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

Date: **February 9, 2009**

Project: **SMMC to become a subsidiary corporation of MaineHealth**

Proposal by: **MaineHealth**

Prepared by: **Phyllis Powell, Certificate of Need Manager**
Steven R. Keaten, Healthcare Financial Analyst
Larry Carbonneau, Healthcare Financial Analyst

CON
Directly Affected Party: NONE

COPA
Persons Requesting Notification of an application from the department:
Anthem Blue Cross and Blue Shield
Julius Ciembroniewicz, Esquire - Kozak & Gayer, P. A.

Interveners:
Office of the Attorney General - 22 M.R.S.A. 1855 (6)
Governor's Office of Health Policy and Finance – 22 M.R.S.A. 1855 (6)

CON Recommendation: Approve with conditions
COPA Recommendation: Approve with conditions

	Proposed Per Applicant	**Approved CON**
Estimated Capital Expenditure	$ 101,837,236	$ 101,837,236
Maximum Contingency	$ 0	$ 0
Total Capital Expenditure with Contingency	$ 101,837,236	$ 101,837,236
Third Year Incremental Operating Costs	$ 0	$ 0
Capital Investment Fund (CIF) Impact:	$ 0	$ 0
Bureau of Insurance Regional Impact Estimate		0 %
Bureau of Insurance Statewide Impact Estimate		0 %

I. Abstract

A. From Applicant

i. CON From Applicant

"The Board of Trustees and Corporators of Southern Maine Medical Center propose to amend Webber Hospital Association d/b/a Southern Maine Medical Center (SMMC) Articles of Incorporation and Bylaws so that MaineHealth shall become its sole member thereby making SMMC a subsidiary corporation of MaineHealth (Membership). SMMC will maintain its existing corporate form. MaineHealth will be substituted for SMMC's existing corporators. The scheduled effective date is December 31, 2008 subject to gaining all required approvals, consents and authorizations."

"Webber Hospital Association is a non-profit § 501(c)(3) health care corporation doing business as Southern Maine Medical Center (SMMC), located in Biddeford, Maine, and providing a critically necessary continuum of high quality inpatient and outpatient health care services and primary and specialty physician services for the residents of York county."

"This project contemplates the maintenance of SMMC as a health facility in its current form. Day to day operation of the facility will remain as currently, subject to oversight by MaineHealth, and with future service and financial initiatives requiring approval by MaineHealth."

"The "Definitive Agreement" between MaineHealth and SMMC, signed by the Chief Executive Officers of each of the parties on February 28, 2008, reflects all consideration passing between MaineHealth and SMMC."

"Please refer to Exhibit I-A: Definitive Agreement."

"The SMMC Board of Directors will continue, and SMMC's current corporators will serve as an advisory committee. New members of the SMMC Board must be nominated by sitting members of the SMMC's Board, and are subject to the approval of MaineHealth as the sole member. At SMMC's request, at least 80% of the individuals elected and serving on the SMMC Board must be residents of York County. MaineHealth has agreed that it will not withhold approval of any SMMC board member nominated by the SMMC Board unless it has a rational basis for doing so."

"All property of SMMC pre-closing will remain the property of SMMC post-closing. SMMC will retain its tax-exempt charitable status. Endowment funds of SMCC, including funds held in trust or otherwise for the benefit of SMMC or its subsidiaries, will remain assets of SMMC subject to budgeting control of the SMMC Board of Trustees."

I. Abstract

"Day-to-day operational control of SMMC will reside with the SMMC Board of Trustees and SMMC management. The following activities and decisions of SMMC will require approval by MaineHealth: new SMMC's board members nominated by the SMMC board; appointment of SMMC's Chief Executive Officer; SMMC's annual operating and capital budgets; business marketing and strategic plans; disposition of assets of more than $250,000; incurrence of indebtedness outside the ordinary course of business in excess of $500,000; and initiating or terminating existing services."

"No change to the existing level and array of healthcare services provided by SMMC can occur unless it is initiated by SMMC and approved by MaineHealth."

"The Definitive Agreement also makes provisions for the composition of the MaineHealth Board. The SMMC Board may nominate for election two trustees to the MaineHealth Board serving for initial three-year terms. Thereafter, the SMMC Board may nominate one trustee to the MaineHealth Board. MaineHealth has also agreed that MaineHealth Board of Corporators will be geographically diversified as necessary over the same three-year period, with a goal of not less than ten percent of the total MaineHealth corporators will be residents of York County."

"As a member of MaineHealth, SMMC will continue and increase its participation in development and implementation of MaineHealth-initiated and sponsored health status improvement, clinical integration, and quality improvement initiatives. SMMC will also have access to shared administrative resources of the MaineHealth system, including legal services, financial services, strategic planning, program development and human resource management. SMMC may also participate in MaineHealth's health benefit and workers' compensation plans, and its professional liability insurance trust."

"MaineHealth has also submitted a letter of intent to the Department in anticipation of filing an application for a Certificate of Public Advantage (COPA) for the proposed acquisition of control by MaineHealth of SMMC as a subsidiary corporation (Membership). The issuance of a Certificate of Public Advantage is governed by the Hospital and Health Care Provider Cooperation Act, 22 M.R.S.A. Chapter 405-A, which prescribes a review process for evaluation of the transaction under detailed statutory standards. Under an agreement of the involved parties, and directive from the Department, this is a combined CON/COPA application."

"There is no capital expenditure requiring a Certificate of Need as described in 22 M.R.S.A. § 329 (3) involved in making SMMC a subsidiary corporation of MaineHealth (Membership). There are no incremental third year operating costs associated with this project. The project does not involve a debit against the amount credited to the Capital Investment Fund for the current annual effective period."

"MaineHealth is Fit, Willing and Able – Over the past twelve years, MaineHealth has incorporated into its health system five hospitals, two home health agencies and one hospital administrative support services organization. The DHHS CON unit determined that MaineHealth was fit, willing and able to support those changes in ownership for the five hospitals (Brighton Medical Center, St. Andrews Hospital, Miles Memorial Hospital, Stephens

I. Abstract

Memorial Hospital and Jackson Brook Institute/Spring Harbor Hospital) and one of the home health agencies (Community Health Services of Cumberland County).
MaineHealth is even better positioned today to bring in SMMC as a member than it was for these organizations. MaineHealth has the organizational structures and resources in place to ensure the quality of services at SMMC continues to improve and that SMMC maintains all appropriate licenses, certifications and accreditations. The board of SMMC and all key personnel at SMMC and MaineHealth will remain in place."

"Is Economically Feasible – SMMC's becoming a member of MaineHealth involves no capital expenditure by MaineHealth or SMMC requiring a certificate of need. Neither SMMC, MaineHealth, the State of Maine nor the health care delivery system in Maine will incur any increase in operating expenses as a result of this change in ownership. MaineHealth, as evidenced by its Standard and Poors AA- credit rating and its financial statements, has the financial capability to support this transaction."

"Meets a Public Need – Based on an extensive review and analysis, SMMC's Community Corporators ("owners"), Board of Trustees, Management and Medical Staff determined that it could best meet its mission of providing high quality health care and improving the health of the communities if it became a part of a larger health system. It selected MaineHealth as the organization that best shares SMMC's non profit values and its vision that health care is best delivered as locally as possible. SMMC will secure significant clinical and economic benefits from MaineHealth membership, strengthening its ability to serve its communities. Membership has the potential to positively impact the health status of the community and the quality of care."

"Is Consistent with Orderly and Economic Development – SMMC's joining MaineHealth, (enabling it to take maximum advantage of the benefits described in this application and to expand opportunities for collaborative efforts) is consistent with the orderly and economic development of the healthcare delivery system."

"Is Consistent With the State Health Plan – MaineHealth has developed and implemented the most comprehensive array of initiatives focused on population based health and prevention of any organization in Maine and has committed to continue to re-direct its resources to these initiatives. SMMC's physician recruitment plan is designed to reduce non-emergent ED use. As an affiliate since 1993, SMMC has taken advantage of multiple opportunities for collaboration with MaineHealth and its members to lower costs and increase efficiency and quality. Membership will ensure SMMC's continuing access to these initiatives and further expands opportunities for collaboration in clinical services planning and delivery. Implementing its physician recruitment plan with MaineHealth assistance will improve access to care. The change in ownership should not have any impact on regional and statewide health insurance premiums. MaineHealth's commitment to electronic information systems is extensive, including an ambulatory electronic record, a PACs system for imaging, an electronic ICU monitoring system and its support of Health InfoNet."

"Outcomes and Community Impact – The change in ownership will not negatively affect the quality of care at existing providers, and will not negatively impact SMMC's existing services.

I. Abstract

SMMC's financial condition will benefit through cost reductions resulting from SMMC's access to MaineHealth's administrative integration initiatives. MaineHealth's support and expertise will create additional opportunities for SMMC to improve the quality of care it provides and improve the health of its communities."

"Service Utilization – SMMC joining MaineHealth will have no adverse impact on the utilization of services by residents of the service area."

"Capital Investment Fund – Since there is no capital expenditure and no increase in operating expenses, the change of ownership does not involve a debit against the Capital Investment Fund."

ii. COPA From Applicant

"The Applicants – MaineHealth and Webber Hospital Association, d/b/a Southern Maine Medical Center ("SMMC") – request the Department to issue a Certificate of Public Advantage pursuant to Maine's Hospital and Health Care Provider Cooperation Act, codified at 22 M.R.S.A., §1841, et seq. for a cooperative agreement to which they are parties. The cooperative agreement (included as Appendix I-A) is styled "Definitive Agreement" between MaineHealth and SMMC, and signed by the Chief Executive Officers of each of the parties on February 28, 2008."

"MaineHealth, is a not-for-profit charitable corporation organized and existing under the laws of the State of Maine headquartered in Portland, Maine. MaineHealth oversees a system of healthcare providers, including Maine Medical Center in Portland; Stephens Memorial Hospital in Norway; Miles Memorial Hospital in Damariscotta; St. Andrews Hospital in Boothbay Harbor; Spring Harbor Hospital in Westbrook; Home Health Visiting Nurses; NorDx; Synernet; MMC Physician Hospital Organization; Maine Physician Hospital Organization; and Maine Medical Partners. Collectively the MaineHealth system provides primary, secondary and tertiary hospital care; out-patient services; in-patient and out-patient mental health services; home health services; reference laboratory services; and medical and surgical services through employed physicians. MMC serves as a teaching hospital for the University of Vermont Medical School."

"Webber Hospital Association, d/b/a Southern Maine Medical Center ("SMMC"), is a not-for-profit charitable corporation organized and existing under the laws of the State of Maine, headquartered in Biddeford, Maine. SMMC is a general acute care hospital in Biddeford, Maine, with a licensed capacity of 150 beds. SMMC provides a full range of primary and secondary inpatient and outpatient hospital services and primary and specialty physician services primarily to residents of York County. SMMC provides York County's only inpatient mental health treatment facility. SMMC also provides home nursing care through its affiliate SMMC Visiting Nurses; community education and prevention programs; outpatient services at diagnostic and therapy centers in Saco, Kennebunk, and Biddeford; and medical and surgical services through employed physicians. SMMC has served as a teaching hospital for University of New England's College of Osteopathic Medicine and its medical students. SMMC has been an affiliate of MaineHealth since 1993."

I. Abstract

"The Definitive Agreement between MaineHealth and SMMC reflects all consideration passing between MaineHealth and SMMC under their cooperative agreement, and in summary form provides as follows:"

1. Corporate Structure

"By virtue of the Definitive Agreement, MaineHealth will become the sole member of the non-profit corporation known as Webber Hospital Association, and as such, will have "control" over SMMC within the meaning of 22 M.R.S.A. §1843(1). Applicants are proceeding on the understanding that a transaction of this structure constitutes an agreement for a "merger" within the meaning of 22 M.R.S.A. §1843(1) and (5)."

"Under the Definitive Agreement, SMMC will maintain its existing corporate form. MaineHealth will be substituted for SMMC's existing corporators. SMMC's current corporators will serve as an advisory committee."

2. Board of Trustees of SMMC

"Under the Definitive Agreement, the members of the SMMC Board of Trustees will continue to hold office. New members of the SMMC Board must be nominated by sitting members of SMMC's Board. New Board members are subject to the approval of MaineHealth as the sole member. MaineHealth has agreed that it will not withhold approval of any SMMC board member nominated by the SMMC Board unless it has a rational basis for doing so. At least 80% of the individuals elected and serving on the SMMC Board must be residents of York County."

3. Board of Trustees of MaineHealth

"The Definitive Agreement also makes provisions for the composition of the MaineHealth Board of Trustees. The SMMC Board may nominate for election two trustees to the MaineHealth Board serving for initial three-year terms. Thereafter, the SMMC Board may nominate one trustee to the MaineHealth Board. MaineHealth has also agreed that MaineHealth's Board of Corporators will be geographically diversified as necessary over three-years, with a goal that not less than ten percent of the total MaineHealth corporators will be residents of York County."

4. Property of SMMC

"All property of SMMC pre-closing will remain the property of SMMC post-closing. SMMC will retain its tax-exempt charitable status. Endowment funds of SMMC, including funds held in trust or otherwise for the benefit of SMMC or its subsidiaries, will remain assets of SMMC subject to budgeting control of the SMMC Board of Trustees."

I. Abstract

5. Management of Operations and Oversight of Major Initiatives of SMMC

"Under the Definitive Agreement, day-to-day operational control of SMMC will reside with the SMMC Board of Trustees and SMMC management."

"Under the Definitive Agreement, the following activities and decisions of SMMC will require approval by MaineHealth: SMMC's annual operating and capital budgets; business marketing and strategic plans; disposition of assets of more than $250,000; incurrence of indebtedness outside the ordinary course of business in excess of $500,000; and initiating or terminating existing services."

"No change to the existing level and array of healthcare services provided by SMMC can occur unless it is initiated by SMMC and approved by MaineHealth."

6. Further Commitments of MaineHealth to SMMC:

"Under the Definitive Agreement, MaineHealth has agreed to assist SMMC in its efforts to execute its current plans for the deployment of electronic medical records among SMMC medical staff members, and the execution of SMMC's medical staff development plan."

"With respect to electronic medical records, MaineHealth will provide financial support of at least $2.2 million to SMMC over a period of three years for deployment of an electronic medical system for SMMC and its employed physicians."

"Under the Definitive Agreement, MaineHealth has agreed to provide up to 100% of the debt financing to cover the direct costs of as many as four medical office buildings, as needed, with an aggregate space area of approximately 60,000 square feet, to house physician offices for physicians providing services in SMMC's service area."

"SMMC, as a member of MaineHealth, will have access to MaineHealth's credit facility, and the benefits that derive from the fact that all of the hospital members of MaineHealth stand behind the indebtedness."

"As a member of MaineHealth, SMMC will continue its participation in development and implementation of MaineHealth-initiated and -sponsored health status improvement and clinical integration initiatives. SMMC will also have access to shared administrative resources of the MaineHealth system, including financial services, strategic planning, program development, human resource management, and legal services."

"There are no additional commitments of SMMC to MaineHealth under the Definitive Agreement."

I. Abstract

7. Termination

"The Definitive Agreement contemplates that each of MaineHealth and SMMC has the right to terminate the Agreement within 90 days after the second anniversary of the transaction."

B. CONU Discussion

i. CON Analysis

MaineHealth is a non-profit healthcare corporation that is the parent of several hospitals, nursing facilities, physician practices and other health care related entities located throughout parts of southern, western and mid-coastal Maine. MaineHealth also has numerous strategic affiliation agreements with other hospitals within the same area. By virtue of its size, MaineHealth is the largest such healthcare organization in Maine. MaineHealth's administrative offices are located in Portland, Maine.

Webber Hospital Association d/b/a Southern Maine Medical Center (SMMC) is a non-profit healthcare corporation that is the parent of a 150-bed acute care community hospital and several other healthcare related entities that serve 18 towns in their primary and secondary service area of north coastal York County, Maine. SMMC administrative offices and the hospital are located in Biddeford, Maine. SMMC offices, located in Biddeford, are approximately 20 miles from MaineHealth's offices in Portland.

MaineHealth and SMMC have entered into a "Definitive Agreement" that would make SMMC a subsidiary corporation of MaineHealth (Membership). In addition to the CON application, MaineHealth and SMMC have also simultaneously filed for a Certificate of Public Advantage (COPA).

This project involves additional capital expenditures and/or commitments by MaineHealth of $2.2 million to support electronic medical record deployment for SMMC and their employed physicians. The "Definitive Agreement" encumbers MaineHealth to provide up to 100% of the debt financing to cover the direct costs of as many as four medical office buildings, as needed, with an aggregate space area of approximately 60,000 square feet, to house physician offices for physicians providing services in SMMC's service area. The statute defines capital expenditure as "an expenditure that under generally accepted accounting principles is not properly chargeable as an expense of operation" 22 M.R.S.A. 103-A §328 (3). The statute also excludes the expenditures related to medical office buildings and electronic medical record development. At the Public Hearing on November 17, 2008, the applicants were asked questions regarding the inclusion of these expenses in the financial presentation submitted to CONU. The applicants responded that expenditures related to these projects were not included because they had not determined when these expenditures would occur. Additionally, at the Public Hearing, it was disclosed that SMMC had completed a transaction to acquire a physician's office group located in Saco, ME totaling an estimated $15 million.

I. Abstract

ii. COPA Analysis

The Department, in accordance with its authority under 22 M.R.S.A. §844, can issue a Certificate of Public Advantage (COPA) once it makes certain findings and determines that, by a preponderance of the evidence, the likely benefits resulting from the implementation of the Definitive Agreement outweigh any disadvantages attributable to any reduction in competition likely to result from the Definitive Agreement and its implementation.

MaineHealth is a not-for-profit charitable corporation organized and existing under the laws of the State of Maine. MaineHealth is headquartered in Portland, Maine. MaineHealth oversees a system of healthcare providers, including the following hospitals:

Maine Medical Center in Portland
Stephens Memorial Hospital in Norway
Miles Memorial Hospital in Damariscotta
St. Andrews Hospital in Boothbay Harbor
Spring Harbor Hospital in Westbrook

MaineHealth, in a joint venture with HealthSouth also exhibits control over the New England Rehabilitation Hospital of Portland.

On December 31, 2008, a CON was granted allowing Waldo County Healthcare Inc. to become a subsidiary of MaineHealth.

Because MaineHealth is a parent corporation of one or more acute care institutions licensed and operating in this state under 22 M.R.S.A. §1811, it is therefore a “hospital” within the meaning of 22 M.R.S.A. §1843(5).

Webber Hospital Association, d/b/a Southern Maine Medical Center (SMMC), is a not-for-profit charitable corporation organized and existing under the laws of the State of Maine, headquartered in Biddeford, Maine. SMMC is a general acute care hospital in Biddeford, Maine with a licensed capacity of 150 beds, providing a range of primary and secondary inpatient and outpatient services. Southern Maine Medical Center has been an affiliate of MaineHealth since 1997.

SMMC is licensed and operating in this state under 22 M.R.S.A. §1811, and is therefore a “hospital” within the meaning of 22 M.R.S.A. §1843(5).

II. Fit, Willing and Able

A. From Applicant

i. CON From Applicant

"Summary – MaineHealth is fit, willing and able to bring SMMC into its system. During the past twelve years, MaineHealth has brought five hospitals, two home health agencies and one hospital administrative support services organization in as members of MaineHealth. Bringing all five of the hospitals (Brighton Medical Center, St. Andrews Hospital, Miles Memorial Hospital, Stephens Memorial Hospital and Jackson Brook Institute/Spring Harbor Hospital) and one of the home health agencies (Community Health Services of Cumberland County) required determinations by the Maine Department of Health and Human Services Certificate of Need Unit that MaineHealth was fit, willing and able to support these organizations. Under the leadership of MaineHealth and these organizations' boards, managements and clinical leadership, all have made significant contributions to the communities they serve and have been recognized frequently for those contributions. As an example of the value provided to the communities served, MaineHealth rescued Jackson Brook Institute from bankruptcy and transformed it into the leading provider of mental health services in Maine, Spring Harbor Hospital. Spring Harbor Hospital how serves as the gatekeeper/coordinator for the triaging of mental health admissions to community hospitals, Riverview, and Spring Harbor Hospital for southern, central and western Maine. MaineHealth monitors the quality of services provided by its members and has set a vision of quality to be recognized nationally as a leader in health care quality and safe patient and family centered care. Its members have been recognized nationally by such organizations as U.S. News and World Report, Centers for Medicare and Medicaid, the LeapFrog Group, Solucient, Avatar, The American Nurses Credentialing Committee for Magnet Hospitals, HealthGrades, Governor's Award for Environmental Excellence, The Maine Health Management Coalition and American Cancer Society."

