coordination, and Health information Technology (IT). These measures support the work of the Accountable Care Organization and other healthcare reform initiatives, and address critical areas of transitions of care, preventive health and at-risk populations."

VI. Outcomes and Community Impact

“The 19 System Measures are being rolled out in four phases. Each measure has a workgroup that is accountable for developing a system-wide action plan and establishing a baseline and target for each measure. The measures are reported on a quarterly basis using aggregate and disaggregate data to support transparency, and to provide incentives for improvement. The results of the measures are reviewed at the MaineHealth Quality Improvement Council and the MaineHealth Board of Trustees’ Quality Committee. This information is then presented to the MaineHealth Board of Trustees for further discussion and action.”

“This work is driving system-wide standardization, increased collaboration and communication, and reductions in waste as well as a system-wide culture that supports transparency, education and accountability. Holding ourselves accountable for the 19 system measures has encapsulated all three areas of the Triple Aim including better care, better health, and better expenditures patients.”

“MaineHealth Award Winning Care”

“MaineHealth and its members are recognized for delivering quality care. National and statewide awards and recognitions during 2012 and 2013 include the following:

The Joint Commission - 2012: Maine Medical Center (MMC) named one of the nation’s Top Performers on Key Quality Measures, one of only 620 hospitals. Goodall Hospital received “Top Performer on Key Quality Measurers” award for heart attack, pneumonia and surgical care. The Pen Bay Medical Center Stroke Program recertified Primary Stroke Center Certification.

The Leapfrog Group - 2012: Miles Memorial Hospital named one of three top rural hospitals in the United States for patient safety. MMC granted an “A” Hospital Safety ScoreSM. **2013:** Pen Bay Medical Center Receives National Top Hospital Award, 1 of 67 hospitals nationwide out of 1,200 hospitals that participated in Leapfrog’s survey. Goodall Hospital, Miles Memorial Hospital, Pen Bay Medical Center and Southern Maine Medical Center all received “A” Hospital Safety ScoreSM. Maine Medical Center received a ‘B.’”

“Maine Health Management Coalition - 2013: In celebration of their twenty year anniversary, the Maine Health Management Coalition recognized twenty individuals across the state for teaching and inspiring others to work collaboratively to improve quality and lower the cost of healthcare in Maine. Four MaineHealth physicians were honored as part of this group: **Jeffrey Aalberg, MD; Peter Bates, MD; Mark Fourre, MD; David Giransiracusa, MD.**”

“American Nurses Credentialing Center - 2012: Maine Medical Center redesignated as a Magnet hospital. 2013: SMMC was the first community hospital in Maine and one of fewer than 100 hospitals nationwide to receive Pathway to Excellence designation.”

“National Quality Measures for Breast Centers Program - 2012: Waldo County General Hospital’s Coastal Maine Center for Breast Health became a Certified Participant, only the second site in Maine.”

“Hospital Consumer Assessment of Healthcare Providers and Systems Honors - 2012: Kno-Wal-Lin Home Care and Hospice named Honors recipient, the only home health agency in Maine to receive this honor.”

“National Consortium of Breast Centers National Quality Measures for Breast Centers Program - 2013: Waldo County General Hospital’s Coastal Maine Center for Breast Health recognized as a Certified Quality Breast Center technology. Kim Lenfestey, MSW, the hospital’s breast care patient navigator, received NCBC Breast Patient Navigator Certification.”

“Anthem Blue Cross and Blue Shield Quality Insights Hospital Incentive Program - 2012: St. Andrews Hospital and Healthcare Center and Miles Memorial Hospital ranked first and second respectively in their category.”

“Harvard Pilgrim Health Care Honor Roll - 2013: Lincoln County Healthcare recognized for performance among the top 25 percent nationally on quality and patient experience measures.”

“American College of Surgeons - 2013: SMMC’s Center for Breast Care granted a three-year/full accreditation designation by the National Accreditation Program for Breast Centers (NAPBC), a program administered by the American College of Surgeons.”

“American College of Radiology - 2012: SMMC Center for Breast Care Designated a Breast Imaging Center of Excellence.”

“American Academy of Sleep Medicine - 2012: Pen Bay Medical Center’s Center for Sleep Medicine accredited”

“American Diabetes Association - 2012: Pen Bay Medical Center Diabetes and Nutrition Care Center awarded continued recognition.”