Profile of MaineHealth
"MaineHealth
465 Congress Street
Suite 600
Portland, Maine 04101
http://www.mainehealth.com"

"Maine Health'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 provide organizations."

Service Area
"MaineHealth's service area is defined in the following manner:

II. Fit, Willing and Able

Primary: Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo and York counties.
Secondary: Aroostook, Hancock, Penobscot, Piscataquis and Washington counties."

Members, Affiliated Entities & Related Parties

"MaineHealth consists of the following members:
Maine Medical Center – hospital; Maine Medical Partners – diagnostic, 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 the Portland Community Physicians Organization;

New England Rehabilitation Hospital of Portland - joint venture rehabilitation hospital with HealthSouth;

MMC/Maine General Medical Center Joint Venture Cath. Lab;

Cancer Care Center of York County –MMC/Southern Maine Medical Center/Goodall Hospital joint venture radiation therapy center.

Spring Harbor Hospital – psychiatric hospital.

NorDx, Scarborough, Maine – general and reference laboratory services.

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

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

Intellicare – joint venture providing telephone support services to medical practices.
Maine Molecular Imaging – joint venture providing positron emission tomography (PET) scans.

MaineHealth Vital Network - central monitoring system staffed by intensive care physicians and nurses for intensive care patients in multiple locations.
Lincoln County Health Care – overseeing and coordinating integrated health care services of St. Andrews Hospital and Healthcare Center, and Miles Health Care.

St. Andrews Hospital and Healthcare Center – hospital, nursing home, home health agency, physician practices and assisted living.

II. Fit, Willing and Able

Miles Health Care – hospital, nursing home, home health agency, physician practices and assisted living.

Western Maine Health Care – hospital (Stephens Memorial Hospital), nursing home and physician practices.

Maine PHO – joint Physician-Hospital Organization (PHO) of the PHO's of Maine General Medical Center, Southern Maine Medical Center, Maine Medical Center, Stephens Memorial Hospital and St. Mary's Regional Medical Center.

Maine Behavioral Health Partnership – joint venture of MaineHealth, Maine Medical Center, Sweetser, Spurwink, Southern Maine Medical Center, Spring Harbor Hospital and St. Mary's Regional Medical Center providing behavioral health case management services for self-insured employers.

Synernet – not for profit organization providing group purchasing and consulting services for its member organizations."

"MaineHealth also has affiliation agreements with Southern Maine Medical Center, Maine General Health, Mid Coast Health Services, Pen Bay Healthcare and Sisters of Charity Health System (St. Mary's Regional Medical Center)."

Fit, Willing and Able

"Throughout its history, MaineHealth has demonstrated on numerous occasions its ability to effectively and efficiently integrate a variety of health care organizations into its governance and management structures while maintaining a strong and vibrant role for the local community in governance. Examples include:

- Community Health Services, the largest home health agency serving Cumberland County, joins MaineHealth (1996);
- Brighton Medical Center merged into MMC and its acute care services consolidated at MMC (1996);
- Maine Medical Center and HealthSouth create a 50/50 100 bed joint venture acute rehabilitation hospital at the former Brighton Medical Center, combining MMC's acute rehabilitation program with New England Rehabilitation Hospital's 80 beds (1996);
- St. Andrews Hospital and Health Care Center and Miles Health Care join MaineHealth (1996 – 1997); MaineHealth combines St. Andrews and Miles under a single governance structure to ensure the delivery of services in Lincoln County are fully integrated and coordinated (2008)
- Western Maine Health Care (Stephens Memorial Hospital) joins MaineHealth (1999)
- Through a series of mergers, the financially distressed Jackson Brook Institute is converted to the not-for-profit MaineHealth member Spring Harbor Hospital (1999-2001)
- Synernet, a shared services organization of 7 hospitals, joins MaineHealth (2001)

II. Fit, Willing and Able

- Community Health Services merges with Visiting Nurse Service of Southern Maine and Seacoast New Hampshire, the largest home health agency in York County, to create Home Health Visiting Nurses of Southern Maine (2004)
- The Maine PHO (a joint venture of Physician Hospital Organizations of Maine Medical Center, Southern Maine Medical Center, Maine General Medical Center and St.Mary's Regional Medical Center) becomes a MaineHealth member to integrate regional risk based contracting and quality improvement (1999)"

"Incorporating six of these organizations into MaineHealth membership (Brighton Medical Center, St. Andrews Hospital, Miles Memorial Hospital, Stephens Memorial Hospital, Jackson Brook Institute/Spring Harbor Hospital and Community Health Services) required determinations by the Maine Department of Human Services Certificate of Need Unit that MaineHealth was fit, willing and able to support these 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 duplication of services and improving efficiency, access and quality."

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

- MaineGeneral Health/Maine General Medical Center (1997)
- Southern Maine Medical Center (1993)
- Mid Coast Health Services/Mid Coast Hospital (1999)
- St. Mary's Regional Medical Center (2000)
- One Maine Collaborative (MaineHealth, Eastern Maine Health Care and Maine General Health) (2007)
- Pen Bay Health Care/Pen Bay Medical Center (2008)"

"The increasing complexities of health care delivery, financing and reimbursement make it difficult, if not impossible, for small to medium size organizations to meet the needs of their communities as stand alone organizations. Evidence of these trends of hospitals joining systems include:

- Nationally, 55% of all community hospitals are in health care systems;
- In Maine, 60% of hospitals are members of or affiliated with Maine based or national systems."

"Through a definitive agreement, MaineHealth and the organizations that have joined MaineHealth as members have defined the roles, responsibilities and expectations of the organizations. MaineHealth's approach to governance and management, embodied in the

II. Fit, Willing and Able

Definitive Agreement with Southern Maine Medical Center and with members such as Western Maine Healthcare, Miles Healthcare and St. Andrews Hospital, can best be described as a "decentralized model". The joining organization's board, medical staff and management retain field responsibility for policy, management, fiscal affairs, clinical program development, quality and safety and performance improvement. The CEO's of the member organizations along with the MaineHealth senior staff recommend policy, program development and budget performance targets to the MaineHealth Board of Trustees. The MaineHealth Board reviews and approves member organizations' budgets, strategic plans, property acquisitions and dispositions, debt financing above a certain level and major capital projects."

Commitment to Quality

"MaineHealth is committed to being recognized by patients, payors and providers as the benchmark for quality and safety, patient and family experience and evidence based use of resources. On a quarterly basis the MaineHealth board reviews quality performance measures for all member and affiliate organizations, including:

- National Quality Forum hospitals measures
- Performance of participants in the MaineHealth Vital Network (electronic ICU monitoring system)
- Home health clinical measures
- Long term care clinical measures"

"In 2007, the MaineHealth Board adopted the following 10 year vision for quality and safety:

> "In 2017 MaineHealth will be a nationally recognized leader in health care quality and safe patient and family centered care. We will achieve that status not because we seek national prominence for its sake but rather it will be founded on an unwavering system level commitment to quality and safety and continuously improving the health of the communities we serve. Achieving and sustaining excellence starts with our belief that every single patient in the communities we serve deserves the highest quality health care services that we can provide in an efficient and cost effective manner. We will communicate publicly our quality, safety and cost information to aid patients and their families in making informed choices when seeking health care services. The core of our success will be our boards' and management teams' focusing at all levels on quality and safety as the critical elements driving strategic planning. Across the continuum of care our physicians, nurses, staff, patients and their families will collaborate to set high standards, monitor performance, openly share results and work together to continuously improve quality and safety."

"To implement that vision, MaineHealth has established its Center for Quality and Patient Safety under the direction of Dr. Vance Brown, MaineHealth Chief Medical Officer. The Center will focus on:

II. Fit, Willing and Able

- Board Engagement – All MaineHealth and member board members will complete a core curriculum in quality and safety developed by the Center. That training will enable every board member to better understand quality, safety and performance improvement and enable them to take a greater role in ensuring quality and safety in their organization.
- Education and Consultation – Center staff will provide support and expertise to member organizations in developing and implementing quality and safety initiatives. Responsibility for quality improvement and monitoring will remain at the local level.
- Performance Measurement and Reporting – Member organizations are overwhelmed at present by the number of organizations requesting quality and safety performance information. The Center will provide support for data collection, measurement and reporting allowing members to focus on actual quality and performance improvement.
- Accreditation and Regulatory Support – The Center will provide the support and expertise to ensure member organizations attain and maintain all appropriate licensure and accreditation standards.
- System Wide Performance Targets – Working with members, MaineHealth will identify system wide performance targets to ensure consistency and accountability for major clinical processes. Included in these efforts will be clinical decision support systems that facilitate the monitoring of performance."

"Under MaineHealth's Leadership, our member organizations have been recognized by a wide variety of organizations for the quality of services they provide to their communities. Presented below are a sample of the awards and recognition received. In addition to these awards, MaineHealth has been named for the past two years by Verspan to its list of the Top 100 Integrated Health Networks (based on grades for operations, quality, scope of services and efficiency). In 2007, MaineHealth ranked number 86 and in 2008 we ranked number 40 (See Exhibit II-A). MaineHealth is committed to the communities it serves as evidenced by its 2007 Community Benefit Report (Exhibit II-B)."

MAINEHEALTH NOTABLE AWARDS AND RECOGNITIONS

"Miles Health Care

- Governor's Award for Environmental Excellence - 2002, 2004
- EPA Environmental Merit Award – 2005
- Maine Environmental Leader - 2005
- Participant in Maine's STEP-UP - 2002, 2003, 2004, 2005, 2006, 2007, 2008
- Participant in Governor's Carbon Challenge - 2004, 2005, 2006, 2007, 2008
- NorDx was also honored by receiving a write up in the State Officials Guide (2003) in the chapter of Environmental Management Systems, published by the Council of State Governments
- Avatar Patient Satisfaction, 2003, 2004, 2005, 2006"

II. Fit, Willing and Able

"Spring Harbor Hospital

- **2008:** Board member Anne Pringle named Volunteer of the Year by Maine Governor John Baldacci
- **2008:** Director of Nutritional Services Joseph Pastore wins **Future Horizons Award** from the National Society of Healthcare Foodservice Management (HFM).
- **2007:** $324,000 grant from the Maine Health Access Foundation to continue the hospital's pilot program to integrate mental health treatment within primary care settings in Maine.
- **2007:** $15,000 grant from The Sadie and Harry Davis Foundation to research outcomes of Spring Harbor's intensive community treatment program serving youth and families of Greater Portland.
- **2006:** $12 million grant from The Robert Wood Johnson Foundation for dissemination of research to identify and prevent serious mental illness in youth
- **2006:** $1 million donation from Judy and Al Glickman of Cape Elizabeth to establish the Glickman Family Center for Child & Adolescent Psychiatry at Spring Harbor Hospital
- **2006:** Joint Commission *Gold Seal of Approval* (Spring Harbor Hospital & Spring Harbor Counseling)
- **2005:** Construction of the new Spring Harbor Hospital facility is named 'Project of Distinction' by the Maine chapter of the Project Management Institute.
- **2004:** *Healthcare Leaders* national finalist for *Top Leadership Teams in Healthcare* competition (executive management team)
- **2004:** Spring Harbor Hospital opens Maine's only inpatient treatment unit for youth with developmental disorders and autism
- **2004:** *Warren Williams Assembly Speakers Award* from the American Psychiatric Association (William McFarlane, M.D., director of psychiatric research)
- **2004:** GAINS Center *National Achievement Award* for involvement in the Cumberland County Jail Diversion Grant Program (the ACCESS assertive community treatment team for adults)"

"Western Maine Health Care

- **2008** - Our diabetes self management program received an award from the American Diabetes Association for our self-management program.
- Blue Ribbon Award - Maine Health Management Coalition
- Western Maine Health received the Employer of the Year Award from the Oxford Hills Chamber of Commerce
- **2007** - The FDA awarded SMH with a perfect score for the inspection of our mammography department.
- Our Breast Cancer Team was awarded the Sandra C. Labarec North East Volunteer Values Award by the American Cancer Society
- Blue Ribbon Maine Health Management Coalition (only for part of the year)
- **2006** - The Women's Imaging Center received the first award ever by the Mammography Regulation and Reimbursement Report for breast imaging innovation for our free mammogram coupon program

II. Fit, Willing and Able

- Maine Health Management Coalition Blue Ribbon Award
- Market Square Health Care Center - (WMH's nursing home)
  2007 - SHARP Awards (2)*
  2005 - SHARP award
  Facility of the Year by Advance for Providers, a national magazine for long term care"

"Maine Medical Center

- **U.S. News & World Report**

  2008 #41 of 50 in nation for gynecologic care

  2007 #45 of 50 in nation for orthopedic care
  2007 #50 of 50 in nation for heart care and heart surgery

- **Centers for Medicare & Medicaid Services**

  2007 Top 1% in nation for heart attack
  2007 Top 5% in nation for overall cardiac mortality

- **Committee on Trauma of the American College of Surgeons**

  2007 Certified Level I Trauma Center

- **The Leapfrog Group**

  2006 **Leapfrog** Top 50 Hospitals (based on safety practices)

- **Hospitals & Health Networks Magazine**

  2007 Top 25 "Most Wireless" Hospitals
  2006 Top 100 "Most Wired" Hospitals
  2006 Top 25 "Most Wireless" Hospitals

- **American Nurses Credentialing Committee**

  2006 Magnet Recognition for Excellence in Nursing

- **Maine State Employees Health Commission**

  2006 "Preferred Hospital"

- **Consumer's Digest**

  2005: #4 on list of "50 Exceptional U.S. Hospitals"
  (based on Leapfrog/NQF safety practices)

- **Joint Commission**

  Joint Commission Accredited Hospital
  2007 Disease-specific Certification: Primary Stroke Center
  2006 Disease-specific Certification: Heart Failure

II. Fit, Willing and Able

- **Solucient (formerly HCIA)**

  1999 Top 100 Cardiovascular Hospitals
  2001 100 Top Cardiovascular Hospitals
  2002 100 Top Hospitals
  2004 100 Top Cardiovascular Hospitals

- ***Child* Magazine**

  2003 Top 25 Children's Hospitals

- **Cleverly + Associates Community Value Index**

  2007 Community Value Top 100 Provider

- **HealthGrades**

  2009 Ratings

  Ranked #1 in Maine for Overall Cardiac Services nine years in a row (2001-2009)
  Ranked #1 in Maine for Cardiology Services nine years in a row (2001-2009)
  Ranked #1 in Maine for Cardiac Interventions Procedures seven years in a row (2003-2009)
  Recipient of the HealthGrades Cardiac Care Excellence Award™ five years in a row (2005-2009)
  Only Hospital in Maine to Receive HealthGrades Cardiac Care Excellence Award™ five years in a row (2005-2009)
  Recipient of the HealthGrades Coronary Intervention Excellence Award™ two years in a row (2008-2009)
  Only Hospital in Maine to Receive HealthGrades Coronary Intervention Excellence Award™ two years in a row (2008-2009)
  Ranked Among the Top 5% in the Nation for Cardiology Services seven years in a row (2003-2009)
  Ranked Among the Top 5% in the Nation for Coronary Interventional Procedures seven years in a row (2003-2009)
  Ranked Among the Top 10% in the Nation for Overall Cardiac Services seven years in a row (2003-2009)
  Five-Star Rated for Overall Cardiac Services in 2009
  Only Hospital in Maine Five-Star Rated for Overall Cardiac Services in 2009
  Five-Star Rated for Cardiology Services six years in a row (2004-2009)
  Five-Star Rated for Coronary Interventional Procedures nine years in a row (2001-2009)
  Five-Star Rated in the Treatment of Heart Attack nine years in a row (2001-2009)
  Five-Star Rated in the Treatment of Heart Failure in 2009

  Ranked #1 in Maine for Joint Replacement Surgeries
  Ranked Among the Top 10% in the Nation for Joint Replacement Surgeries
  Recipient of HealthGrades 2008 Joint Replacement Excellence Award™
  Only hospital in Maine to receive HealthGrades 2008 Joint Replacement Excellence Award™ Five-Star
  Rated for Joint Replacement Surgeries
  Five-Star Rated for Total Knee Replacement Surgery
  Five-Star Rated for Total Hip Replacement Surgery

II. Fit, Willing and Able

- **American Red Cross of Southern Maine**

  2007 Outstanding Medical Provider

- **National Research Corporation**

  2004-2005 Healthcare Market Guide, "Consumer's Choice #1, Overall Quality and Image"
  2007-2008 Healthcare Market Guide, "Consumer's Choice #1, Overall Quality and Image"

- **United Way of Greater Portland**

  2004 "Leading the Way" Award

- **Ronald McDonald House − Portland, Maine**

  2004 "Heart of Gold" Award

- **City of Portland**

  1997 Mayoral Proclamation recognizing MMC's value to community

- **Pine Tree Council, Boy Scouts of America**

  2004 Distinguished Citizen Award to Vincent S. Conti

- **U.S. Department of Health and Human Services**

  2005 Medal of Honor for Organ Donation Success

  2008 Medal of Honor for Organ Donation Success

- **2008**
  Family Medicine Centers were awarded three out of three blue ribbons from the Maine Health Management Coalition for the Pathways of Excellence – Primary Care Initiative

- **2007**

  6th Annual Nursing Excellence Awards: Pediatric Diabetes Dream Team receives Team Award

  Communications & Marketing group receives three awards from the New England Society for Healthcare Communications

  R1 (Cardiac Surgical Post-Op and Intermediate Care Unit) receives the 2006 Service Quality Innovation Award from Avatar

  Environmental Services named Department of the Year by Health Facilities Magazine and the American Society for Healthcare Environmental Services

  Special Care Unit awarded 2007-2008 Beacon Award for Critical Care Excellence by the American Association of Critical-Care Nurses"

II. Fit, Willing and Able

"SMMC

- **Avatar Patient Satisfaction Awards**

Exemplary Service Overall Best Performer (Among the Top 12 Hospitals in the Nation)	2005, 2006, 2007, 2008
Five Star Service Exceeding Patient Expectations	2004, 2005, 2006, 2007, 2008
Best in the Nation, Outpatient Services	2004, 2005, 2006, 2007
Five Star Service Outpatient Services	2004, 2005, 2006, 2007, 2008

- **Maine Hospital Association Caregiver of the Year Award for the State of Maine**
  Caregiver of the Year Award- 2005 and 2006

- **State of Maine Volunteer of the Year Award**
  Maine's Volunteer of the Year- 2005, 2006

- **Centers for Medicare & Medicaid Services**
  Exceeded national average for composite heart attack, heart failure, pneumonia and SCIP scores: 2007

- **Joint Commission**
  Joint Commission Accredited Hospital

- **Maine Health Management Coalition**
  Awarded two out of three Blue Ribbons for Patient Safety and Clinical Quality

- **Maine State Employees Health Commission**
  Blue Ribbon "Preferred Hospital"- 2008

- **Kennebunk-Kennebunkport Chamber of Commerce**
  Business of the Year Award - 2007

- **United Way of York County**
  Among Top 10 Contributing Organizations for 2007 Campaign.

- **Clinical Accreditations**
  American College of Surgeons Level 2b Accredited Bariatric Center
  American College of Radiology Magnetic Resonance Imaging Accreditation
  American Association of Blood Banks Accreditation
  College of American Pathologists Accreditation
  American College of Surgeons Commission on Cancer Accreditation with commendation
  American College of Accreditation for all of our Mammography programs and also for Ultrasound"

"Licenses, Certifications & Accreditations

"Statements of Deficiencies" and site visit reports from the previous three years for all the health care facilities and services in which MaineHealth member organizations have been involved are on file with the Department of Health and Human Services' Division of Licensing and Regulatory Services."

II. Fit, Willing and Able

"Presented below is information on our members' current licenses, certifications and accreditations."

MaineHealth® Members' Current Licenses, Certifications and Accreditations

MaineHealth® Member	Facility/Service	State Licensed	CMS Certified	Joint Commission/Other Accreditation
Maine Medical Center	Hospital	✓	✓	✓
New England Rehabilitation Hospital (MMC joint venture)	Hospital	✓	✓	✓
Spring Harbor Hospital	Hospital	✓	✓	✓
St Andrews Hospital & Healthcare Center	Hospital	✓	✓	
St Andrews Hospital & Healthcare Center	Nursing Home	✓	✓	
St Andrews Hospital & Healthcare Center	Home Health	✓	✓	
St Andrews Hospital & Healthcare Center	Assisted Living	✓		
Miles Health Care	Hospital	✓	✓	
Miles Health Care	Nursing Home	✓	✓	
Miles Health Care	Home Health	✓	✓	
Miles Health Care	Assisted Living	✓		
Western Maine Health Care	Hospital	✓	✓	
Western Maine Health Care	Nursing Home	✓	✓	
Home Health Visiting Nurses of Southern Maine	Home Health	✓	✓	✓
NorDx	Laboratory Services		✓	✓

Profile of Southern Maine Medical Center

"Southern Maine Medical Center
1 Medical Center Drive
Biddeford, Maine

www.smmc.org"

"Webber Hospital Association is a non-profit § 501(c)(3) health care corporation doing business as Southern Maine Medical Center (SMMC), providing a critically necessary continuum of high quality inpatient and outpatient health care services and primary and specialty physicians services for the residents of York county. The Webber Hospital Association serves as the parent corporation of SMMC Visiting Nurses (also a 501(c)(3) nonprofit corporation), with offices located in Biddeford and Kennebunk."

II. Fit, Willing and Able

"Southern Maine Medical Center's (SMMC) mission is to improve the health status of the community through patient care and education."

"SMMC serves a primary and secondary service area of 18 towns:

Primary Service Area:	Arundel, Biddeford, Dayton, Kennebunk, Kennebunkport, Old Orchard Beach and Saco
Secondary Service Area:	Alfred, Buxton, Hollis, Limerick, Lyman, Ogunquit, Sanford, Scarborough, Shapleigh, Waterboro, Wells"

"SMMC is a 150-licensed bed full-service, not-for-profit, acute care community hospital providing medical, surgical, obstetric, pediatric, mental health and many outpatient services to the full-time residents of north coastal York County and the many seasonal visitors and part-year residents of the region."

"SMMC has been providing high quality medical care to this region since November 2, 1899. On February 24, 1979 the current facilities, located 1/4 mile from Exit 4 of the Maine Turnpike in Biddeford, Maine, were put into service."

"SMMC offers a full range of services including:

- a fully-staffed, 24-hour Emergency Department
- major and minor surgery capabilities
- diagnostic services including laboratory, non-invasive testing and imaging services
- a 10-bed Medical/Surgical Special Care Unit supported by the MaineHealth VitalNetwork
- 95 Medical/Surgical inpatient beds
- a 13-bed inpatient Mental Health Unit (the only inpatient mental health unit in York County), Day Hospital, and 24-hour emergency mental health evaluation services
- a 13-bed Obstetric Unit
- fully staffed ancillary and support services
- community outreach centers in Kennebunk, Biddeford and Saco
- health promotion and chronic disease management programs, such as Healthy Families, Pediatric Mental Health Assessment Clinic, Prenatal Clinic, Healing Heart Program, Pulmonary Rehabilitation Program, etc.
- home health services through its SMMC Visiting Nurses subsidiary (formerly Southern Maine Health & Homecare Services)
- primary and specialty physician services through SMMC PrimeCare Physicians Services"

"The medical staff of SMMC consists of 176 active physicians, plus 46 consulting and courtesy staff physicians. They represent the specialties of family and general practice; internal medicine, including the subspecialties of cardiology, dermatology, infectious diseases, physiatry, pulmonology, oncology-hematology, neurology, gastroenterology, rheumatology and

allergy/immunology; pediatrics; anesthesia; obstetrics and gynecology; general surgery; orthopedic surgery; otolaryngology; urology; ophthalmology; neurosurgery; oral surgery and general dentistry; podiatry; psychiatry; pathology; radiology; and emergency medicine."

"Exhibits II-C, II-D and II-E present the SMMC Annual Reports for 2006, 2007 and 2008."

"Licenses, Certifications & Accreditations

"Statements of Deficiencies" and site visit reports from the previous three years for all the health care facilities and services in which SMMC has been involved are on file with the Department of Health and Human Services' Division of Licensing and Regulatory Services."

"SMMC is licensed by the State of Maine, Department of Health and Human Services, certified for participation in the Medicare and Medicaid programs, and fully accredited by the Joint Commission on Accreditation of Healthcare Organizations."

"Please refer to Exhibit II-F: SMMC's General Hospital License issued by the Maine Department of Health and Human Services."

"Please refer to Exhibit II-G:SMMC's Hospital Accreditation issued by the Joint Commission on Accreditation of Healthcare Organizations"

"SMMC is a member of the MHA (Maine Hospital Association), Voluntary Hospitals of America and an affiliate of MaineHealth."

"SMMC is governed by a voluntary Board of Directors, currently comprised of 23 members. Edward J. McGeachey is President and Chief Executive Officer of the Hospital, a position he has held since 1988."

Key Personnel and Organizational Chart(s)

"The following are the key senior managers involved in this proposal. All will continue in their respective positions following SMMC becoming a member of MaineHealth."

"William Caron, President and 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 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."

II. Fit, Willing and Able

"Edward J. McGeachey, President and Chief Executive Officer, SMMC. Previously Mr. McGeachey was Assistant Executive Director and Director of Social Services at SMMC. Prior to joining SMMC, Mr. McGeachey worked as a clinical social worker for Sweetser Children's Home Saco, Maine, and in private practice."

"Norman Belair, Chief Financial Officer, SMMC. Prior positions include Vice President of Finance, Eastern Maine Medical Center, Bangor, Maine; Vice President, The Thomas Agency, Portland, Maine, a healthcare financial consulting firm; Vice President of Finance, MaineGeneral Health, Waterville, Maine; Vice President of Finance, Mid-Maine Health Systems; Controller, Kennebec Valley Medical Center, Augusta, Maine; and various positions with Ernst & Whinney, Portland Maine and Orlando, Florida."

"Frank Lavoie, MD, Executive Vice President, SMMC. Dr. Lavoie received his emergency medicine training at the University of Texas Health Science Center/Parkland Memorial Hospital, Dallas, Texas. Prior to his current position, he was Chief of Emergency Medicine at SMMC."

"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 Internal Medicine and in Family Practice"

"Michael Albaum, MD, Executive Vice President, SMMC. Prior to joining SMMC, Dr. Albaum was CEO of PrimeCare Physician Associates. He also practices internal medicine."

"Exhibits II-H and II-I present the current and proposed MaineHealth organizational charts**."**

B. CONU Discussion

i. CON Criteria

Relevant criteria 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.

ii. CON Analysis

MaineHealth's current member affiliates' licenses, certifications and accreditations are numerous with all being State Licensed, CMS Certified and several are Joint Commission accredited. MaineHealth has demonstrated that they are capable of delivering the proposed services at the proper standard of care. They have been able to successfully integrate other healthcare systems into the parent corporation while continuing to meet licensing standards. On December 31, 2008, MaineHealth was granted a Certificate of Need for Waldo County Healthcare, Inc to become a member of MaineHealth.

SMMC current license is valid until February 28, 2009. The Medical Facilities Unit of the Division of Licensing and Regulatory Services last completed a site survey on April 20, 2007 and deficiencies were recorded. The applicant submitted a plan of correction on May 11, 2007

that was accepted by the Division on June 7, 2007. SMMC is Medicare and MaineCare certified. SMMC's hospital and home care are currently accredited by the Joint Commission; SMMC was last accredited on September 15, 2007. Currently not all member hospitals of MaineHealth are Joint Commission accredited.

iii. COPA Criteria

The Department, in accordance with its authority under 22 M.R.S.A. §844, can issue a Certificate of Public Advantage (COPA) once it makes certain findings and determines that by a preponderance of the evidence that the likely benefits resulting from the implementation of the Definitive Agreement outweigh any disadvantages attributable to any reduction in competition likely to result from the Definitive Agreement and its implementation.

iv. COPA Analysis

This section is not relevant for a Certificate of Public Advantage. No analysis is required.

v. Conclusion

CON RECOMMENDATION: CONU recommends that the Commissioner find that MaineHealth and Southern Maine Medical Center are 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.

The applicants are eligible to request a Certificate of Public Advantage and the Definitive Agreement qualifies for consideration under the Hospital Cooperation Act.

COPA RECOMMENDATION: This section requires no COPA recommendation.

III. Financial Capability of Applicants and Financial Impact of Project

A. From Applicant

i. CON From Applicant

"SMMC becoming a member of MaineHealth involves no capital expenditure by SMMC or MaineHealth requiring a certificate of need. Neither SMMC, MaineHealth, the State of Maine or the health care delivery system in Maine will incur any net increase in operating expenses as a result of SMMC becoming a member of MaineHealth."

"Attached as Exhibits III-A, III-B and III-C are audited financial statements for MaineHealth, Southern Maine Medical Center and Maine Medical Center. While Maine Medical Center is not the applicant, the CON unit has expressed an interest in reviewing its audited financials as part of its review of this application. A review of the financials of MaineHealth and SMMC demonstrate the financial ability of both organizations to support ongoing operations. Further evidence of MaineHealth's financial strength is that since 2003 it has maintained an AA-credit rating from Standard & Poors. Its rating was reconfirmed as recently as June 2008."

"Also attached as Exhibit III-D is the CON Unit Financial Forecast Module. The module was completed based on instructions provided to MaineHealth by CON Unit staff and Bureau of Insurance staff at a technical assistance meeting on August 15, 2008 and in multiple conversations and meetings with CON Unit staff during the past two months. The application is a joint application by MaineHealth and Southern Maine Medical Center. Nowhere in our application or in the information we have supplied to the CON Unit in completing the Financial Module will you find a "payment" to SMMC by MaineHealth or Maine Medical Center for assets or other considerations that would constitute a capital expenditure (as defined by CON regulations or generally accepted accounting principles) in return for SMMC agreeing to becoming a member of MaineHealth."

"The CON Unit Financial Module was intended for use in the review of "projects" that include a capital expenditure that results in incremental operating expenses, e.g., depreciation, interest, staff and supplies. Several of the tables included in the module require the applicant to identify those capital expenditures or the associated operating costs and/ or incremental revenue resulting from the project. CON Unit staff have made certain modifications to the module to accommodate this CON application which requires review only because there is a change of ownership, not a capital expenditure or incremental third year operating expenses."

"Given the unique nature of this application in terms of the modifications required by the CON Unit in completing the Financial Module, we have provided the following additional information and assumptions used in completing selected tables in the module."

III. Financial Capability of Applicants and Financial Impact of Project

"Table 1A-Project Cost and Table 1B Construction Timing present the assets of Southern Maine Medical Center as of April 30, 2007, not a new capital expenditure. "Related Hospital Acquisition Costs-Line 5 Acquisition of Fixed Assets" of $41,242,623 is the net plant, property and equipment line from the SMMC balance sheet and "Related Hospital Acquisition Costs-Line11 Other" of $60,594,613 is SMMC's total assets minus net plant, property and equipment, not a new capital expenditure. "Table 1B Construction Timing" treats SMMC existing assets like a "construction" project, but there is no construction or capital expenditure."

"Table1C-Deprecation Expense treats the existing net property and equipment assets of SMMC from Table 1A as if they were a new annual capital expenditure and calculates new depreciation expense of $4,524,599 on those assets. These are existing assets of SMMC and depreciation of those assets is already included in subsequent schedules. Since this is not a new capital expenditure, there is, in fact, no additional annual depreciation as calculated by Table 1C."

"Table 2 – Debt Financing Arrangement, Sources and Uses of Funds treats the long term debt of SMMC of $25,588,327 as of June 30, 2007 as if it were new debt resulting from the change of ownership and as if there were an equity contribution of $73,558,982 and "other sources" of $2,689,927 being made as the sources of funds to reach a "Capital Project from Table 1A" total of SMMC's existing assets of $101,837,236. As part of this change of ownership there is no new debt to be financed or equity contributions required since neither MaineHealth or Maine Medical Center is making a "payment" to SMMC as a condition of joining MaineHealth. If such a "payment" were being made, presumably, it would show up in subsequent schedules as an increase in SMMC assets (which it does not) since there is no payment by MaineHealth or Maine Medical Center."

"Tables 3A, 3C, 4,5,8,12B and 13 present, as instructed by the CON Unit staff, in the "Project Only" column charges, revenue, expenses and utilization which are the existing and forecasted activity for SMMC. There are no capital expenditures or incremental operating expenses for a "project" in these entries."

"Table 6B-Operating Expenses Project Only presents SMMC's expenses for 2010-2012 for salaries and wages, employee benefits and supplies and other expenses not including depreciation or interest. As instructed by the CON Unit staff, at the bottom of Table 6B, we have provided information on changes in SMMC's expenses related to membership in MaineHealth, i.e., dues paid to MaineHealth to support MaineHealth's operations and savings to SMMC resulting from its participation in MaineHealth's employee health insurance plan, participation in other MaineHealth insurance programs and efficiencies from other administrative and clinical integration initiatives. MaineHealth dues are calculated as 0.0045 times SMMC's total operating revenue, the same procedure used for all MaineHealth members. The 0.0045 assessment is assumed to remain at that level. Using total operating revenues for SMMC as presented in Table 9B and adding back in bad debt (calculating net revenue according to generally accepted accounting principles) results in the following calculations of SMMC dues to MaineHealth."

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Southern Maine Medical Center	2010	2011	2012
Total Operating Revenue	$120,272,980	$126,684,000	$133,522,000 (A)

III. Financial Capability of Applicants and Financial Impact of Project

Difference in Net Self-Pay	$6,953,020	$7,448,000	$7,982,000 (B)
	$127,226,000	$134,132,000	$141,504,000
MaineHealth Dues Rate	0.0045	0.0045	0.0045
SMMC Dues	$572,517	$603,594	$636,768

(A) From Table 9B

(B) Add back in bad debt from Table 9B

"SMMC savings from MaineHealth membership are then calculated in Table 6B as follows":

Southern Maine Medical Center	2010	2011	2012
Dues to MaineHealth	$572,517	$603,594	$636,768
Savings from MaineHealth Initiatives	$572,517	$603,594	$636,768
Net Savings	$0	$0	$0

"SMMC's dues to MaineHealth are offset by its savings from participation in MaineHealth's employee health insurance plan, participation in other MaineHealth insurance programs and efficiencies from other administrative and clinical integration initiatives."

"Table 20-Capital Investment Fund Calculation presents on the "Future Values (As Reported)" portion of the table existing depreciation and interest of SMMC for 2012 (from Table 9B), the MaineHealth dues and the savings from health insurance and other insurance programs, all of which are correct entries. Table 20 calculates on the "Current Values Adjusted for Time Value of Money" portion of the table a "Charge for CIF" of ($0) and "Insurance Cost" of ($0). As calculated by Table 20, SMMC joining MaineHealth involves no capital expenditure by SMMC or MaineHealth requiring a certificate of need and does not result in any increase in operating expenses for SMMC, MaineHealth, Maine Medical Center, the State of Maine or the health care delivery system in Maine."

"Table 24 Calculation of CON Filing Fee treats the existing assets of SMMC of $101,837,236 as a capital expenditure and, as a result, a CON filing of $100,000. Since there is no capital expenditure, we respectfully disagree with this calculation. Based on the absence of a capital expenditure, the filing fee should be the $5,000 minimum."

"Compliance with DHHS Licensure, CMS Certification, Joint Commission Accreditation, Local Zoning, Environmental Protection and Other Applicable Statutory and Regulatory Requirements"

"MaineHealth membership will encourage SMMC's continuing compliance with State licensure, Medicare certification requirements, and Joint Commission accreditation requirements. SMMC

will continue to comply with applicable zoning requirements, environmental protection regulations, and other applicable municipal, State and Federal ordinances, statutes and regulations."

ii. COPA From Applicant

1. Introduction

"As the Application form (Section XI) recognizes, the Hospital and Health Care Provider Cooperation Act provides that

> The department shall issue a certificate of public advantage for a cooperative agreement if it determines that the applicants have demonstrated by a preponderance of the evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition likely to result from the agreement. 22 M.R.S.A. §1844(5).

"The Act enumerates six potential advantages from a cooperative arrangement, and five potential disadvantages, and directs the Department to weigh in the aggregate the balance of potential advantages over potential disadvantages."

"Although the statute recites first the six potential advantages to be weighed and then the potential disadvantages, the Department's application in this section III(B) largely reverses the order and, with the exception of potential efficiencies, focuses largely on the potential disadvantages resulting from any reduction in competition between MaineHealth and its member entities and SMMC as a result of the Definitive Agreement."

"The discussion in this section will address the points in the order dictated by the Application. We refer the Department to the discussion in Section XI to obtain an overview of the Applicants' position on the benefits of the transactions versus its potential disadvantages."

"For the reasons set forth below, the Applicants believe that there are no significant adverse competitive effects likely to result from the Definitive Agreement."

"The Department's Application Guidelines, issued on July 7, 2008, request the Applicants to delineate their respective service areas, and to set forth a pre- and post-transaction "market share."

"SMMC's service area covers most of the towns in York County. Its primary service area includes: Arundel, Biddeford, Dayton, Kennebunk, Kennebunkport, Old Orchard Beach and Saco; and its secondary service area includes: Alfred, Buxton, Hollis, Limerick, Lyman, Ogunquit, Sanford, Scarborough, Shapleigh, Waterboro, Wells."

III. Financial Capability of Applicants and Financial Impact of Project

"MaineHealth does not have a hospital service area, because it does not itself provide hospital services. Two of MaineHealth's hospital members – Maine Medical Center and Spring Harbor Hospital – have services areas that are adjacent to or partially overlap SMMC's service area."

"Maine Medical Center's hospital service area extends throughout the State of Maine and into coastal New Hampshire. MMC includes within its self-defined "primary service area" all the towns of Cumberland and York Counties. Maine Medical Center's "secondary service area" comprises the nine counties in southern, central and western counties in Maine : Androscoggin, Oxford, Franklin, Somerset, Sagadahoc, Kennebec, Lincoln , Knox and Waldo. Maine Medical Center's "tertiary service area" comprises the five counties in northern and eastern Maine (Penobscot, Piscataquis, Hancock, Washington and Aroostook counties)."

"Spring Harbor Hospital's primary and secondary service areas essentially mirror MMC's primary and secondary service areas."

"It is not clear from the Department's Application Guidelines whether the Department is seeking a "market share" computed as a percentage of patients (or revenues) for these service areas, or instead is seeking to have the Applicants suggest a "market" for antitrust purposes, and compute market shares based on such a peculiarly-defined market."

"The two concepts – "service area," traditionally used in CON filings – and "market share," used in antitrust law – are related, but they are not synonymous. "Service area" refers to the geographic area that the hospital serves. "Market" for antitrust purposes, constitutes the relevant area in which to assess a transaction or conduct under consideration. [1] "Service" area and

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[1] One court summarized the concept of "market" for antitrust purposes as follows:

> The term "relevant market" encompasses notions of geography as well as product use, quality, and description. The geographic market extends to the "'area of effective competition' ... where buyers can turn for alternate sources of supply." *Moore v. Jas. H. Matthews & Co*., 550 F.2d 1207, 1218 (9th Cir.1977) (citing *Otter Tail Power Co. v. United States*, 410 U.S. 366, 369 n. 1, 93 S. Ct. 1022, 1026 n. 1, 35 L.Ed.2d 359 (1973) and *Standard Oil Co. v. United States*, 337 U.S. 293, 299-300 n. 5, 69 S. Ct. 1051, 1055 n. 5, 93 L.Ed. 1371 (1949)). The product market includes the pool of goods or services that enjoy reasonable interchangeability of use and cross-elasticity of demand. *Syufy Enterprises*, 793 F.2d at 994, (citing *United States v. E.I. duPont de Nemours* & Co., 351 U.S. 377, 394-95, 76 S.Ct. 994, 1006-07, 100 L.Ed. 1264 (1956) (the "Cellophane" case)).

Oltz v. St. Peter's Community Hosp., 861 F.2d 1440, 1446 (9th Cir. 1988).

In most antitrust cases involving hospitals, the <u>product</u> component of the market is defined as "general acute inpatient services." *See Freeman Hospital*, 69 F.3d at 268 (government stipulated that the relevant product market was "acute care inpatient services"); *Butterworth Health Corp*., 946 F.Supp. at 1290-91 (relevant product market is "general acute care inpatient hospital services" and "primary care inpatient services"); *Mercy Health Servs*., 902 F.Supp.968, 976 (N.D. Iowa, 1994), *vacated on grounds of mootness*, 107 F.3d 632 (8th Cir. 1997). (government stipulated that the relevant product market was "acute care inpatient services").

"market" are thus related but very different concepts, and the share of a "service area" and share of "market" should not be confused.[2]"

a. Service Area Shares

"Because the Application Guidelines requested the Applicants to provide a description of their service area and a market share, the Applicants understand the Department to be asking for SMMC's and MaineHealth's hospitals' "service area" shares."

"Using Maine Health Data Organization inpatient discharge data for 2007, SMMC's primary service area share of all hospital discharges is 55.2% and its secondary service area share is 11.8%."

"Using the same database, Maine Medical Center's primary service area share of all hospital discharges from SMMC's service area is 26.0%; and its secondary service area share is 39.1%."