“American Telemedicine Association - 2012: Waldo County General Hospital’s Speech Pathology Department received Training Program Accreditation, only the fourth institution in the United States to receive accreditation.”

“HomeCare Elite - 2012: HomeHealth Visiting Nurses (HHVN) and Waldo County Home Health and Hospice named to the Top 25% of the 2012 HomeCare Elite™. 2013: Waldo County Home Health and Hospice placed on the Top 500 HomeCare Elite.”

“US News and World Report - 2012: MMC named the Best Hospital in Maine by US News and World Report and singled out for exemplary quality service in Cancer, Gynecology, Nephrology, Orthopedics, and Urology. 2013: MMC named the Best Hospital in Maine by US News and World Report and singled out for exemplary quality service in: Cancer, Cardiology and Heart Surgery, Diabetes and Endocrinology, Geriatrics, Gynecology, Nephrology, Orthopedics, and Urology.”

“Becker’s Hospital Review - 2012: Waldo County General Hospital listed as one of the 100 Great Community Hospitals across the country.”

“Maine Tobacco Free Hospital Network Gold Standards of Excellence Program - 2013: **Six MaineHealth member hospitals given gold awards:** Goodall Hospital, Maine Medical Center, Pen Bay Medical Center, Southern Maine Medical Center, Stephens Memorial Hospital and Waldo County General Hospital. Three designated silver: Miles Memorial Hospital, St. Andrew's Hospital and Spring Harbor Hospital.”

“Beacon Hospice - 2012: Western Maine Health’s Oxford Hills Internal Medicine honored for their commitment to excellence.”

“Potential Impact on Existing Providers’ Quality of Care”

“MaineHealth and FCHN do not anticipate nor are there any terms or conditions applicable to the Proposed Transaction that should have any impact on existing providers’ quality of care as a result of MaineHealth acquiring control of FCHN and its subsidiaries including FMH.”

Certificate of Need Unit Discussion

i. CON Standard

The relevant standard for inclusion in this section is 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

Both FCHN and MaineHealth have received numerous awards for delivering quality care (listed above). FMH will continue its' Quality Management Process which relies on Quality Assurance and Performance Improvement which are based on safety, effectiveness, patient-centered care, timeliness, efficiency and equity. A detailed description of Franklin Memorial Hospitals Quality Management plan was included in the CON application. FMHC membership in MaineHealth will allow for system-wide standardization, increased collaboration and communication and reduction in waste. MaineHealth and has developed a series of 19 clinical quality metrics that capture the three areas of the Triple Aim including better care, better health, and better patient expenditures. Education, transparency and accountability across the entire system will enhance high quality outcomes.

As noted in the public need section of this analysis a significant number of patients in the FCHN patient service area receive services elsewhere. Of particular note is that 30% of the patients receive services at Central Maine Medical Center and related facilities while only 9% receive services at Maine Medical Center. The applicant states that all referrals will continue to be based on an assessment of the patient's needs, the resources available and reasonably accessible by the patient and the patient's preference, therefore historical referral patterns will remain unchanged. It is important that CONU monitor the referral patterns. As a result CONU is including the following condition.

Condition: The applicant is to report referral patterns in the FCHN service area. The report will include the patients' diagnosis, permanent residence and hospital where the patient receives services. This report will be required on an annual basis within 90 days of its fiscal year end beginning with the time when the Certificate of Need was approved until a full three years have elapsed since the date of the project commencement.

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.

VII. Service Utilization

From Applicant

“Risk of Inappropriate Increases in Service Utilization”

“The Proposed Transaction will not increase health care utilization unnecessarily and will not create inappropriate or unnecessary demand. FCHN, its subsidiaries and providers will participate in MaineHealth’s health status improvement, clinical integration and quality improvement initiatives, which are designed to reduce service utilization.”

“FCHN and its predecessors have a long history of health status improvement, population health management and community health initiatives. FCHN will become a member of MaineHealth, a robust integrated healthcare system that is focused on clinical and community health improvement, quality and safety, population health management and administrative excellence. FCHN and MaineHealth have each focused on population health, preventative care and community health initiatives.”

“MaineHealth has developed and implemented the most comprehensive array of initiatives focused on population based health and prevention of disease of any organization in Maine and continues redirecting its resources to these initiatives. All MaineHealth members participate in these initiatives, contributing to their development and best practices.”