"Using the same database, Spring Harbor Hospital's primary service area share of all hospital discharges for SMMC's service area is1.6%; and it secondary service area share at 1.9%."

"None of these shares is expected to change in any major way during the first two years of as a result of the implementation of the Definitive Agreement. Insofar as SMMC is successful in implementing its medical staff development plan, the Applicants expect that SMMC's share of discharges from its service area will gradually increase and MMC's share of discharges from SMMC's service area will gradually decrease."

If the transaction under consideration is a merger proceeding, that relevant geographic market consists of the smallest area in which price or non-price competition could be potentially affected by the proposed transaction. In F.*T.C. v. Tenet Health Care Corp*., 186 F.3d 1045, 1052:, the court defined a geographic market hospital services as follows:

> A geographic market is the area in which consumers can practically turn for alternative sources of the product and in which the antitrust defendants face competition. [cit. om.] * * * A properly defined geographic market includes potential suppliers who can readily offer consumers a suitable alternative to the defendant's services. *See Bathke v. Casey's General Stores, Inc*., 64 F.3d 340, 346 (8th Cir.1995). Determination of the relevant geographic market is highly fact sensitive. *See Freeman Hosp*., 69 F.3d at 271 n. 16. The proper market definition can be determined only after a factual inquiry into the commercial realities faced by consumers. *See Flegel*[*v. Christian Hosp*., 4 F.3d 682, 689 (8th Cir.1993)] at 690.

[2] See *F.T.C. v. Tenet Health Care Corp*., *supra*, at 1052:

> The FTC proposes a relevant geographic market that essentially matches its service area: a fifty-mile radius from downtown Poplar Bluff. It is from this service area that the two hospitals obtain ninety percent of their patients. A service area, however, is not necessarily a merging firm's geographic market for purposes of antitrust analysis. *See Bathke*, [*Bathke v. Casey's General Stores, Inc*., 64 F.3d 340, 346 (8th Cir.1995)]at 346 (noting that "trade area" and "relevant market" are precisely reverse concepts).

b. Market Shares

"Insofar at the Department's Application Guidelines are requesting the Applicants to provide a computation of "market" share based on an antitrust law notions of "relevant market," the presentation and interpretation of such information can be very complex. There is no mechanical or incontrovertible method to define a "relevant market." Certain market definitions can clearly be ruled out, but identifying other definitions as correct is usually a search for a holy grail – a very expensive one that contributes significantly to the high costs of antitrust litigation."

"In the context of the Hospital and Health Care Provider Cooperation Act, and this Application in particular, a resource-consuming search for the best "market" definition is unnecessary, for three reasons, described below in increasing order of importance."

"First, even in pure antitrust analysis (which, as explained below is not applicable here), market share calculation is only the first step in the antitrust evaluation of business conduct.[3] Many times – and this has occurred in the hospital merger context - what appears to high post-merger market shares are, on closer analysis, not indicative of likely competitive effects.[4] Market share analysis is simply one tool – an indirect method – of attempting to make the dispositive assessment – whether the merger will confer on the merging entities "market power" that they would not have had but for the merger. Market power in this context is the ability post-merger of firms to raise price, and to reduce supply. If this determination can be made directly, rather than by resorting to inference from market share statistics, so much the better."

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[3] In the antitrust algorithm, market definition allows the computation of a market share for antitrust purpose, and market share is used as a starting point to draw inferences about the competitive effects of a transaction. In modern antitrust analysis, both courts and antitrust enforcement agencies make clear that market share is only a starting point for analysis of competitive effects. *American Council of Certified Podiatric Physicians and Surgeons v. American Board Of Podiatric Surgery, Inc*., 185 F.3d 606, 623 (6th Cir. 1999) ("market share is only a starting point for determining whether monopoly power exists, and the inference of monopoly power does not automatically follow from the possession of a commanding market share"); *Mercy Health Servs*., 902 F.Supp.968, 976 (N.D. Iowa, 1994), *vacated on grounds of mootness*, 107 F.3d 632 (8th Cir. 1997) ("Although a great deal of emphasis is placed on market share statistics, they are not conclusive indicators of anticompetitive effects. * * * the defendants can overcome the presumption of illegality by showing that the market-share analysis gives an inaccurate reflection of the acquisition's probable effect on competition within the relevant market").

[4] *See Federal Trade Commission v. Butterworth Health Corp*, 121 F.3d 708 (6th Dir. 1997) (unpublished), *affirming* 946 F.Supp. 1285 (W.D. Mich. 1996) (decision for merging hospitals with a combined post-merger market share of 70%; noting evidence that, contrary to reflexive inference of anticompetitive effect from merger leading to high market share, an increased market share is associated with lower prices for nonprofit hospitals). *See also* Statement Of The Department Of Justice Antitrust Division On Its Decision To Close Its Investigation Of XM Satellite Radio Holdings Inc.'s Merger With Sirius Satellite Radio Inc. March 24, 2008(http://www.usdoj.gov/atr/public/press_releases/2008/231467.htm) (explaining why a merger of the only two satellite radio service providers would not be anti-competitive: "The Division's investigation indicated that the parties are not likely to compete with respect to many segments of the satellite radio business even in the absence of the merger.").

"Second, the statute under which the Applicants are operating here is not an antitrust statute. The antitrust laws presume that the preservation of competition is a preeminent objective, and will not tolerate an argument of the form that competition may produce negative outcomes as a matter of policy.[5] Section 7 of the Clayton Act, 15 U.S.C. § 20, prohibits mergers that "may substantially lessen competition" Mergers that "may" reduce competition *ipso facto* are prohibited."

"The Hospital Cooperation Act, by contrast, directs the Department to inquire – and not to presume – whether there is any reduction in competition resulting from the cooperative agreement, and if so, whether any such reduction found will produce "disadvantages." All of the negative criteria listed in 22 M.R.S.A. § 1845(5)(B) are phrased in terms of the Department's "evaluation *of any disadvantages attributable to a reduction in competition* likely to result from a cooperative agreement." (emphasis added)."

"This is a key point. Unlike the antitrust laws, the Hospital Cooperation Act does not presume that any demonstrated likely reduction in competition proves that a proposed merger is harmful. Instead, likely *disadvantages* that result *from* a reduction in competition are to be weighed in the balance against other factors. The statutory scheme therefore counsels against an approach that presumes the preservation of competition is of such overriding importance that it trumps other considerations.[6]"

"Third and finally – and related to the second point – unlike the antitrust laws, the Hospital Cooperation Act does not contemplate a one-time-only interchange between the applicants and organs of government concerning the competitive effects of the transaction at issue. Federal officials enforcing federal antitrust laws are predisposed to deal with potentially anti-competitive mergers on a one-time basis: by seeking a court injunction against it or a court-ordered

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[5] *National Soc. of Professional Engineers v. U. S.*, 435 U.S. 679, 695 (1978):

> The assumption [of the antitrust laws] that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers. Even assuming occasional exceptions to the presumed consequences of competition, *the statutory policy precludes inquiry into the question whether competition is good or bad*.
>
> (emphasis added)

[6] As applied, the antitrust laws are at best neutral, and at times even promotive, of capacity duplication. Duplication is often a consequence of firms entering a market to compete against incumbents. If the effect of entry, or a drop in demand, is to produce overcapacity, then fierce price cutting or other aggressive sales tactics may break out as firms compete voraciously to be one of the survivors. Overcapacity is regarded as a tolerable byproduct of the competitive process, and the antitrust laws have been interpreted to prohibit agreements intended to ameliorate the effects of overcapacity. *See, eg. U.S. v. Socony-Vacuum Oil Co,*.
310 U.S. 150 (1940) (agreement among oil producers to buy up oversupply of "distressed gasoline" (gasoline in which the market price was less than the cost of manufacture) declared *per se* illegal). By contrast, the Hospital Cooperation Act directs the Department to place a positive value on cooperative agreements that promote the "[a]voidance of duplication of hospital or other health care resources." 22 M.R.S.A. § 1855(5)(5).

divestiture. These enforcement officials attempt to avoid remedies that entail ongoing governmental involvement of the merging parties' post-merger conduct.[7]"

"The Hospital Cooperation Act, on the other hand, invites and requires ongoing governmental oversight of the applicants' post-merger conduct, and a later regulatory adjustment, if the transaction, contrary to first prediction, has unintended negative effects that override its benefits. The Act authorizes the Department to attach enforceable regulatory conditions on a certificate of public advantage that are reasonably necessary to ameliorate any likely disadvantages [attributable to any reduction in competition] of the type specified in [22 M.R.S.A. § 1844(5)] paragraph B." 22 M.R.S.A. § 1855(5)(C)(1). The Act also directs the Department to conduct a post-merger review of the transaction between 12 and 30 months after the consolidation to determine if these conditions are being satisfied. 22 M.R.S.A. § 1845(1), (2)(A)(2), (3). The Department is also empowered to "impose additional conditions to ameliorate any disadvantages attributable to any reduction in competition, or seek a court order revoking the certificate . . ., if the department determines in any additional supervisory activities . . . that, as a result of changed or unanticipated circumstances the benefits resulting from the activities authorized under the certificate and the unavoidable costs of revoking the certificate are outweighed by disadvantages attributable to a reduction in competition resulting from the activities authorized under the certificate." 22 M.R.S.A. § 1845(3)(B). "Changed or unanticipated circumstances" under this provision includes "the realization of unanticipated anticompetitive effects from the agreement." *Id*."

"There are no provisions similar to these in the federal and Maine antitrust statutes."

"In short, the Hospital and Health Care Provider Cooperation Act is in some respects similar to but is also substantially different from an antitrust statute. The Act is regulatory. It embraces goals that the antitrust laws do not. It does not presume that competition is a policy objective that trumps all others. It directs the Department to value non-competition factors, and to focus on disadvantages likely to result from a reduction of competition, not on any reduction of competition in and of itself. [8]"

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[7] U.S. Dept. of Justice, Antitrust Division, Antitrust Division Policy Guide to Merger Remedies (2004), pp. 7-8 (available at http://www.usdoj.gov/atr/public/guidelines/205108.pdf) ("Structural remedies generally will involve the sale of physical assets by the merging firms. * * * A conduct remedy usually entails injunctive provisions that would, in effect, manage or regulate the merged firm's post merger business conduct. * * * Structural remedies are preferred to conduct remedies in merger cases because they are relatively clean and certain, and generally avoid costly government entanglement in the market.) The federal antitrust enforcement officials' preference for one-time structural remedies places a premium on accurately predicting the competitive effects of a merger at the pre-merger stage, because once a merger occurs, it is often difficult to "unscramble the eggs" *California v. American Stores Co*., 495 U.S. 271, 297-298 (1990) (Kennedy, J. concurring); *FTC. vs. Dean Foods, Inc.*, 384 U.S. 597, 606, n. 5 (1966) ("Administrative experience shows that the [Federal Trade] Commission's inability to unscramble merged assets frequently prevents entry of an effective order of divestiture").

[8] The antitrust laws' single focus on competition values alone is echoed in federal antitrust enforcement authorities' public opposition to state certificate-of-need regulation. One September 15, 2008, the Antitrust Division of the Department of Justice and the Federal Trade Commission provided a joint written statement to a State of Illinois

"For this reason, an algorithm that seeks to draw *prima facie* inferences about the legality of a transaction based on market share is not well suited to wholesale importation into the Hospital and Health Care Provider Cooperation Act. Computing a pre- and post- transaction "market share" does not do very much to advance the inquiry required by the Act."

"Because the Department's Application Guidelines have requested that the Applicants provide "the current market share of each party to the cooperative agreement and describe the anticipated market share upon initiation of the cooperative agreement," MaineHealth has requested its retained economic consulting firm Micro Economic Consulting and Research Associates "(MiCRA") to provide a "first cut" approximation of a "market" that might be used for antitrust purposes. MiCRA has performed the requested analysis, and it is included as part of Appendix III-B, and is discussed in succeeding sections of this Application. MiCRA's analysis comes with all of the caveats set forth above."

"Regardless of how "service area" or "market" is defined, and how such shares are computed, as noted previously the Applicants do not expect combined "service area shares" or "market shares" of SMMC or the MaineHealth hospitals to change in any material way as a result of the implementation of the Definitive Agreement. Treating Southern Maine Medical Center post transaction as a member of MaineHealth, Southern Maine Medical Center's current "service area share" can be added to MaineHealth's "service area share." Relative to other hospitals, the transacting hospitals are not anticipating any net gain or loss of "share" to other hospitals as a result of the Definitive Agreement."

"If there is any adjustment of shares, it is likely to be a minor increase in SMMC's share of its service area relative to Maine Medical Center's. As noted in a succeeding sub-section, some of the inflow to Maine Medical Center from SMMC's primary service may reflect a shortage of available physician resources at SMMC. Insofar as the Definitive Agreement facilitates SMMC's execution of its medical staff development plan, SMMC may start to address some of

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legislative task force, urging repeal of the state's certificate-of-need laws. Among other things, the agencies asserted in their statement that:

> experience and expertise has taught us that Certificate-of-Need laws impede the efficient performance of health care markets. By their very nature, CON laws create barriers to entry and expansion to the detriment of health care competition and consumers. They undercut consumer choice, stifle innovation, and weaken markets' ability to contain health care costs. Together, we support the repeal of such laws, as well as steps that reduce their scope.
> * * *
> Our concerns about the harm from CON laws are informed by one fundamental principle: market forces tend to improve the quality and lower the costs of health care goods and services. They drive innovation and ultimately lead to the delivery of better health care.

Joint Statement of the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission Before the Illinois Task Force on Health Planning Reform, September 15, 2008 (reprinted at http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf.).

the medical staff capacity shortfalls, and to that extent, retain cases that otherwise may have ended up at Maine Medical Center."

"With these preliminary considerations now addressed, the Application proceeds to discuss the Definitive Agreement and the statutory criteria inquiring into any likely disadvantages attributable to a reduction of competition."

2. No Adverse Impact on Prices or Reimbursement Arising From Any Reduction in Competition between SMMC and MaineHealth Members

"The Applicants believe that there are no likely adverse consequences from the Definitive Agreement on the ability of health care payors to negotiate optimal payment and service arrangements with hospitals or health care providers. The analysis canvasses four areas of potential competition: A) general hospital services; B) mental health services; C) physician services; and D) home health services."

a. General Hospital Services

"SMMC and the MaineHealth member hospitals contract with the major private payors: Anthem, Cigna, Aetna, and Harvard Community Health Plan."

"Because of their respective missions and philosophies, as well as differences in the nature of their service offerings, any potential for price competition between MaineHealth's member hospitals and SMMC is extremely limited".

"MaineHealth's Maine Medical Center is the nearest general medical and surgical hospital to SMMC – approximately 18 road miles separate the two institutions. With the exception of Spring Harbor Hospital, which provides mental health services exclusively, none of the other MaineHealth member hospitals is positioned to serve the geographic area that is also served by SMMC.[9]"

"Maine Medical Center is a 606-bed tertiary care and teaching institution with a broad referral base, serving as a provider of community hospital services for greater Portland and a provider of complex care (sometimes called "tertiary care") for all of the citizens of southern, central and western Maine."

"Maine Medical Center has not and does not seek actively to draw patients from SMMC's service area that could otherwise be properly treated at SMMC. In part this reflects MaineHealth's philosophy, which is to support the provision of care locally when the care can be competently and efficiently delivered locally. It also reflects the fact that specialists and sub-specialists who practice at Maine Medical Center rely on primary care physicians and some

[9] MaineHealth's Stephens Memorial hospital is located in South Paris; Miles Memorial Hospital is in Damariscotta; and St. Andrews Hospital is in Boothbay Harbor. These facilities are community hospitals, and are well over an hour's driving time away from SMMC.

specialty physicians from around the state, including SMMC's service area, for the referral of patients. MaineHealth and Maine Medical Center seek to support these referral patterns, and thus are disinclined to undertake initiatives that could compromise the ability of local physicians and facilities to maintain viable practices with minimum economies of scale."

"MaineHealth's and Maine Medical Center's philosophy has animated several initiatives over the last decade that include SMMC. Among these are the following:

- Maine Medical Center supported the development of a cardiac catheterization lab at SMMC in 2000 and 2001, providing department resources to assist Southern Maine Medical Center in the planning of the lab, training of staff, and operation of the facility. Maine Medical Center has five cardiac cath labs at its facility in Portland.

- Maine Medical Center, Goodall Hospital and SMMC have collaborated in the establishment and operation of a jointly owned cancer care center and related oncology practice in York County, known as the Cancer Care Center of York County. Maine Medical Center has its own cancer care program and three linear accelerators in Portland and Scarborough.

- MaineHealth has included SMMC as a participant in its group purchasing program. SMMC estimates that it has derived savings of $1,059,658.00 since October 2005 as a result of its group purchasing participation with MaineHealth.

- MaineHealth has included SMMC in the development of quality-based clinical protocols for the handling of cases involving myocardial infarction and chronic obstructive pulmonary disease.

- MaineHealth's affiliate Spring Harbor Hospital manages the inpatient psychiatric unit at SMMC and provides the unit with 2.5 FTE psychiatrists, a nurse manager, and a nurse practitioner.

- MaineHealth's laboratory affiliate NorDx has provided operation support to SMMC's onsite laboratory service.

- MaineHealth's VitalNetwork – electronic intensive care unit monitoring programs – provides near round-the-clock coverage for SMMC's special care unit.

- MaineHealth affiliates provide the storage and electronic backbone for the PACS imaging system operated at SMMC.

- MaineHealth provides consultative and clinical support for SMMC's sleep lab."

"These initiatives would not have taken place if MaineHealth had considered itself an active rival to SMMC for patient patronage in SMMC's primary service area."

III. Financial Capability of Applicants and Financial Impact of Project

"None of the managed care payors has suggested to either MaineHealth or to SMMC that it would like to negotiate an exclusive or even a preferred arrangement for the provision of community level hospital services for residents of SMMC's primary service area to the exclusion of the other institution."

"There is little reason to believe that payors could or would seek to induce any form of competition for patient patronage between MaineHealth's hospitals and SMMC, given the comparative separateness of MMC's and SMMC's medical staffs, and the prevailing patient origin information, described below."

"The minimal overlap between the medical staffs of SMMC and MMC, and their respective distance from each other, largely forecloses any significant probability of robust competition between the two institutions for the patronage of patients and payors. Of the 186 members on the medical staff at SMMC with active admitting privileges, only 35 also have admitting privileges at Maine Medical Center. Even this level of overlap is overstated, because 10 of the 35 have not admitted to either SMMC or MMC in the last two years, and of the remaining 25, 18 have admitted patients to only one of the two hospitals (and not the other) during the last two years.[10]"

"By comparison, MaineHealth estimates that approximately 70% of the physicians on the medical staff at Mercy Hospital in Portland are also on the medical staff of Maine Medical Center."

"The lack of overlap between SMMC and MMC staff physicians means that very few clinicians have the opportunity to offer their patients a choice of hospitalization between SMMC and MMC when either institution would be suitable. An SMMC staff physician without MMC staff privileges would have to advise the patient that if he or she were to be hospitalized at SMMC, the SMMC physician could continue to provide care at the hospital, but that if the patient wanted to be hospitalized at MMC, his or her care would have to be transferred to another physician. A lack of physician overlap between two merging hospitals limits the ability of third-party payors to leverage one against the other for price concessions.[11]"

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[10] According to data assembled by SMMC and MMC medical staff records, there were 35 physicians with privileges at SMMC that also had privileges at MMC in 2006-08. Of this group, 10 of 35 were cross-privileged in a technical sense only, admitting no patients to either SMMC or MMC in the July-to-July period 2006-07 and 2007-08. Of the remaining 25, 18 did not admit to both SMMC and MMC during this two year period. Seven of the physicians admitted patients only to SMMC (and not to MMC) in 2006-07 and 2007-08; and 11 admitted patients only to MMC (and not to SMMC) in 2006-07 and 2007-08. The remaining 7 physicians admitted patients to both MMC and SMMC in 2006-07 or 2007-08. Four of the 7 admitted only one patient to MMC during 2006-07; and of these 4; three admitted 0 patients to MMC in 2007-08. A fifth admitted 2 patients to MMC in each of 2006-07 and 2007-08. The remaining two physicians averages 8 admissions to MMC in each of 2006-07 and 2007-08.

[11] More specifically, provided that a third-party payor deems it important to have in its physician network the medical staffs who practice at both merging hospitals, any threat (express or implied) to exclude one or the other hospital from the payor's hospital panel is credible only if the payor believes it would be (1) feasible to negotiate privileges at the other merging firm's hospital for those physicians who practice at the party hospital that is being leveraged, and (2) after negotiating privileges at the other merging firm's hospital for these physicians, their patients would, in fact, access that other hospital (as opposed to switching to an insurer, or inducing their employer to switch to an insurer) who contracts with the leveraged hospital.

"Patient origin data compiled by the Maine Health Data Organization ("MHDO") confirms the proposition that SMMC and MMC do not robustly compete against each other. MHDO compiles inpatient discharge data, and includes data fields for patient residence zip code and diagnostic related group. ("DRG's"). This data base can be analyzed to determine to what extent patients residing in SMMCs' primary service area receive services at MMC that could be readily provided at SMMC."

"To perform the analysis, it is necessary to focus on those types of services in which there can be little doubt but that SMMC is as readily capable of providing the service as MMC. Otherwise, the analysis will be skewed in a way that does not measure the potential for competition between the two institutions."

"As noted earlier, MaineHealth has requested its retained economic consulting firm Micro Economic Consulting and Research Associates "(MiCRA") to provide a "first cut" approximation of a "market" that might be used for purposes of evaluating likely competitive effects of the proposed SMMC-MaineHealth transaction. MiCRA's analysis is included as part of Appendix III-B, and relies on the MHDO database."

"MiCRA's approach looks first at the number of patients from the area where SMMC draws 80% of its patients in standard DRG's – a so-called "80% service area." The approach then analyzes the locations where patients from this 80% service area actually receive hospital services – SMMC, MMC, and other hospitals. The approach then refines the analysis to focus on those categories of services offered at both SMMC and MMC and where, at least theoretically, the patient presumably could have readily received the services either at SMMC or MMC."

"Without further refinement, the resulting approximation would overstate the extent of competition between Southern Maine Medical Center and Maine Medical Center, and thus the degree of any potential reduction in competition after the Definitive Agreement is implemented."

"To obtain a truer picture, as MiCRA's analysis explains, one should screen out additional cases in which, because of circumstances, a patient is not likely to have a good choice of where to obtain hospital services. Two screens were identified. The first is emergency room admissions. Given the distance between SMMC and MMC, inpatient admissions that transpire from the need for care at the nearest emergency room, or for uninsureds or for MaineCare covered patients, will in many instances represent admissions for which the two hospitals would not actively compete for patients. The second screen is physician privilege status common to both hospitals. Patients whose attending physician has admitting privileges at SMMC or MMC, but not both, also represent admissions for which the two hospitals in many instances would not actively compete.[12]"

[12] By applying these screens, MiCRA's more refined analysis is faithful to the modern understanding of the role of market share in antitrust analysis. Market share computation, as noted above, is the beginning, not the end of the analysis, and the core of the antitrust inquiry is to assess what will be the likely effects of the transaction on any existing price and price-related competition.

"As the data demonstrate, in 2005 and 2006, out of a total number of 10,293 inpatient admissions to either SMMC or MMC from SMMC's 80% service area, based on common SMMC-MMC DRGs, only 130 – approximately 1% – were admissions other than through the emergency room and by a physician with privileges at both SMMC and MMC. MiCRA's analysis concludes that Southern Maine Medical Center and Maine Medical Center probably could "compete" only for very few patients in SMMC's 80% service area."

"As a second and alternative analytical approach to accurately measuring competition between the two institutions, MaineHealth has compiled a listing of DRG's for which SMMC has at least 20 discharged patients residing in SMMC's primary service in the category for calendar year 2006. (Appendix III-C). By hypothesis, SMMC was deemed equally capable to MMC in providing the services included within the DRG to all such patients in this service area, even though within a number of DRG's there are case complexities (patient co-morbidities such as heart disease or diabetes, for example) that would render them less suitable for otherwise routine procedures outside of a tertiary hospital setting. The listed DRG's collectively account for 73.3% of all of SMMC's inpatient cases from its primary service area."

"Excluding cases involving newborns and joint replacements (both of which are discussed below), SMMC's share of these 20 or more discharged cases from its primary service area is generally high and Maine Medical Center's share is generally low – usually 15% or lower. For example, among adult cases of pneumonia, SMMC's share was 85% and MMC's share was only 4% ; for cases of chronic obstructive pulmonary disease ("COPD"), SMMC's share was 88% and MMC's share was 5%. Pneumonia and COPD comprise two of SMMC's top five most frequently discharged inpatient diagnoses, and are considered primary community hospital cases."

"MMC's shares do not account for established work-related commuting patterns that may make it more likely that some residents in SMMC's primary service area might use Portland-area physicians as their primary care provider, or as a specialist for the ongoing treatment of a chronic medical condition, and thus making them more likely to be hospitalized in a Portland hospital.[13] It also does not take into account case difficulty within a DRG. Although two patients may have the same DRG, one of those cases may prove particularly difficult and thus necessitate treatment in a tertiary setting, which MMC provides. Therefore, for cases that could be effectively treated at either SMMC or MMC, the shares on the attached table likely overstates MMC's share and understates SMMC's share."

"Among cases involving newborns, SMMC's share is smaller and MMC's share is higher than the cases discussed above. MMC's average share of these cases is slightly higher than its share among the first group of cases – approximately 21-22%. The relatively lower numbers at SMMC, and higher number at MMC, is explained by both temporal and idiosyncratic factors.

[13] To illustrate: approximately 450 employees of Maine Medical Center – 9% of its total Maine work force – reside in SMMC's primary service area. Presumably other large Portland-area based employers would have a comparable number of employees residing in SMMC's primary service area.

III. Financial Capability of Applicants and Financial Impact of Project

SMMC was renovating its birthing unit during this period, and also experienced a shortfall in the number of ob/gyn physicians practicing in the community at this time. This no doubt explains some of the lower numbers at SMMC. SMMC believes that many expectant mothers working outside the home will be prone to choose an ob/gyn physician nearby to their place of work, because prenatal care during a pregnancy will require a series of physician office visits during working hours. Expectant mothers residing in SMMC's primary service area whose employment is in the greater Portland area may thus be more likely to select a Portland-area ob/gyn. Finally, MMC's higher obstetrics share may reflect in part the expectant mother's or family's risk aversion when it comes to the delivery process, post-partum care, and the possible need for neonatal intensive care services available in Portland and only at MMC."

"With respect to surgeries such as major joint replacement, MMC's share of cases in SMMC's PSA is slightly higher than its share of non-joint replacement, non-newborn cases. There are two factors that contribute to this. The first is the demand for joint replacements from senior citizens, who have a higher rate of co-morbidities, and thus are more suitable for otherwise routine procedures in a tertiary hospital setting. By way of example, a patient 75+ years of age who requires a joint replacement and who has a history of heart disease or diabetes is generally not regarded as suitable for the surgery in a setting other than a tertiary care center. The DRG's for major joint replacement, however, do not differentiate among patients by age, or co-morbidities. As a result, the DRG totals for MMC likely include a substantial number of persons who could not have received joint replacement surgery at SMMC."

"The second factor is a relative shortage of orthopedic surgeons at SMMC. SMMC's medical staff development plan presupposes that SMMC's service areas can support five orthopedic surgeons. However, from February 2006 until the summer of 2008, there were three orthopedic surgeons on the staff at SMMC. This shortage contributed to longer wait times for orthopedic surgery at SMMC, and consequently some "leakage" of cases to Portland. Anecdotally, SMMC officials were advised that patients who were candidates for orthopedic care were being told that could not be seen for "weeks" by the orthopedic surgeons in Biddeford, but could be seen within days – if not the next day – by orthopedic surgeons in Portland. If SMMC is successful in executing its physician staff development plan – and the Definitive Agreement is intended to assist SMMC in this endeavor – then in several years, the share of such surgeries performed at MMC may decline to the 15% or lower level."

"Again, the data on the whole corroborate the proposition that the level of competition for patients whose patronage could be competed for is modest.[14] Even the indicated amounts shown may be overstated, because some of the patients residing in SMMC's primary service area may commute to Portland for work, and may use as a primary care physician or a specialist treating a chronic medical condition a physician without staff privileges at SMMC."

[14] Over all DRG's in which SMMC has 20 or more discharges of patients from SMMC's primary service area, SMMC's share was 67.3%; MaineHealth's member hospital's share (MMC's and Spring Harbor's share was 17.6%; and other hospitals' combined share (York, Goodall and Mercy Hospitals) was a cumulative 13.2%. Mercy Hospital's share of newborn cases from SMMC's primary service area was approximately 20%.

III. Financial Capability of Applicants and Financial Impact of Project

"Finally, as the data shows, for those modest number of patients in SMMC's primary service area who may be willing to travel to Portland for their services, Mercy Hospital remains an option and as such a competitive constraint. Mercy Hospital is a 150-bed hospital in Portland that offers the full spectrum of services that SMMC does, plus additional services. It is in the process of a multi-phase rebuilding of facilities at a location on the Fore River in Portland, with direct limited access highway connection to Interstate 295. It will be the first and newest facility that a patient traveling north from SMMC's service area would encounter."

"For these reasons, the Applicants do not believe that there will be any increase in the price paid by consumers for hospital care as a result of any reduction in competition between Southern Maine Medical Center and MaineHealth hospitals incident to the implementation of the Definitive Agreement."

"SMMC and MaineHealth's member hospitals currently have contracts in place with major payors. Each does not know for sure what are the key financial terms of the other's contracts with payors. In the spring of 2008 SMMC negotiated a 3-year contract with Anthem. Post Definitive Agreement, that contract will be honored by SMMC and MaineHealth, as will all other currently in force contracts between SMMC and its payers."

"When SMMC's contracts with payors expire by their terms, MaineHealth will seek to include services at SMMC as part of its system-wide contracts with payors. Generally speaking, these contracts are structured as discounts from charges, with the discount varying by hospital cost, and by the type of product (managed care, PPO, indemnity) offered by the payor."

"Historically, MaineHealth negotiated contracts with private payers that provide them discounts from Maine Medical Center's charges, with the particular level of discount keyed to the lines of business in which the insurers are engaged.[15] For example, a discount of x% might be provided for services delivered to patients covered by a preferred provider arrangement, while a discount of y% might be provided for services delivered to a patient covered under a particular type of managed care product. The discounts provided for each line of business do not vary significantly from payor to payor. One of the purposes of this approach is to help assure a competitive insurance market in southern Maine. It is MaineHealth's intention to maintain this approach following SMMC's merger into the System."

b. Mental Health Services

"The Applicants have also considered whether there may be any likely disadvantages resulting from any material reduction in competition for the provision of mental health services as a result of their Definitive Agreement. Their answer is "no"."

"The entities to compare are SMMC and MaineHealth's Spring Harbor Hospital. This is because MMC, unlike SMMC and Spring Harbor Hospital, does not provide mental health services to

[15] Three years ago, one payor asked MaineHealth to blend its discount rate in to a single discount, regardless of insurance product, and MaineHealth accommodated that payor's request.

persons with a mental health-only diagnosis. MMC serves only dual diagnosis patients – i.e., patients with an underlying medical condition requiring hospitalization who also may require mental health services."

"To analyze the theoretical level of competition for inpatient mental health services between SMMC and Spring Harbor, services not offered at either or both hospitals must be excluded, by definition. Accordingly, the analysis must exclude

- substance abuse admissions. Neither Spring Harbor nor SMMC admits inpatients whose primary mental health diagnosis is substance abuse.

- children and adolescents. SMMC admits adult only mental health inpatients."

"Applying these filters, the remaining mental health inpatient admissions from SMMC's combined primary and secondary service areas in 2007 at SMMC were 395 and 164 at Spring Harbor."

"The residual cases should be further discounted for those in which the payors are MaineCare and Medicare. MaineCare and Medicare set their respective rates of reimbursement by fiat as an implementation of government policy. MaineCare and Medicare reimbursement rates are not set by negotiation in a competitive market context. Excluding MaineCare and Medicare from the previous remainder, the residual non-Medicare and MaineCare mental health admissions in 2007 from SMMC's combined primary and secondary service areas were 159 at SMMC and 105 at Spring Harbor."

"Finally, there is no current active competition for these remaining cases between Spring Harbor Hospital and SMMC. Spring Harbor Hospital is now managing and its psychiatrists are now covering the 13-bed inpatient psychiatric unit at SMMC. Spring Harbor's assistance in this regard made it possible for SMMC to keep open the psychiatric unit following the unexpected departure of two psychiatrists at SMMC in 2007."

"SMMC officials believe that the demand for such services outstrips the supply of 13 beds for its inpatient unit. Even if Spring Harbor were not managing SMMC's psychiatric unit, SMMC would have no need to "compete" for patient patronage given the excess demand."

"In sum, there is no competition between SMMC and Spring Harbor Hospital for mental health patients, and *a fortiori* no material disadvantages likely to result any reduction in competition as a result of the implementation of the Definitive Agreement."

c. Physician Services

"The vast majority of physicians who practice at Maine Medical Center are in private physician practice groups. Through its affiliate Maine Medical Partners, MaineHealth indirectly employs some physicians. Some are in sub-specialties generally not practiced except in association with tertiary care institutions. Still others are in the primary care specialties."

"Distributed in sites around Greater Portland (but not in York County), Maine Medical Partners employs 7 family practitioners, 16 MMC residents, 23 pediatricians,[16] and 18 internal medicine specialists. It does not employ any generally practicing obstetricians, gynecologists,[17] general surgeons, pulmonologists or cardiologists. The other physician employees of Maine Medical Partners have subspecialties not available from the medical staff at SMMC."

"There are several large physician practices providing primary care in greater Portland. On its web site, the physician practice Intermed lists 28 internal medicine physicians; 10 family practice physicians and 5 pediatricians. Bowdoin Medical Group's web site lists 11 family practice physicians in greater Portland and 1 in Biddeford. Martin's Point's web site lists 7 family practice physicians, 3 internal medicine physicians, and two pediatricians in its Portland location. Mercy Primary Care's web site lists 10 family practice physicians in greater Portland. There are also numerous smaller primary care physician practices in the Portland area."

"As of September 2008, SMMC employed few physicians. These included 10 emergency department physicians; 6 hospitalists, who provide care to hospital inpatients, and not in the physician office setting; 3 general surgeons; 1.6 FTE occupational medicine physicians; 1 FTE internal medicine physician, 1 FTE orthopedic surgeon; and 1 FTE pediatric medicine physician."

"As of October 1, 2008, SMMC employed the 42 physicians formerly employed by the physician practice PrimeCare Physician Associates, with approximately half comprising primary care physicians. [SMMCs' transaction with PrimeCare is described in further detail in Section IV of this application ("Public Need")] The former PrimeCare physicians now employed by SMMC include (by specialty): 6.75 FTE internal medicine physicians; 7.625 FTE family practice physicians; 2.0 FTE pediatric/internal medicine physicians; 2.0 FTE pulmonologists; 1.0 FTE endocrinologist; 3.5 FTE pediatricians; 4 cardiologists; 2.0 FTE gastro-enterologists; 2.0 FTE neurologists; 2.0 FTE general surgeons; ~5.0 FTE ob/gyn physicians; and 1.0 FTE Sports Medicine physician."

"Even with the addition of these PrimeCare physicians, the competitive effects of the SMMC-MaineHealth Definitive Agreement on physician services is negligible, for two reasons."

"First, primary care physician services tend to be delivered locally. The distribution of physicians even within a single physician practice among multiples locations (e.g. Intermed's five sites in Portland and in Yarmouth; Bowdoin Medical Group's locations in Saco, West Falmouth, South Portland and Gorham; PrimeCare's four locations) corroborates this point."

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[16] Two of the pediatricians are located in Saco. In terms of manpower capacity, the two pediatricians represent collectively 2 FTE units.

[17] Maine Medical Partners employs two OB/GYN's who provide such services as part of a maternal and child health practice. They do not have open practices generally for expectant mothers or gynecological care. Collectively, the two clinicians provide less than 1 FTE of capacity.

"Second, even if SMMC-employed physicians (augmented by PrimeCare physicians) were regarded as competing with Maine Medical Partners-employed physicians, the same analysis would require treating all greater Portland physicians (not just Maine Medical Partners-employed physicians) as "competing" with SMMC-employed physicians. The share represented collectively by SMMC-employed and Maine Medical Partners-employed physicians in this hypothetical is a minor share, not capable of exercising any market power by virtue of its relative size."

d. Home Health Care Services

"SMMC has a home health care affiliate known as SMMC Visiting Nurses. SMMC Visiting Nurses provides skilled nursing, physical therapy, occupational therapy, speech/language pathology, medical social work counseling and home health aide contacts for assistance with personal hygiene and activities of daily living."

"In the fiscal year ending April 2007, SMMC Visiting Nurses made 22,576 home visits to a total of 1428 patients. Half of these visits were for skilled nursing care. For this fiscal year, SMMC's total revenues were $3.1 million. 70% of the SMMC Visiting Nurses volume is attributable to referrals of discharged patients from SMMC, or of patients under treatment by physicians on the medical staff of SMMC. Between 70% and 75% of SMMC Visiting Nurses' billings are to Medicare and another 12% to 15% are to MaineCare."

"If donations to SMMC Visiting Nurses were excluded from the calculation, over the last five years on average SMMC Visiting Nurses has operated with negative cash flow – i.e., revenues from home health services have been less than the costs of providing those services."

"There are at least five other entities providing similar home health services to patients in SMMC's primary service area: Home Health Visiting Nurses of Southern Maine (an affiliate of MaineHealth); VNA Home Healthcare (an affiliate of Mercy Hospital); York Hospital Home Care; Gentiva Health Services; Interim Healthcare; and Kennebunkport Visiting Nurses.[18]"

[18] The Department's web site (http://www.maine.gov/dhhs/beas/resource/alzheimer/york.htm) lists the following entities as providers of home health services for Alzheimer's patients in York County:

Name	Location
Arcadia Health Care	Springvale
Interim Health Care	Kennebunk
Kennebunk Health & Home Care	Kennebunk
Action Nursing Care	Old Orchard Beach
Caremark, Inc	Old Orchard Beach
The Nurses Station/Life Church	Saco
Gentiva Health Services	Saco
Visiting Nurse Service	Saco
Home Resource of ME	Westbrook
Visiting Nurse Service	York
York Hosp. Home Health Care	York

III. Financial Capability of Applicants and Financial Impact of Project

"Home Health Visiting Nurses of Southern Maine (HHVN), as noted above, is an affiliate of MaineHealth. HHVN is the product of a merger in 2004 between Community Health Services, based in Portland, and Visiting Nurse Service of Southern Maine and Seacoast New Hampshire, based in York County. HHVN provides home health services. In fiscal year 2007, HHVN made 114,336 home visits to a total of 7,357 patients, and realized gross revenues of $16.6 MM. HHVN serves most of York and all of Cumberland counties, and portions of Sagadahoc, Androscoggin and Oxford Counties."

"The Applicants believe that there will be no significant disadvantages to home health patients or payors attributable to any reduction in competition as a result of the Definitive Agreement. As noted above, 70% of SMMC visiting nurses' patients are attributable to SMMC and its staff physicians, and Medicare and MaineCare, which set reimbursement rates by governmental fiat rather than through a competitive process, collectively represent between 82% and 90% of SMMC Visiting Nurse' billings. In addition, given the number of other home health care providers serving York County, patient choice among home health care providers will continue to be robust."

3. No Adverse Impact on Other Competitors or Vendors

"The Applicants believe there will be no significant disadvantages attributable to reduction in competition among covered entities or other persons furnishing goods or services to, or in competition with, covered entities that are likely to result directly or indirectly from the Definitive Agreement. In particular, the Applicants believe that there will be no reduction in competition from Mercy Hospital, York Hospital, or Goodall Hospital from the implementation of the Definitive Agreement, and therefore no disadvantages attributable to any such reduction in hospital competition."

"The Applicants also believe that there will be no reduction in competition for the patronage of vendors who provide goods or services to MMC or SMMC that would result from the implementation of the Definitive Agreement, and therefore no disadvantages attributable to any such reduction in hospital competition. SMMC is already a member of the MaineHealth-sponsored joint buying group that achieves economies of scale savings for its members, and the Definitive Agreement does not change this status. The labor markets from which MMC and SMMC procure paraprofessional services are regional in scope, and there are many entities – other hospitals, physicians' offices, clinics, insurance companies, nursing homes, and home health agencies - participating in these labor markets."

"The Applicants believe that there will be no adverse impact on patients or clients on the price of health care services. This conclusion flows in part from the analysis set forth above. There is no current rivalry between SMMC and MMC for patient patronage, as the data demonstrate, and there is no record to suggest that managed care payors are likely to stimulate price-related rivalry by threatening to exclude one of the institutions from the payor network or otherwise steer patients to the other institutions."

III. Financial Capability of Applicants and Financial Impact of Project

4. Efficiencies

"Immediately achievable operational cost efficiencies have not been a major motivation for the Definitive Agreement. This is in part because MaineHealth has already included SMMC as an affiliate in its group purchasing program. The parties have estimated that since October 2005, SMMC has achieved savings of $1,059,658.00 in its purchases as a result of its participation in this MaineHealth initiative."