“Utilization of health care services by residents of the FCHN service area is not affected except to the extent that FCHN implementation of MaineHealth’s evidence-based, best practice health status improvement and clinical integration initiatives reduces utilization in the long term. This is the intent of MaineHealth’s population health management programs, which seek to align the delivery of care with the Triple Aim: improving patient experience, improving quality, and reducing overall cost of care.”

“FCHN’s History:

In the late 1960s and early 1970s, a cadre of diverse, brilliant, and creative physicians in Franklin County shared an unusually idealistic vision for the future of health care. These medical pioneers believed that a health care delivery system ought to value prevention and community health as part of its business model. They believed that it was not sufficient to reimburse providers for downstream emergency and acute care; they argued that complementary financial incentives needed to be available for clinicians and others who worked to prevent disease and injury in the first place. With the aid of a grant obtained from the federal Office of Economic Opportunity, this innovative group of individuals formed Rural Health Associates (RHA), one of the nation’s first Health Maintenance Organizations in an era long before HMOs became the subject of cynicism.”

“RHA employed physicians and, again a first in Maine, physician assistants, to provide primary care to members. The organization developed and operated three ambulatory health centers at strategic locations in remote corners of the region, and connected members to specialty care by employing RHA specialists based at the hospital.”

“RHA physicians and other clinicians offered blood pressure screenings in supermarkets and schools—unprecedented at the time—and even set up interactive telemedicine and computerized records long before satellite technology or the internet were in use. The organization trained a group of local people to serve as health advocates, assigned to different towns to visit people and offer health education and resources. Eventually they formed a partnership with the area university, University of Maine at Farmington, to develop a training program for advocates.”

“RHA’s influences are still felt in the Franklin community and at FCHN today. The original clinicians and advocates who ignited this movement have remained in the community, and many continue to be leaders at FCHN.”

“Many innovations originated by RHA remain as unique elements in today’s FCHN, including the presence of rural health centers with telemedicine capacity, the widespread availability of free screenings in community settings, and the integral involvement of physician assistants and now nurse practitioners. The University of Maine at Farmington program for health advocates grew to become Maine’s first Community Health Education program, now one of the university’s most popular majors and a key supplier of talented young people for Maine’s growing community health infrastructure.”

“In the late 1980’s and early 1990’s the hospital network and some of the former RHA physicians worked with others in the community to form the Healthy Community Coalition, with the goal of organizing and reinforcing community health efforts. Most of all, the RHA experience has instilled in the health system of the region the belief in the centrality of community health and prevention to the operations of the delivery system.”

“MaineHealth Population-based Initiatives”

“The mission of MaineHealth is “Working together so our communities are the healthiest in America”. MaineHealth has made financial and human resource commitments to this mission, based on the following beliefs:

- Health care costs in Maine (and nationally) will continue to increase due to demographic, technological and normal inflation factors which are generally beyond our control;
- If healthcare is to remain affordable to the vast majority of our citizens, changes will need to be made to the manner in which we currently provide and finance that care;
- The long-term solution to balancing increased utilization is to improve the health of the people of Maine;
- The health care challenge requires short-term solutions which improve the quality (both care delivery and outcomes), cost-efficiency (both clinical and administrative) and access to health care.”

“MaineHealth’s approach to improving the health of its communities focuses on two major types of initiatives:

- Health status improvement initiatives which address a health issue which is amenable to intervention based on specific, scientifically based programs
- Clinical integration initiatives which seek to improve the delivery of coordinated, integrated services to selected populations, particularly those with chronic diseases or for conditions where clinical guidelines and protocols have been demonstrated to improve outcomes.”

“Management of populations with chronic diseases has become a major focus of MaineHealth’s clinical integration initiatives. During the next 15 years, the population in Maine over the age of 65 is expected to double. Based on national studies, it may be anticipated that 60% of the population will have at least one chronic condition and 40% will have two or more. A recent study by researchers at Johns Hopkins, the US HHS Agency for Health Research and Quality and the University of Pennsylvania predicts that by 2030, 87% of the population will be overweight, 51% will be obese and the prevalence of overweight children will nearly double.”

“Since 1999, MaineHealth has been building health status improvement and clinical integration initiatives to address these challenges, funding them through a combination of MaineHealth dues, investment income and grants.”

“MaineHealth and its members are clearly committed to population based health and prevention and are redirecting resources to support those initiatives. Beginning in FY 2006, MaineHealth began providing partial support for these initiatives through fund balance transfers from member organizations.”