"MaineHealth and SMMC believe that they can achieve approximately $500,000 in additional cost savings for SMMC post-merger as a result of the streamlining of various operations."

"The MaineHealth/SMMC combination will also provide modest economies of scale in administrative items. As a member of the MaineHealth system, SMMC may utilize MaineHealth's existing planning staff, legal staff, and internal audit processes. Currently, SMMC must purchases these services from external vendors."

"As a member of MaineHealth, SMMC will be able to borrow at interest rates more favorable than it has been able to achieve as a stand-alone institution. At current rates, the Applicants anticipate that SMMC's borrowing rate will be 1.5 % lower than rates currently available to it. Assuming that SMMC were to expend the funds in its current capital expenditure forecasts in the next three years, and that 25 % of these funds would be borrowed, the savings to SMMC would amount to $252,000.00 over a five-year period."

"Although not susceptible to quantification, the Applicants believe that their combination will produce savings from cost avoidances in the future. As noted above, SMMC's capital and operating budgets are subject to approval of MaineHealth. Given the geographic proximity of the institutions – there are 18 driving miles between them – the Applicants expect that many major service initiatives undertaken by SMMC or MMC will of necessity include the other within its scope, and for that reason, reflect economies of scale made possible by the inclusion of both entities and minimize duplication that might otherwise occur."

III. Financial Capability of Applicants and Financial Impact of Project

B. CONU Discussion

i. CON Criteria

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

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

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

ii. CON Analysis

CONU staff prepared a template (modified for mergers) that allowed for financial information from the two applicants to be placed on the same template. The applicants are the two organizations: MaineHealth and SMMC. MaineHealth is a large organization with multiple subsidiaries and joint ventures. MaineHealth has succeeded in making these separate entities self-sufficient with the bulk of inter-company activity related to membership fees, purchase by buying groups, collective financing opportunities and legal and technical expertise. For this merger, CONU staff determined that for the project to be considered financially viable, CONU would look at the capacity of MMC as an example of MaineHealth's overall financial health because the revenues and capitalization of MMC accounts for a significant portion of MaineHealth. Showing that MMC is capable of supporting the operations of SMMC during the three years under consideration, CONU has sufficient information for a positive recommendation regarding this determination.

SMMC's audited financial statements indicate that they had revenues in excess of expenditures for 2008 and 2007 of $1,082,494 and $6,328,211 respectively. Their ratios were remarkably similar for the time periods in the audited financial statements as compared to the projected periods of 2010 through 2012. The auditor's opinion of the financial statements was unqualified. Cash and cash equivalents was $9,366,923 in 2008 which was 8% of the year's cash outlays indicating a days cash on hand from cash and cash investments of at least 116 days. Investments of $34,900,599 give the organization a significant amount of liquidity if the need arose to convert to cash. Property and equipment made up 44% of the balance sheet. Net assets of $82 million with only $126 million in assets indicate a well capitalized hospital. Long term debt in 2008 was $26.4 million, an increase of $1.6 million from the previous year end. The financial statements reinforce that SMMC is a financially viable operating entity.

On January 16, 2001, SMMC received CON approval to add a Cardiac Catheterization Lab at a maximum allowable capital expenditure of $489,300.

III. Financial Capability of Applicants and Financial Impact of Project

On July 26, 2005, SMMC received CON approval for major expansion of their Emergency Department and Surgical Services Department at a maximum allowable capital expenditure of $23,530,000. This project received a subsequent review approval, on July 11, 2006, increasing the maximum allowable capital expenditure to $26,000,000. As of the Public Hearing held on November 17, 2008, the applicant stated that approximately $3 million of this project had yet to be completed on the Surgical Services portion. The last implementation report received on this project, dated September 10, 2008, through the period July 2008 showed an unexpended balance of $4.3 million.

To partially fund the above projects, in fiscal year 2007, SMMC received $16.7 Million in revenue bonds through the Maine Hospital and Higher Education Financing Authority (MHHEFA).

On August 5, 2008, SMMC received a not-subject-to-review (NSTR) letter authorizing the purchase of imaging equipment and communication systems from PrimeCare Physician Associates totaling $3,219,000.

SMMC financial statements do not fully represent the entity's current financial position since SMMC acquired PrimeCare Physician Associates ("PrimeCare") later in calendar year 2008. This was learned at the Public Hearing conducted on November 17, 2008. This purchase is also not reflected in the Financial Forecast Module the CONU asked the applicants to submit with their CON application. This purchase of PrimeCare's assets represents an additional estimated $15 million that should have been reflected as both an asset and liability in the Financial Forecast Module.

The applicants provided limited explanations for the financial projections and provided limited commentary regarding this section and its determinations. The CONU Financial Forecast Module completed by the applicant is consistent with comments made at the technical assistance meeting that savings from benefits would at least offset the administrative fee SMMC would pay to MaineHealth to become a member. Additional commitments by the applicants would result in savings greater than those included in the Financial Forecast Module.

The entities involved plan no reductions in staff related to this proposed transaction. Savings for SMMC are limited to the net difference between employee benefits costs/other insurance savings and the additional fee for becoming a member of MaineHealth. Net patient service revenues in 2010, the first projected year for SMMC after the merger, are expected to be $116.6 million.

Additional financial ratios, as well as financial projections, are on file with CONU. The following discussion relies on the information presented by the applicant. At the technical assistance meeting held on July 31, 2008, the applicant was presented a format for completing significant financial projections, as well as instructions regarding some modifications to the spreadsheet to account for the fact that this project is a merger of two hospital systems, as well as operating expenses. Twenty-three ratios were developed with the applicant's submission to help elucidate the current financial position for Maine Medical Center, MaineHealth's largest

hospital, and the impact of the proposed project on Maine Medical Center's operating and financial feasibility.

The years presented in the Financial Forecast Module show both hospitals alone and then combined for the sole purpose of showing that MaineHealth's major subsidiary (Maine Medical Center) has the capacity to support this merger.

There are four areas of financial ratio analysis related to the ability of the applicant (MaineHealth) to support the project (SMMC) financially. These ratios are profitability, liquidity, capital structure and activity ratios.

Profitability ratios attempt to show how well the hospitals do in achieving an excess of revenues over expenditures (providing a return). Generating revenue in excess of expenditures is important to secure the resources necessary to update plant and equipment, implement strategic plans, or respond to emergent opportunities for investment. Losses, on the other hand, threaten liquidity, drain other investments, and may threaten the long-term viability of the organization. The profitability ratios reported here include the operating margin, which measures the profitability from operations alone, the net margin (called total margin in some sources), which measures profitability including other sources of income, and the return on total assets.

Please note, that for the purposes of this analysis, the CONU is using MMC's financial data to demonstrate that MaineHealth is capable of financially supporting SMMC. The tables below show projected financial results of SMMC in 2012, the third operating year after the agreement. For CON purposes, historical performance of SMMC is not germane to the question of whether MaineHealth has the capacity to financially support SMMC.

Financial Performance Indicators

Profitability	MMC 2006	MMC 2009	MMC 2012	SMMC 2012	Combined 2012
Operating Margin	6.00%	6.06%	6.81%	1.39%	6.05%
Net Margin	9.43%	9.51%	10.68%	2.11%	9.49%
Return on Total Assets	5.83%	5.97%	6.48%	2.20%	6.11%

All three margins indicate that if the proposed project occurs, that Maine Medical Center and SMMC would remain profitable. These margins indicate the ability of the applicant to take on additional expenses based upon excess of revenues over expenditures.

Non-profit hospitals need to perform at financially sustainable levels in order to carry out their public missions. An adequate operating margin is a key indicator of the financial health of a hospital. Of great concern to CONU is the determination of the reasonableness of the methodology the applicant has used in determining the appropriateness of the timing and scope

of the project. Over time, capital expenditures can and need to be made in order to meet the goals expressed in the State Health Plan. CONU evaluates the applicant's ability to organize and respond to its challenges in improving and maintaining the health care system.

Operating margins in the high performing hospital group have seen greater improvements in margins, while hospitals in the low performing group are sliding. High performing hospitals are doing better now than five years ago. Over the same time, lower performing hospitals are generally doing worse than five years ago. There is a widening gap between high and low performing hospitals. Improvement in operating profits for high-performing hospitals drives this widening performance gap. As a comparison, operating margins in the Northeast Region are considerably lower than in other regions.

The Maine State average for operating margin in 2006 was 3.80%. Maine Medical Center was at 6.00%. SMMC in 2012 is projected to be 1.39%. The impact on the combined operations would be a decrease in operating margin of 0.76%. This decrease is significantly less than the decreases seen in other projects that have been approved in the past year.

The trend for operating margin in the State of Maine has been improving from a low of -1.35% to the present high of 3.8%. Maine Medical Center's margin for the past four operating years including 2007 averaged 6.0%; 2005 was 15.90% which helped to offset the -0.54% that Maine Medical Center reported in 2004. SMMC was profitable during the same timeframe (2000-2005) but considerably less so.

The effect of this project on operating margins, as projected by the applicants, is not significant. This project is not expected to cause a significant impact on the operating margin on MaineHealth.

Financial Performance Indicators

Profitability	MMC 2006	MMC 2009	MMC 2012	SMMC 2012	Combined 2012
Operating Surplus	$33,413,000	$41,557,999	$56,271,000	$1,853,000	$58,124,000
Total Surplus	$52,547,000	$65,221,999	$88,254,000	$2,681,000	$91,076,000

This table validates that the applicant has the capacity to financially support this project, based upon profitability.

Liquidity: Current ratios and acid test ratios are indicators of the ability of a hospital to meet its short-term obligations. The acid test ratio is generally considered to be a more stringent measure because it recognizes only the most liquid assets as resources available for short-term debt; the current ratio assumes that inventory and accounts receivable can be liquidated sufficiently to meet short-term obligations. Days in accounts receivable and average payment period also are used to monitor liquidity. Respectively, they indicate the average length of time the hospital

takes to collect one dollar of receivables or pay one dollar of commercial credit. Together, they can provide a cursory indication of cash management performance.

Financial Performance Indicators

Liquidity	MMC 2006	MMC 2009	MMC 2012	SMMC 2012	Combined 2012
Current Ratio	2.75	2.52	3.23	2.00	3.12
Days in Patient Accounts Receivable	18.54 Days	24.90 Days	23.48 Days	40.59 Days	25.82 Days
Days Cash on Hand	232.83 Days	210.89 Days	282.32 Days	122.39 Days	258.55 Days
Average Payment Period	96.77 Days	93.34 Days	86.06 Days	46.90 Days	80.24 Days

In terms of liquidity, Maine Medical Center currently has substantial liquidity. This is caused, in part by, a significant delay in making payments to its vendors. It is interesting to note that the projection indicates a decreasing lag over the forecasted period. The average payment period for Maine Medical Center is significantly longer than most other hospitals reviewed by CONU. Forecasted average payment periods are a very conservative 86 days; because this is a continuation of recent trends, it strengthens the assurance that cash needs can be met. Days in accounts receivable decreases over the period by 1.5 days. Days cash on hand was in a range of 230-280 days in the 2006-2009 periods and is projected to decrease to 259 days during the course of the project. This may be an indication that future projects may not be incorporated in the projection.

Liquidity measures a hospital's ability to manage change and provide for short-term needs for cash. This liquidity alleviates the need for decision making to be focused on short term goals and allows for more efficient planning and operations of a hospital.

Days Cash On Hand is a ratio that is an industry accepted, easily calculated, method to determine a hospital's ability to meet cash demands.

The year 2006 marked a steep decline of cash on hand nationally. The applicant's major member, Maine Medical Center, had gross patient service revenue closing in on $1 Billion annually and cash on hand of 232 days in 2006, clearly MMC has significantly more cash on hand than the average hospital in its peer group. Interestingly, S & P Bond ratings showed no clear distinction between ratings and cash on hand for investment grade ratings. This may mean that high performing hospitals do attempt to control excess levels of cash on hand.

In 2006 the average days cash on hand for all sources for hospitals in the State of Maine was 97.9 days. Calculated days cash on hand for Maine Medical Center in 2006 was approximately 232 days, indicating that Maine Medical Center was in the 90th percentile. SMMC is expecting days cash on hand to be 122 days in 2012.

According to the same source, between 2000 and 2004 the average days cash on hand remained about 68 days. In 2006, cash on hand reached a five year low. Between 2006 and 2012 average days cash on hand for Maine Medical Center is projected to increase by 50 days. In 2004, hospitals in the State of Maine had 15% less days cash on hand than the Northeast Region at 80 days, 12 days more than the Maine average. In 2006, Maine hospitals had increased their cash on hand by 50% in two years to be 30 days above the regional average.

The impact of the proposed project is calculated to be a decrease of 24 days cash on hand in the third operating year as compared to the results predicted by Maine Medical Center if the agreement did not occur (with and without this project). This is a minor decrease in days cash on hand. The project does not entail combining the two hospitals' operations; however, consideration of the ability to financially support the smaller hospital requires the consideration of the combined results of the two hospitals. Based upon source information, the "combined hospital" is projected to be greater than the 90th percentile for days cash on hand, compared to today's industry averages, with or without the project. Therefore this project will not have a substantial impact on Maine Medical Center's operating ability to meet its cash demands. Even if actual cash on hand is lower, based on additional investments in programs and technology, MaineHealth should be able to adequately support SMMC, based upon liquidity.

Activity and Capital Structure: Activity ratios indicate the efficiency with which an organization uses its resources, typically in an attempt to generate revenue. Activity ratios can present a complicated picture because they are influenced both by revenues and the value of assets owned by the organization. The total asset turnover ratio compares revenues to total assets. Total assets may rise (or fall) disproportionately in a year of heavy (dis)investment in plant and equipment, or decrease steadily with annual depreciation. Thus, it is helpful to view total asset turnover at the same time as age of plant. Debt service coverage is reviewed in greater detail. Debt service coverage measures the ability of a hospital to cover its current year interest and balance payments.

Financial Performance Indicators

Solvency	MMC 2006	MMC 2009	MMC 2012	SMMC 2012	Combined 2012
Equity Financing	66.97%	69.24%	73.06%	72.87%	73.05%
Debt Service Coverage	11.23	7.66	9.68	TBD	TBD
Cash Flow to Total Debt	28%	33%	42%	31%	33.22%
Fixed Asset Financing	64%	39%	39%	33%	38.53%

Many long term creditors and bond rating agencies evaluate capital structure ratios to determine the hospital's ability to increase its amount of financing. During the past 20 years, the hospital industry has radically increased its percentage of debt financing. This trend makes capital

structure ratios important to hospital management because these ratios are widely used by outside creditors. Values for these ratios ultimately determine the amount of financing available for a hospital. Debt service coverage is the most widely used capital structure ratio. Debt service coverage minimums are often seen as loan requirements when obtaining financing. Debt service coverage is the ratio of earnings plus depreciation and interest expense to debt service requirements. In 2006, the median Maine hospital's debt service coverage (DSC) was 3.48x.

Maine Medical Center had a DSC in 2006 of 11.23x, which places it in the range of 90th percentile. The trend has been statewide for 2002-2006 has been increasing with a low of 2.36 in 2002 and a high of 3.71 in 2004. The trend for Maine Medical Center has been decreasing for the last 4 years from 11.23x to 7.66x. The trend, as projected by Maine Medical Center, for this project 2008-2015 is that DSC is expected to partly rebound to 9.68% for the "combined hospitals". The amount of debt on the projected worksheets for SMMC is the same for both 2011 and 2012 so the ratios in 2012 and for the combined operations will need to be determined later. No additional information was presented to reliably determine this ratio for 2012.

Maine Medical Center has the capacity and the ability to have adequate debt service coverage. If Maine Medical Center were to maintain its debt service coverage at a ratio consistent with its recent history, a change of 1.16x (assuming all 2011 debt for SMMC with no income or revenue) would not significantly impact its ability to service its loans.

The 2008 Almanac of Hospital Financial and Operating Indicators commented: "Low performance hospitals have historically used more debt to finance net fixed assets than high performance hospitals. With the removal of capital cost pass through, long term debt will become most costly relative to equity. High performance hospitals are restructuring their capital positions to reflect this shift in the relative costs of debt and equity capital. However, we expect fixed asset financing ratios to continue to remain stable during the next 5 (five) years as hospitals curtail their growth in new capital expenditures and reduce their reliance on long term debt."

The Northeast has considerably higher rates in financing fixed assets than other regions. The 2006 average for hospitals in the State of Maine was 52% in regards to fixed asset financing. In 2006, Maine Medical Center was at 64%, which is the 50^{th}-75^{th} percentile for the State of Maine. For the years 2002-2006, for hospitals with revenues similar to Maine Medical Centers, 63% is about the average. SMMC reported a fixed asset financing ratio of only 33%.

The fixed asset financing ratio over the past 5 years has remained relatively consistent in the State of Maine.

Efficiency Ratios: Efficiency ratios measure various assets and how many times annual revenues exceed these assets.

III. Financial Capability of Applicants and Financial Impact of Project

Financial Performance Indicators

Efficiency	MMC 2006	MMC 2009	MMC 2012	SMMC 2012	Combined 2012
Total Asset Turnover	0.62	0.63	0.61	1.01	0.63
Fixed Asset Turnover	2.04	1.45	1.61	2.29	1.66
Current Asset Turnover	1.55	1.78	1.54	4.33	1.67

Total asset turnover (TAT) provides an index of the number of operating revenue dollars generated per dollar of asset investment. Higher values for this ratio imply greater generation of revenue from the existing investments of assets. Larger hospitals usually have lower values for turnover than smaller hospitals. This can be attributed to two factors: (1) larger hospitals are more likely to have newer physical plants; and (2) capital intensity is often greater in larger hospitals due to more special services and higher levels of technology.

In 2006, according to the source cited above, Maine hospitals had a TAT of 1.12.

For 2006, Maine Medical Center had a TAT of 1.55. This is indicative of the relative age of the hospital and expected because of the significant hospital improvements over the past decade.

In the period of 2000 – 2004 there has been a steady increase in the TAT for Maine hospitals. The expected trend for Maine Medical Center is for TAT to remain the same during the time frame of this project 2009-2012. This is reflective of a hospital planning to spend approximately the same percentage of funds on capital improvements or investments in technology. The projected operating costs in the third operating year are expected to remain unchanged. For the Bureau of Insurance, this amount is adjusted to a current value of $0 in order to calculate the impact of this project on commercial insurance premiums. The impact on the Capital Investment Fund (CIF), if approved, would be $0. The third year operating costs include $636,768 in projected savings related to benefit costs and an increase of $636,768 in fees to MaineHealth. No decreases in operating costs due to State Health Plan initiatives are included.

In completing this section of the analysis, the CONU concludes that, as proposed, the applicants can financially support the project. Demands on liquidity and capital structure are expected to be adequate to support projected operations. Financing and turnover ratios show little impact on the organization as a whole from successfully engaging in this project. Maine Medical Center has shown current earnings, which are not expected to be significantly impacted by this project.

As previously noted, several financial capital expenditures were not included in the Financial Forecast Module. These capital expenditures would have a negative impact on these ratios if they were to be included. These expenditures do not impact the Capital Investment Fund (CIF) calculation and would not be reviewable expenditures under the CON statute.

Changing Laws and Regulations

CONU staff is not aware of any imminent or proposed changes in laws and regulations that would impact the project. MaineHealth presently has the organizational strength to adjust to reasonable changes in laws and regulations.

iii. COPA Criteria

Relevant criteria under the COPA law that should be discussed in this section are:

- The likely gains in the cost efficiency of services provided by the hospitals or others;
- The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents or other health care payers to negotiate optimal payment and service arrangements with hospitals or health care providers;
- The extent of any disadvantages attributable to reduction in competition among covered entities or other persons furnishing goods or services to, or in competition with, covered entities that is likely to result directly or indirectly from the cooperative agreement; and
- The extent of any likely adverse impact on patients or clients in the price of health care services.

iv. COPA Analysis

Federal Anti-Trust Law allows the government to intervene if an impediment to competition occurs. The statute regarding Certificate of Public Advantage is less restrictive because impacts on competition need to be weighed against advantages provided for in the agreement. In considering the cases cited below, the Department is determining, based on Federal case law, the reasonable assertions regarding the findings required in Federal cases to permit intervention. The Department has determined that it is necessary to determine a service area for the applicant hospitals and surrounding competitors. The applicants asserted that the relevant service area included 80% of its hospital patients.

Under the Clayton Act, courts will define the relevant market in terms of product and geography and then assess the likely consequences of any changes in competition in that market. Here, the product market is acute inpatient services. However, the Department has determined that the analysis of federal courts under the Clayton Act serves as a useful tool in analyzing the project under the Maine statute. The Department has used the analysis to determine its own methodology to review relevant markets for this project.