“Below are the MaineHealth budgets for these initiatives for FY 2010 through FY 2014.”

“MaineHealth Clinical Integration / Health Status Improvement Budgets (in 000s)

	<u>FY</u> <u>2010</u>	<u>FY</u> <u>2011</u>	<u>FY</u> <u>2012</u>	<u>FY</u> <u>2013</u>	<u>FY2014</u>
Clinical Integration	\$4,733	\$4,995	\$6,173	\$6,913	\$7,438
Health Status Improvement	3,804	4,314	4,971	4,707	6,347
Community Education	<u>2,537</u>	<u>2,573</u>	<u>2,540</u>	<u>2,359</u>	<u>2,999</u>
Total	<u>\$11,074</u>	<u>\$11,882</u>	<u>\$13,684</u>	<u>\$13,979</u>	<u>\$16,784</u> ”

“MaineHealth has not asked for more than what could be well used, and has continued to be successful in securing other support through grants. MaineHealth has adopted a strategy that recognized that, while it has been reasonably successful in its initiatives, MaineHealth must step up the scope and pace of these initiatives by committing up to 1% of its net assets annually to support these initiatives.”

“MaineHealth emphasizes collaboration in developing and implementing clinical integration and health status improvement initiatives; all provider organizations are welcome to join MaineHealth and use its tools. There are no competitors. The approach is based on bringing together providers to design and implement evidence based approaches to the care of patients and on measuring results.”

“Presented below are brief summaries of the major health status improvement and clinical integration initiatives supported by these resources. Detailed descriptions of these initiatives and the outcomes they have produced to improve the health of communities MaineHealth serves are on file with the Certificate of Need Unit are included in this application by reference.”

- “AH! Asthma Health – a comprehensive patient and family education and care management program targeting childhood asthma initially and now expanded to include adults;
- Target Diabetes – a comprehensive diabetes education and care management program;
- Caring for ME – designed to improve the ability of primary care providers to care for patients with depression and to educate patients and families on their roles in self-management;
- Healthy Hearts – designed to improve the care of patients with congestive heart failure and to educate patients and families on their roles in self-management;

- Clinical Improvement Registry – a computer based system provided to primary care practices in the MMC Physician-Hospital Organization and several other hospital physician organizations. The Registry provides patients and physicians with data on the management of chronic illnesses including asthma, diabetes, cardiovascular disease, depression and heart failure;
- MMC Physician Hospital Organization Clinical Improvement Plan – the Plan includes funding 23 practice based registered nurse care managers which support 265 physicians in 71 primary care practices; currently they are focusing on diabetes, depression and asthma;
- Raising Readers – a health and literacy project that provides books to all Maine Children from birth to age five at their Well Child visits;
- Care Partners – provides free physician and hospital care, drugs and care management to over 1,000 adults in Cumberland, Kennebec and Lincoln counties who do not qualify for federal and state programs;
- Center for Tobacco Independence – MaineHealth through a contract with the State manages the statewide smoking cessation program;
- Acute Myocardial Infarction/Primary Coronary Intervention Project – collaborative effort of 11 southern, central and western Maine hospitals, and their medical staffs that standardizes and improves the care of patients experiencing a heart attack;
- Stroke Program – assures that all patients with stroke receive the most up to date, high quality, efficient care; provides a coordinated system of care for stroke patients who must be transferred to another facility;
- Emergency Department Psychiatric Care – follows a medical clearance protocol for patients seen in the ED who need hospitalization; follows medication recommendations for agitated patients; and decreases the need for restraints and seclusion, including training ED staff how best to work with agitated patients;
- Healthy Weight Initiative – addresses adult and youth obesity, including a 12 step action plan (“Preventing Obesity: A Regional Approach to Reducing Risk and Improving Youth and Adult Health”);
- Youth Overweight – MaineHealth and MMC have joined with several other organizations including Hannaford, United Way, Unum, Anthem and TD Banknorth, to design and implement a 5 year initiative on youth overweight;
- Blood Transfusion – system protocols to reduce blood transfusions
- Hand Hygiene - system plan to reduce hospital infections through hand hygiene monitoring.
- The MaineHealth Cancer Resource Center – MaineHealth’s initiative focusing on:
 - Adopting evidence-based clinical care guidelines,
 - Reporting on quality metrics,
 - Attaining cancer care accreditation,
 - Improving access to specialists, clinical trials and genetic counseling services,
 - Developing patient navigation and survivorship programs,
 - Improving the Network Registry and
 - Coordinating services regionally.