III. Financial Capability of Applicants and Financial Impact of Project

Four federal court cases are considered below:

FTC v. Tenant Health Care Corporation 186 F. 3d 1045 (8th Cir 1989) A "service area" is generally defined as the area from which a hospital defines 90% of its inpatients. The court also found that in certain cases this is not binding but rather the product being provided is also important. The Department will report both 80% and 90% markets. This information proves useful in two ways, it buttresses the information provided by the applicants by way of expert analysis and provides the Commissioner with information not clearly defined elsewhere as to the geographic area where patients in the effected area draw their inpatients from. The Department believes that a 90% service area is more appropriate and therefore is adopting a 90% service area as its base analysis because SMMC would not be able to stay open if they did not maintain its customers in these areas. Deriving its inpatient revenue from only the 80% service area would not be sufficient to provide for operations.

State of California v. Sutter Health System, Alta Bates Medical Center and Summit Medical Center 130 F. Supp. 2d 1409 (N.D. Cal 2001) Ordering zip codes by market did not portray as accurately as ordering zip codes by the actual number of patients. Service area overlap, indicating patients could practically turn to other hospitals in the event of a significant price increase.

The departmental methodology is therefore derived from zip codes and by the actual number of patients. It should be noted that the two applicants were consistent with their descriptions of the areas they serve in comparison with the department's certificate of public advantage inpatient service area.

FTC v. Freeman 69 F. 3d 260 (8th Cir. 1195) Determination of a relevant market is that geographic area to which consumers can practically turn for alternative sources of the product. Definition of a geographic market is highly fact driven and is therefore different in each case. The importance for the department is that the methodology described here is only completely relevant for this project. Other projects, if they occur will require changes in the methodology based upon the relevant facts of those projects. The case also provides guidance to the Department regarding the methodology needed to include or exclude zip codes. Overlapping service areas indicate practical alternatives for patients.

FTC v. Butterworth Health Corp. 946 F. Supp 1285 (W.D. Mich. 1996) This case addressed the governments need to show the likelihood of ultimate success under the Clayton Act where the merger would result in significant efficiencies. The Department realizes that as the regulatory body for the Hospital and Health Care Provider Cooperation Act it is held to certain standards, it is necessary to identify the scope and the basis for a decision. The Department has developed tables and maps indicating relevant markets.

The Department is adopting the court findings in the previous cases because they provide a framework for the department to analyze the relevant market and determine the reliability of the applicants analysis and the likelihood of a different conclusion based on the data available.

III. Financial Capability of Applicants and Financial Impact of Project

The Department requested, from the Maine Health Data Organization (MHDO), a database containing information regarding inpatient utilization data. The goal was to define a service area for each individual hospital. The hospitals that were included are defined as all the hospitals with a primary service area inclusive of the primary service area for the two primary hospitals applying for the certificate of public advantage. These hospitals are:

Bridgton Hospital
Central Maine Medical Center
Franklin Memorial Hospital
Goodall Hospital
Inland Hospital
MaineGeneral – Augusta
MaineGeneral – Waterville
Maine Medical Center
Mercy Hospital
Mid Coast Hospital
Miles Memorial Hospital
Parkview Adventist Medical Center
Rumford Hospital
Southern Maine Medical Center
Stephens Memorial Hospital
St. Mary's Regional Medical Center
Waldo County General Hospital
York Hospital

The results from this analysis can be seen in the maps provided in Attachment A: 2006 Hospital Service Area by MHDO Discharge Data. This includes maps and charts depicting hospital service areas at 80% and 90% LIFO (LIFO stands for Little In From Outside, this means that relatively few inpatients for a hospital come from outside the area described in the following review and shown in Attachment A). In the cases cited above, this methodology was used to include zip codes as part of the relevant service areas. The dataset used was 2006 (MHDO) hospital inpatient discharge data. In 2006, there were 163,705 hospital record counts in Maine.

MaineHealth and SMMC have entered into a Definitive Agreement by which SMMC would become a hospital member of the MaineHealth system. Under the Definitive Agreement, MaineHealth would become the sole member of the non-profit corporation known as Webber Hospital Association, and as such, the Definitive Agreement will effect a "merger" consistent with 22 M.R.S.A. §1843(1)(5). Under the agreement, SMMC will maintain its existing corporate form. MaineHealth will be substituted for SMMC's existing incorporators. A separate advisory committee would be formed by SMMC comprised of the former incorporators.

The "Definitive Agreement" constitutes a "cooperative agreement" within the meaning of 22 M.R.S.A. §1843 (1) (C) because the agreement will effect a merger of two or more hospitals.

III. Financial Capability of Applicants and Financial Impact of Project

Under the Definitive Agreement, the members of the SMMC Board of Trustees will continue to hold office. New members of the SMMC Board must be nominated by sitting members of SMMC's Board. New Board members are subject to the approval of MaineHealth as the sole member. MaineHealth has agreed that it will not withhold approval of any SMMC board member nominated by the SMMC Board unless it has a rational basis for doing so. At least 80% of the individuals elected and serving on the SMMC Board must be residents of York County.

Under the agreement, the SMMC Board may nominate, for election, two trustees, to the MaineHealth Board, serving for initial three-year terms. Thereafter, the SMMC Board may nominate one trustee to the MaineHealth Board. The board presently has 15 members including William Caron, President of MaineHealth.

Under the agreement, MaineHealth has agreed that MaineHealth's Board of Incorporators, which has over 25 members, will be geographically diversified as necessary over three years. The goal is that not less than 10% of the corporators of MaineHealth will be York County residents.

Under the agreement, all property of SMMC will remain property of SMMC. SMMC will retain its tax-exempt charitable status. Endowment funds of SMMC, including funds held in trust will remain assets of SMMC. Day to day operational control of SMMC will reside with the SMMC Board of Trustees and SMMC management.

Under the agreement, the following activities and decisions of SMMC will require approval by MaineHealth:

- SMMC's annual operating and capital budgets;
- Business marketing and strategic plans;
- Disposition of assets of more than $250,000;
- Incurrence of indebtedness outside the ordinary course of business in excess of $500,000; and
- The initiation of new services or terminating existing services.

Under the agreement, no change in existing level of services and array of healthcare services provided by SMMC can occur unless it is initiated by SMMC and approved by MaineHealth.

MaineHealth has agreed to a capital expenditure of up to $2.2 million over a period of 3 years for deployment of an electronic medical record system for members of SMMC's medical staff and employed physicians.

MaineHealth has agreed to provide up to 100% of the financing to cover the direct costs of as many as four medical offices to house physician office space. This is an unquantified capital expenditure.

MaineHealth has agreed to assist SMMC in its efforts to execute SMMC's medical staff and retention plan.

III. Financial Capability of Applicants and Financial Impact of Project

SMMC will have access to MaineHealth's credit facility and the benefits of the hospital members of MaineHealth that stand behind the indebtedness incurred through this credit facility.

SMMC will continue its participation in development and implementation of MaineHealth initiated and sponsored clinical integration initiatives.

SMMC will have access to shared administrative resources of the MaineHealth system, including financial services, strategic planning, program development, human resource management and legal services.

Each party has the right under the Definitive Agreement to terminate the Agreement within 90 days of the second anniversary of the transaction implementation date.

An Agreement on Conditions was forwarded on December 17, 2008. The agreement signed by the applicants, the Department of Attorney General and the Governor's Officer of Health Policy and Finance, agreed that certain conditions would be incorporated into a Certificate of Public Advantage issued to the Applicants. Discussion of the agreement and other statements by the interveners received as part of the comment period submissions will be discussed in the appropriate sections of this review.

Webber Medical Association d/b/a Southern Maine Medical Center (SMMC-ORG) consists of one hospital, Southern Maine Medical Center (SMMC). The hospital is located in Biddeford, Maine, York County. The zip code for SMMC is 04005. SMMC is described on MaineHealth's website as a "150-bed, full service, acute care hospital providing medical, surgical, obstetric, pediatric and mental health services to the full-time residents of northern York County and the many seasonal and part-year residents of the region."

MaineHealth consists of Member hospitals: Maine Medical Center, Miles Health Care, St. Andrews Hospital, Spring Harbor Hospital and Stephens Memorial Hospital. Located in Portland, New England Rehabilitation Hospital of Portland (NERHP) is a joint venture of Maine Medical Center and HealthSouth. NERHP provides both inpatient and outpatient physical rehabilitation services. It is the only self-supporting acute rehabilitation hospital in Maine. Spring Harbor Hospital is licensed as a Behavioral Health facility.

MaineHealth also maintains affiliate relationships with four other Medical Centers in Maine. As described on MaineHealth's website they include:

- "MaineGeneral Health is a provider of progressive services and programs, supported by advanced technology, at both the Waterville and Augusta campuses".

- "Mid Coast Health Services is a community hospital in Brunswick, serving the region with a range of services."

- "PenBay Healthcare is a community healthcare system dedicated to caring for the sick and injured and to improving the health and quality of life of the people of mid-coast

Maine. Its flagship hospital, Penobscot Bay Medical Center, has 109 acute care beds."

- "St. Mary's Regional Medical Center is a 233-bed acute care facility that brings the best of medical technology and preventative services to Androscoggin County and all of Maine."

On December 31, 2008, a CON was approved to allow Waldo County Healthcare, Inc. to become a member of MaineHealth.

Statewide Discharges:

Statewide, 163,705 hospital discharges occurred at 41 distinct facilities in 2006. As seen in Table 1, MaineHealth, through its member hospitals and affiliates, accounted for 48.3% of medical discharges in Maine in 2006. This equals 79,029 discharges.

Table 1

Hospital	TOTAL	Percentage of Statewide Discharges
Southern Maine Medical Center	6,426	3.9%
Maine Medical Center	30,210	18.5%
Spring Harbor Hospital	2,436	1.5%
Stephen's Memorial Hospital	2,396	1.5%
Waldo County General Hospital	1,993	1.2%
Miles Memorial Hospital	1,981	1.2%
New England Rehab	1,613	1.0%
St. Andrew's Hospital	417	0.3%
MaineGeneral - Waterville	7,916	4.8%
St. Mary's Regional Medical Center	7,119	4.3%
MaineGeneral - Augusta	6,507	4.0%
Mid Coast Hospital	5,129	3.1%
Penobscot Bay Medical Center	4,886	3.0%
Total	79,029	48.3%
Non-Affiliated Hospitals	84,676	51.7%
Statewide Totals	163,705	100.0%

The applicants, SMMC and MaineHealth, at its main facility, Maine Medical Center (MMC) accounted for 3.9% and 18.5%, respectively of these discharges. As seen in Table 2, SMMC and MMC are the 8th and 1st largest hospitals ranked by discharges in Maine.

Table 2

Hospital	TOTAL
Maine Medical Center	30,210
Eastern Maine Medical Center	20,389
Mercy Hospital	

III. Financial Capability of Applicants and Financial Impact of Project

	9,781
Central Maine Medical Center	9,731
MaineGeneral - Waterville	7,916
St. Mary's Regional Medical Center	7,119
MaineGeneral - Augusta	6,507
Southern Maine Medical Center	6,426

The total number of discharges in 2006 for hospitals that MaineHealth is the parent corporation was 37,072 or 22.64%. As seen in Table 3, Maine Medical Center accounts for 81.5% of discharges from Member facilities.

Table 3

Hospital	**TOTAL**	**Percentage of Discharges**
Maine Medical Center	30,210	81.5%
Spring Harbor Hospital	2,436	6.6%
Stephen's Memorial Hospital	2,396	6.5%
New England Rehab	1,613	4.4%
St. Andrew's Hospital	417	1.1%
Total	37,072	100.0%

As seen in Table 4, if this application had occurred in 2006, MaineHealth member hospitals would account for 43,498 discharges or 26.57%. This application and analysis does not consider the impact of Waldo County Healthcare, Inc. This is relevant because MaineHealth already provides a significant portion of hospital admissions in the State of Maine. The Attorney General's Office has not initiated proceedings against the Memberships already in existence. Table 4 also shows how much larger MMC is than the other current member hospitals.

Table 4

Hospital	**TOTAL**	**Percentage of Discharges**
Maine Medical Center	30,210	69.5%
Southern Maine Medical Center	6,426	14.8%
Spring Harbor Hospital	2,436	5.6%
Stephen's Memorial Hospital	2,396	5.5%
	1,613	3.7%

New England Rehab		
St. Andrew's Hospital	417	1.0%
Total	43,498	100.0%

According to the 2006 data, SMMC is the second largest member hospital accounting for 1 discharge for every 4.7 discharges that occurred at Maine Medical Center.

SMMC COPA Hospital Service Area

In order to explain how the Department determined the relevant service areas, the methodology and the files used to determine the data are explained below. For purposes of replicating the information below, the Department has documented the steps taken.

The first step for determining where SMMC draws a significant portion of its patients was to obtain data from MHDO. The information related to discharges of patients whose residence was recorded as York or Cumberland County. The total number of records was 48,492 or 29.62% of discharges. The file contained 6,196 discharges from SMMC. In 2006, SMMC had 6,446 inpatient discharges. The 6,196 discharges is 96.42% of discharges from Southern Maine Medical Center. The 6,196 discharges from SMMC were from 60 distinct zip codes. Eliminating zip codes with the smallest number of discharges so that the remaining zip codes accounted for at least 90% of SMMC's discharges left 18 discreet zip codes. These 18 zip codes define the hospital service area and account for at least 90% of the discharges from SMMC. At 5,816 discharges it represents 90.5% of discharges. The first excluded zip code accounts for .65% of the discharges; this is not considered significant compared to the number of discharges in the last included zip code.

The following Table 5 displays discharges for York and Cumberland County and is divided into two groups: 15,679 discharges in SMMC defined service area; and 32,813 discharges in the remaining areas of the two counties that are not part of the SMMC service area. The SMMC service area includes 32.33% of the discharges from York and Cumberland Counties. Inside the SMMC service area, 30 hospitals reported discharges. For these hospitals that had inpatients from the SMMC service area, 21 were excluded because they were not part of the 90% service area.

The service area includes 1 zip code outside of York County, 04074 Scarborough, which accounted for 1.2% of SMMC's discharges.

As seen on the Map entitled Southern Maine Medical Center COPA Service Area, contained in Appendix A, the service area for SMMC is predominately the northeast portion of York County and specifically excludes the extreme western zip codes as well as the three northern-most zip codes.

III. Financial Capability of Applicants and Financial Impact of Project

At 80%, SMMC's service area would be limited to Saco, Biddeford, Arundel and Kennebunk. At 90% the area is doubled and includes Scarborough as well as the interior areas of York County north of Saco. The applicants included data reflecting 80% inclusion, whereas the Department has adopted 90%. This shows the significant difference in the methodologies employed by the applicant and the Department.

Spring Harbor and New England Rehab, specialty hospitals, account for 4.5% of the total discharges (704 discharges). They are both member hospitals of MaineHealth. Excluding these discharges, there were 14,919 discharges from general acute care hospitals in SMMC Service Area. This is reflected in Table 5.

SMMC COPA Hospital Service Area (>90% of Total Discharges) *Table 5*

Discharges		**Hospital**					
Zip	Town/ Area	Southern Maine Medical Center	Maine Medical Center	Mercy Hospital	York Hospital	Goodall Hospital	Grand Total
04005	Biddeford	2,008	545	156	7	14	2,730
04072	Saco	989	566	180	5	10	1,750
04043	Kennebunk	658	213	54	129	28	1,082
04064	Old Orchard Beach	480	337	120	10	1	948
04046	Kennebunkport	359	192	38	42	3	634
04073	Sanford	292	476	72	95	1,024	1,959
04002	Alfred	268	186	40	19	153	666
04090	Wells	125	129	30	501	35	820
04061	North Waterboro	91	87	22	4	47	251
04042	Hollis Center	82	179	77	2	10	350
04074	Scarborough	74	1,177	352	5	1	1,609
04083	Springvale	74	147	13	14	309	557
04063	Ocean Park	62	20	10		1	93
04048	Limerick	56	107	31	2	30	226
04030	East Waterboro	55	69	27		40	191
04093	Buxton	54	427	194	2	3	680
04087	Waterboro	49	70	15	1	38	173
04076	Shapleigh	40	58	7	1	94	200
		5,816	4,985	1,438	839	1,841	14,919

*The shaded cells are included within the hospital service area.

There are five hospitals discharging patients within SMMC's service area. These hospitals and the percentage of discharges from this area are presented in Table 6.

Hospital Market Share SMMC Service Area (90%) *Table 6*

Hospital		Discharges	% of Discharges
Southern Maine Medical Center		5,816	38.98%

III. Financial Capability of Applicants and Financial Impact of Project

Maine Medical Center		4,985	33.41%
Goodall Hospital		1,841	12.34%
Mercy Hospital		1,438	9.64%
York Hospital		839	5.62%
		14,919	100.00%

SMMC has the largest share of discharges from the SMMC service area (38.98%). MMC has the second largest percentage or 33.41%. The hospitals combined account for 72.39% of the discharges. Table 7 presents discharges by major diagnostic category. One diagnostic category was eliminated for privacy reasons.

Discharges by Major Diagnostic Category *Table 7*

	Hospital					
	SMMC	MMC	Goodall Hospital	Mercy	York	Grand Total
CIRCULATORY SYSTEM	763	1,175	304	101	169	2,512
DIGESTIVE SYSTEM	688	466	178	114	105	1,551
RESPIRATORY SYSTEM	763	366	274	59	84	1,546
PREGNANCY AND CHILDBIRTH	528	535	218	168	89	1,538
NEWBORNS & OTHER NEONATES	520	481	217	167	86	1,471
MUSCULOSKELATAL/CONNECTIVE SYSTEM	391	492	149	201	67	1,300
NERVOUS SYSTEM	303	376	88	36	53	856
KIDNEY, URINARY TRACT	299	164	72	39	25	599
MENTAL ILLNESS AND DISORDERS	435	36	4	8	3	486
HEPATOBILLIARY SYSTEM	210	125	50	22	36	443
ALCOHOL AND DRUG ABUSE	48	8	6	342	4	408
INFECTIOUS AND PARASITIC DISEASES	131	116	90	44	16	397
FEMALE REPRODUCTIVE	121	126	58	53	20	378
ENDOCRINE, NUTRITIONAL, METABOLIC	179	116	38	21	23	377
SKIN, SUBCUTANEOUS, BREAST	139	68	35	24	29	295
INJURIES, POISONING AND TOXIC EFFECTS	100	75	25	8	13	221
EAR, NOSE, THROAT	39	54	8	17	4	122
MYELOPROLIFERATIVE DISEASES	15	87	9	2	5	118
MALE REPRODUCTIVE	62	30	2	6	2	102
BLOOD AND BLOOD ORGANS	36	41	11	4	3	95
FACTORS INFLUENCING HEALTH	32	6	1	1	2	42
MULTIPLE SIGNIFICANT TRAUMA	5	24	1			30
EYE	6	5	3	1	1	16

III. Financial Capability of Applicants and Financial Impact of Project

BURNS	3	12				15
Grand Total	5,816	4,984	1,841	1,438	839	14,918

Percentages of discharges that varied more than 20% distant from the overall market share are shaded in Table 8. A significant number of circulatory cases are seen at MMC, most likely reflecting their designation as a Level 1 Trauma Center. A greater percentage of respiratory disease and kidney disease discharges are seen at SMMC. As reflecting Mercy Hospital's inpatient ward for alcohol and drug use, 83% of those cases are discharged through Mercy even though they are in SMMC's defined service area. Multiple trauma and burn cases are significantly shifted to MMC, again, most likely reflecting their designation as a Level 1 Trauma Center. The significance of hospitals providing singular services indicates that the residents of these areas already travel to different hospitals for specific services.