- The MaineHealth Mental Health Integration Program - helps people get effective and efficient care for mental and behavioral health problems through primary care providers.
 - Provides training and materials to primary care offices throughout the MaineHealth system.
 - Services include screening, assessment and treatment approaches for mental health conditions commonly seen and treated in primary care, including depression, anxiety and substance abuse.
 - More than 2/3rds of MaineHealth hospital-owned primary care practices have integrated mental health professionals; the only other large health system nationally that may have a greater percent of practices integrated may be Intermountain Health System.
 - MaineHealth's Mental Health Integration Program and its leadership have received national recognition from such entities as: the Institute for Healthcare Improvement; Collaborative Family Healthcare Association; and the federal Substance Abuse and Mental Health Administration, Health Resources and Services Administration and Agency for Healthcare Research and Quality.
- Matter of Balance Volunteer Lay Leader Model
 - Developed by MaineHealth's Partnership for Healthy Aging in collaboration with MMC's Geriatric Center, Southern Maine Agency on Aging and the University of Southern Maine
 - Designed to reduce older adults' fear of falling and to increase their activity levels.
 - Participation is associated with total medical cost savings; cost savings in the unplanned inpatient, skilled nursing facility and home health settings; and a \$938 decrease in total medical costs per year.
 - Participation associated with an increase in physician office visits, increased use of physical therapy and occupational therapy and a notably lower mortality rate among participants compared with matched controls.

(Report to Congress: The Centers for Medicare & Medicaid Services' Evaluation of Community-based Wellness and Prevention Programs under Section 4202 (b) of the Affordable Care Act, CMS, 2013.)"

"MaineHealth and its members are clearly committed to population based health and prevention and are redirecting resources to support those initiatives. MaineHealth believes that these initiatives are entirely consistent with the best evidence-based practices regarding how to approach chronic disease. Evidence from our programs demonstrates that the Chronic Care Model can and does work. Letourneau et al, "Rural Communities Improving Quality through Collaboration," Journal for Healthcare Quality, (National Association for Healthcare Quality, Vol. 28, No. 5, pp. 15-27)."

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 project will not result in an inappropriate increase in service utilization in the Franklin County area. No new services or facilities have been developed due to this project and FCHN's service area remains unchanged. One of the goals of membership in MaineHealth is to adopt MaineHealth's evidence-based, best practice health status improvement and clinical integration initiatives in order to positively impact utilization.

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. Timely Notice

Letter of Intent filed:	January 15, 2014
Subject to CON review letter issued:	January 27, 2014
Technical assistance meeting held:	February 10, 2014
CON application filed:	February 24, 2014
CON certified as complete:	February 24, 2014
Public Information Meeting Held:	Waived
Public Hearing held:	April 03, 2014
Comment Period Ended:	May 03, 2014

IX. Findings and Recommendations

IX. 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;

IX. Findings and Recommendations

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 has demonstrated 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:

Condition: The applicant is to report improvements in quality and outcome measures related to the community services instituted to reduce chronic disease, obesity, colorectal cancer, dental care, domestic violence, fatal motor vehicle deaths, suicide and substance abuse. This report will be required on an annual basis within 90 days of its fiscal year end beginning with the time period when the Certificate of Need was approved until a full three years have elapsed since the date of the project commencement.

Condition: MaineHealth will notify DHHS whether it intends to make a Notice and Report filing with the Federal Trade Commission under the HSR Act.

If MaineHealth makes a Notice and Report HSR filing, MaineHealth will:

- . Provide to DHHS any letter from the Federal Trade Commission acknowledging the filing of the Notice and report.
- . Notify DHHS if the Federal Trade Commission or Department of Justice has granted a request for early termination of 30-day waiting period requirement; or if the Federal Trade Commission or Department of Justice has made a formal request for additional information that would extend the 30 day waiting period.
- . Notify DHHS if the Federal Trade Commission or Department of Justice has allowed the waiting period and any subsequent extension to lapse without taking further action, thereby allowing the transaction to occur.

Condition: The applicant is to report referral patterns in the FCHN service area. The report will include the patients' diagnosis, permanent residence and hospital where the patient receives services. This report will be required on an annual basis within 90 days of its fiscal year end beginning with the time when the Certificate of Need was approved until a full three years have elapsed since the date of the project commencement.