Percent of Discharges by Major Diagnostic Category *Table 8*

	Hospital				
MDC	SMMC	MMC	Goodall Hospital	Mercy	York
CIRCULATORY SYSTEM	**30.37%**	**46.78%**	12.10%	**4.02%**	6.73%
DIGESTIVE SYSTEM	44.36%	30.05%	11.48%	**7.35%**	**6.77%**
RESPIRATORY SYSTEM	**49.35%**	**23.67%**	**17.72%**	**3.82%**	5.43%
PREGNANCY AND CHILDBIRTH	34.33%	34.79%	14.17%	10.92%	5.79%
NEWBORNS & OTHER NEONATES	35.35%	32.70%	14.75%	11.35%	5.85%
MUSCULOSKELATAL/CONNECTIVE SYSTEM	**30.08%**	37.85%	11.46%	**15.46%**	5.15%
NERVOUS SYSTEM	35.40%	**43.93%**	10.28%	**4.21%**	6.19%
KIDNEY, URINARY TRACT	**49.92%**	27.38%	12.02%	**6.51%**	**4.17%**
MENTAL ILLNESS AND DISORDERS	**89.51%**	**7.41%**	**0.82%**	**1.65%**	**0.62%**
HEPATOBILLIARY SYSTEM	**47.40%**	28.22%	11.29%	**4.97%**	**8.13%**
ALCOHOL AND DRUG ABUSE	**11.76%**	**1.96%**	**1.47%**	**83.82%**	**0.98%**
INFECTIOUS AND PARASITIC DISEASES	33.00%	29.22%	**22.67%**	11.08%	**4.03%**
FEMALE REPRODUCTIVE	32.01%	33.33%	**15.34%**	**14.02%**	5.29%
ENDOCRINE, NUTRITIONAL, METABOLIC	**47.48%**	30.77%	10.08%	**5.57%**	6.10%
SKIN, SUBCUTANEOUS, BREAST	**47.12%**	**23.05%**	11.86%	8.14%	**9.83%**
INJURIES, POISONING AND TOXIC EFFECTS	45.25%	33.94%	11.31%	**3.62%**	5.88%
EAR, NOSE, THROAT	31.97%	**44.26%**	**6.56%**	**13.93%**	**3.28%**
MYELOPROLIFERATIVE DISEASES	**12.71%**	**73.73%**	**7.63%**	**1.69%**	**4.24%**
MALE REPRODUCTIVE	**60.78%**	29.41%	**1.96%**	**5.88%**	**1.96%**
BLOOD AND BLOOD ORGANS	37.89%	**43.16%**	11.58%	**4.21%**	**3.16%**
FACTORS INFLUENCING HEALTH	**76.19%**	**14.29%**	**2.38%**	**2.38%**	4.76%
MULTIPLE SIGNIFICANT TRAUMA	**16.67%**	**80.00%**	**3.33%**	**0.00%**	**0.00%**
EYE	37.50%	31.25%	**18.75%**	**6.25%**	6.25%
BURNS	**20.00%**	**80.00%**	**0.00%**	**0.00%**	**0.00%**

As shown in Table 9, eliminating those MDCs that have a systematic tendency to be served by a single hospital, reduces the number of relevant cases to 13,979. This is reflected by the presence of specialty services by hospital.

Competitive Discharges *Table 9*

	Hospital					
MDC	SMMC	MMC	Goodall Hospital	Mercy	York	Grand Total
CIRCULATORY SYSTEM	763	1,175	304	101	169	2,512
DIGESTIVE SYSTEM	688	466	178	114	105	1,551
RESPIRATORY SYSTEM	763	366	274	59	84	1,546
PREGNANCY AND CHILDBIRTH	528	535	218	168	89	1,538
NEWBORNS & OTHER NEONATES	520	481	217	167	86	1,471
MUSCULOSKELATAL/CONNECTIVE SYSTEM	391	492	149	201	67	1,300
NERVOUS SYSTEM	303	376	88	36	53	856
KIDNEY, URINARY TRACT	299	164	72	39	25	599
HEPATOBILLIARY SYSTEM	210	125	50	22	36	443
INFECTIOUS AND PARASITIC DISEASES	131	116	90	44	16	397
FEMALE REPRODUCTIVE	121	126	58	53	20	378
ENDOCRINE, NUTRITIONAL, METABOLIC	179	116	38	21	23	377
SKIN, SUBCUTANEOUS, BREAST	139	68	35	24	29	295
INJURIES, POISONING AND TOXIC EFFECTS	100	75	25	8	13	221
EAR, NOSE, THROAT	39	54	8	17	4	122
MYELOPROLIFERATIVE DISEASES	15	87	9	2	5	118
MALE REPRODUCTIVE	62	30	2	6	2	102
BLOOD AND BLOOD ORGANS	36	41	11	4	3	95
FACTORS INFLUENCING HEALTH	32	6	1	1	2	42
EYE	6	5	3	1	1	16
Grand Total	5,325	4,904	1,830	1,088	832	13,979

Goodall Hospital

Goodall Hospital is located in Sanford, Maine in York County. Goodall serves the fifth largest group of inpatients in this area. One other hospital's service area (SMMC) is defined as being within the boundaries of York and Cumberland Counties. In fact, its entire service area is in York County. Sanford is 15.12 miles from Southern Maine Medical Center and is west of Biddeford; the main connector is Rt. 111.

The number of zip codes in its service area is 16. The 16 areas defined by these zip codes included 10,148 admissions at 26 hospitals in Maine in 2006. Only 7 hospitals had inpatient admissions greater than 1% of the total and therefore 19 hospitals are excluded. The remaining seven hospitals include Spring Harbor and New England Rehabilitation Hospital of Portland. Excluding these leaves 9,654 inpatients. As presented in Table 10, Goodall Hospital's service area represents 90.8% of Goodall's 2,330 admissions in 2006.

Goodall Hospital Service Area (90%) *Table 10*

		Hospital					
	Zip	MMC	Mercy	SMMC	York	Goodall	

Sanford	04073	476	72	292	95	1,024	1,966
Springvale	04083	147	13	74	14	309	558
Alfred	04002	186	40	268	19	153	666
Lebanon	04027	37	4	26	25	96	190
Shapleigh	04076	58	7	40	1	94	200
Acton	04001	45	9	25	12	91	182
North Berwick	03906	59	6	19	123	77	284
North Waterboro	04061	87	22	91	4	47	252
East Waterboro	04030	69	27	55		40	191
Waterboro	04087	70	15	49	1	38	173
Wells	04090	129	30	125	501	35	824
Limerick	04048	107	31	56	2	30	226
Kennebunk	04043	213	54	658	129	28	1,083
Maplewood	04095	29	8	24	5	26	92
Biddeford	04005	545	156	2,008	7	14	2,736
Newfield	04056	11	4	2		14	31
Total		2,268	498	3,812	938	2,116	9,654

As seen in Table 11, Goodall's service area contains two other hospitals that have more admissions than Goodall. SMMC has 39.5% of admissions and Maine Medical Center has 23.5% of admissions. Goodall Hospital has 21.9% of admissions.

Hospital Market Share Goodall Service Area (90%) *Table 11*

Southern Maine Medical Center	3,812	39.5%
Maine Medical Center	2,268	23.5%
Goodall Hospital	2,116	21.9%
Mercy Hospital	938	9.7%
York Hospital	498	5.2%
	9,654	100.0%

Table 12 presents both the service area and patients for Southern Maine Medical Center and Goodall Hospital to show where they overlap and where they do not overlap.

Eleven zip codes are common to both hospital service areas. Five zip codes are exclusive to Goodall Hospital. These areas are generally inland with three north of Goodall, one west and one south of Goodall. SMMC has only one area south of its location that is not part of the common service area. This is Kennebunkport which is due east of Kennebunk where SMMC has 23.5 inpatients compared to each Goodall inpatient.

Comparison of Inpatient Service Areas *Table 12*

		Goodall	General Direction	Southern Maine Medical Center
04074	Scarborough		North of SMMC	74
04064	Old Orchard Beach		North of SMMC	480
04063	Ocean Park		North of SMMC	62
04072	Saco		Contiguous to Biddeford	989

04093	Buxton		North of SMMC	54
04042	Hollis Center		North of SMMC	82
04048	Limerick	30	North of Both Hospitals	56
04061	North Waterboro	47	North of Both Hospitals	91
04087	Waterboro	38	North of Both Hospitals	49
04005	Biddeford	14	SMMC	2,008
04002	Alfred	153	In Between	268
04030	East Waterboro	40	In Between	55
04073	Sanford	1,024	Goodall	292
04083	Springvale	309	Contiguous to Sanford	74
04076	Shapleigh	94	Northwest of Goodall	40
04090	Wells	35	South of SMMC	125
04043	Kennebunk	28	South of SMMC	658
04046	Kennebunkport		South of SMMC	359
04056	Newfield	14	North of Goodall	
04001	Acton	91	North of Goodall	
04095	Maplewood	26	North of Goodall	
04027	Lebanon	96	West of Goodall	
03906	North Berwick	77	South of Goodall	
Totals		2,116		5,816

As shown in Table 13, Goodall has 33% of the inpatients in the common areas encompassing 5,528 inpatients or 69.7% of the combined patients in the individual service areas. SMMC captures more than two-thirds of the inpatients in 5 of the 11 zip codes. Goodall captures more than 2/3 of the inpatients from 3 zip codes. The remaining three zip code areas are weighted toward SMMC and are in between the northern areas that are not in both service areas of the two hospitals but in one or the other.

Common Service Areas (SMMC-Goodall) *Table 13*

		Goodall	Percent of Common Share	Southern Maine Medical Center	Percent of Common Share
04048	Limerick	30	35%	56	65%
04061	North Waterboro	47	34%	91	66%
04087	Waterboro	38	44%	49	56%
04005	Biddeford	14	1%	2,008	99%
04002	Alfred	153	36%	268	64%
04030	East Waterboro	40	42%	55	58%
04073	Sanford	1,024	78%	292	22%
04083	Springvale	309	81%	74	19%
04076	Shapleigh	94	70%	40	30%
04090	Wells	35	22%	125	78%
04043	Kennebunk	28	4%	658	96%
Totals		1,812	33%	3,716	67%
% of Individual service are that are common			**85.63%**		**64%**

III. Financial Capability of Applicants and Financial Impact of Project

Table 16 reflects cases that occur at one of the two hospitals at least 50 times a year. Of the patients treated for Circulatory System, SMMC has 60% while Goodall has 40%.

Market Share Common Areas - SMMC and Goodall Regular Cases *Table 14*

	SMMC	Goodall	SMMC	Goodall
CIRCULATORY SYSTEM	461	303	60%	40%
RESPIRATORY SYSTEM	456	271	63%	37%
DIGESTIVE SYSTEM	414	175	70%	30%
PREGNANCY AND CHILDBIRTH	368	215	63%	37%
NEWBORNS & OTHER NEONATES	367	214	63%	37%
MUSCULOSKELATAL/CONNECTIVE SYSTEM	236	143	62%	38%
MENTAL ILLNESS AND DISORDERS	304	3	99%	1%
KIDNEY, URINARY TRACT	202	71	74%	26%
NERVOUS SYSTEM	182	87	68%	32%
HEPATOBILLIARY SYSTEM	136	49	74%	26%
INFECTIOUS AND PARASITIC DISEASES	90	90	50%	50%
ENDOCRINE, NUTRITIONAL, METABOLIC	116	35	77%	23%
FEMALE REPRODUCTIVE	80	57	58%	42%
SKIN, SUBCUTANEOUS, BREAST	86	34	72%	28%
INJURIES, POISONING AND TOXIC EFFECTS	55	24	70%	30%

York Hospital

Inpatient Data from York Hospital includes zip codes from 320 distinct zip codes. There were 4,136 discharges from York Hospital in 2006. A large number of patients to York hospital are not permanent residents of Maine of the contiguous service area. Table 15 summarizes a total of 9,358 discharges in the York service area.

Patient Share York Hospital Service Area *Table 15*

York Hospital	3,614	39%
Southern Maine Medical Center	1,895	20%
Maine Medical Center	1,786	19%
Goodall Hospital	1,757	19%
Mercy Hospital	306	3%
	9,358	100%

Unlike Goodall Hospital, York Hospital is the largest hospital provider of inpatient services in its service area. The service area includes 5 communities in New Hampshire. The shaded areas in Table 16 reflect areas that are included in the individual service area of the hospitals listed.

York Hospital Defined Service Area excl. Specialty Hospitals (87.37% Admissions 2006) *Table 16*

Count of MDC **Hospital**

Town	Zip	York Hospital	Maine Medical Center	SMMC	Goodall	Mercy	Total

York	03909	693	16	77		6	792
Wells	04090	501	125	129	35	30	820
Kittery	03904	461	13	45	2	7	528
Eliot	03903	262	8	30	2	2	304
So. Berwick	03908	255	12	31	7	10	315
Cape Neddick	03902	188		19		1	208
York Beach	03910	157		6		1	164
Ogunquit	03907	130	6	17	1	7	161
Kennebunk	04043	129	658	213	28	54	1,082
North Berwick	03906	123	19	59	77	6	284
Cutts Island	03905	120		11		1	132
Berwick	03901	112	10	26	13	8	169
Sanford	04073	95	292	476	1,024	72	1,959
Moody	04054	74	4	10	3	1	92
Portsmouth, NH	03801	69	4	21			94
York Harbor	03911	66		6		2	74
Dover, NH	03820	45		30	2	2	79
Kennebunkport	04046	42	359	192	3	38	634
Lebanon	04027	25	26	37	96	4	188
Alfred	04002	19	268	186	153	40	666
Rollinsford, NH	03869	18	1	2		1	22
Somersworth, NH	03878	16		16	2		34
Springvale	04083	14	74	147	309	13	557
Grand Total		3,614	1,895	1,786	1,757	306	9,358

Mercy Hospital

III. Financial Capability of Applicants and Financial Impact of Project

Mercy Hospital draws inpatients from a surprisingly large number of zip codes; 53 zip codes accounted for 8,706 inpatient stays or 89% of the 9,781 discharges in 2006. There were 62,810 admissions in Mercy's service area. 42 Maine hospitals had discharges from this area. 94% or 59,231 discharges were from 16 hospitals with more than 100 discharges within the service area. This is presented in Table 17.

Patient Share Mercy Hospital Service Area *Table 17*

Maine Medical Center	21,200	36%	Goodall	1,435	2%
Mercy Hospital	8,706	15%	Parkview Adventist Medical Center	1,374	2%
Southern Maine Medical Center	5,769	10%	York Hospital	841	1%
Central Maine Medical Center	4,442	7%	Bridgton Hospital	789	1%
St. Mary's Regional Medical Center	4,400	7%	Inland Hospital	668	1%
Mid Coast Hospital	3,145	5%	Acadia	232	0%
MaineGeneral - Waterville	3,078	5%	Eastern Maine Medical Center	212	0%
MaineGeneral - Augusta	2,830	5%	Pen Bay Medical Center	110	0%
	53,570	90%		5,661	10%
			Total Inpatients	59,231	100%

As seen in Table 18, Appendix A, Mercy's entire service area is included in Maine Medical Center's service area and is reflected by cell shading.

Maine Medical Center

MMC's service area encompasses an area with 113,001 hospital discharges in 2006. The service area has 162 distinct zip codes. This service area has inpatient discharges from all 42 hospitals in the state. Excluding specialty hospitals, 28 hospitals, including MMC, had more than 250 (0.225% of survey) inpatients from this service area in 2006. Table 19 presents market share for all hospitals.

Maine Medical Center Service Area (90%) Market Share *Table 19*

Maine Medical Center	27,126	24.97%	Central Maine Medical Center	8,104	7.46%
Goodall Hospital	2,225	2.05%	St Mary's Regional Medical Center	6,446	5.93%
Southern Maine Medical Center	6,121	5.63%	Parkview Adventist Medical Center	1,947	1.79%
York Hospital	2,863	2.64%	Cary Medical Center	1,076	0.99%

Mercy Hospital	9,394	8.65%	St Joseph Hospital	1,560	1.44%
Bridgton Hospital	1,292	1.19%	MaineGeneral - Waterville	6,329	5.83%
Stephen's Memorial Hospital	1,858	1.71%	MaineGeneral - Augusta	5,776	5.32%
Rumford Hospital	686	0.63%	Inland Hospital	1,376	1.27%
St Andrew's Hospital	321	0.30%	Franklin	1,910	1.76%
Mid Coast Hospital	4,814	4.43%	Redington-Fairview General	1,526	1.40%
Maine Coast Memorial Hospital	812	0.75%	Acadia Hospital	1,097	1.01%
Miles Memorial Hospital	1,569	1.44%	Eastern Maine Medical Center	5,920	5.45%
Pen Bay Medical Center	3,892	3.58%	Northern Maine Medical Center	533	0.49%
Waldo	1,029	0.95%	The Aroostook Medical Center	1,044	0.96%
Total	64,002	58.91%	**Total**	44,644	41.09%
				108,646	100.00%

Table 20 presents the top five hospitals by discharges in Maine Medical Center's service area.

Maine Medical Center Service Area (90%) Top 5 Market Share *Table 20*

Maine Medical Center	27,126	24.97%
Mercy Hospital	9,394	8.65%
Central Maine Medical Center	8,104	7.46%
St Mary's Regional Medical Center	6,446	5.93%
MaineGeneral - Waterville	6,329	5.83%
Others (23)	51,247	47.17%
Total	108,646	52.83%

Maine Medical Center Service Area (Table 21) is included in attachment A due to its size.

Mid Coast Hospital

Mid Coast Hospital is an affiliate hospital of MaineHealth. Its service area includes 32 discrete zip codes, 27,672 discharges and 11 hospitals with at least 100 inpatients from within its service area.

Table 22 is the percentage of market share each hospital has in Mid Coast Hospital's service area.

Market Share for Mid Coast Hospital's Service Area (90%) Table 22

Mid Coast Hospital	4,611	17.23%	Miles Memorial Hospital		4.19%

III. Financial Capability of Applicants and Financial Impact of Project

				1,120	
Central Maine Medical Center	4,608	17.22%	MaineGeneral-Waterville	822	0.03%
St. Mary's Regional Medical Center	4,485	16.76%	Mercy Hospital	768	2.87%
Maine Medical Center	4,013	15.00%	Pen Bay	369	1.38%
MaineGeneral- Augusta	3,624	13.54%	St. Andrew's Hospital	280	1.05%
Parkview Adventist Medical Center	1,918	7.17%	Acadia	144	0.54%
			Total	26,762	100.00%

Table 23 presents the Mid Coast Hospital service area.

Mid Coast Hospital Service Area *Table 23*

		Hospital							
Town	Zip	Mid Coast	CMMC	St. Mary's General	Maine Medical Center	Maine General-Augusta	Parkview Hospital	Other	Grand Total
Brunswick	04011	1,301	34	49	510	9	680	4	2,684
Bath	04530	866	16	25	208	9	224	2	1,422
Topsham	04086	460	30	16	200	5	200	2	953
Woolwich	04579	189	8	4	62		33		312
So. Harpswell	04079	175	11	7	108		93		413
Wiscasset	04578	170	4	12	107	6	30	2	493
Durham	04032	156	7	3	318	1	115	1	724
Bowdoinham	04008	132	11	15	50	1	51	1	273
Lisbon Falls	04252	124	192	95	65	2	77	4	572
Richmond	04357	124	17	13	56	79	63	1	377
Popham Beach	04562	116	1	3	51		28	1	204
West Bowdoin	04287	95	48	15	30	1	49	1	247
Durham	04222	85	49	37	93		54	1	348
Georgetown	04548	65	6	2	12	1	11		100
Lisbon	04250	60	225	116	43	1	39		490
Dresden	04342	59	3	7	28	21	8	1	144
Lewiston	04240	56	2,104	2,676	276	39	13	25	5,263
Gardiner	04345	43	48	44	206	721	32	17	1,253
Boothbay Harbor	04538	41	4	2	62	3	5	1	355
North Edgecomb	04556	33		1	25	1	1		109
Orrs Island	04066	32	2	2	15		17		68
Pownal	04069	28	14	1	55		23	2	146
Augusta	04330	26	73	83	347	2,559	15	62	3,851
Auburn	04210	22	1,563	1,164	210	19	5	10	3,047
Boothbay	04537	22			58	1	2	1	195

Damariscotta	04543	22	2	4	97	2	3	1	464
Waldoboro	04572	22	4	5	114	15	3	3	660
Yarmouth	04096	21	6	2	452		12		652
Litchfield	04350	20	119	73	39	36	21		328
Newcastle	04553	18	2	5	52	2			259
Bailey Island	04003	14		2	7		10		34
Jefferson	04348	14	5	2	57	90	1	1	322
Grand Total		4,611	4,608	4,485	4,013	3,624	1,918	144	26,762

Waldo County General Hospital

Waldo County General Hospital received a CON to become a member of MaineHealth on December 31, 2008. Table 24 shows the market share for the hospitals having a significant presence in this service area.

Market share - Waldo Service Area @ 90% *Table 24*

Waldo County General Hospital	1,787	38.86%
Eastern Maine Medical Center	1,213	26.38%
Penobscot Bay Medical Center	607	13.20%
Maine Medical Center	289	6.29%
St. Joseph Hospital	200	4.35%
MaineGeneral - Waterville	148	3.22%
Others	354	7.70%
	4,598	

As seen in Table 25, Waldo County shares a significant portion of its service area with both Eastern Maine Medical Center and Maine Medical Center.

Waldo Service Area *Table 25*

		Hospital					
Town	Zip	Waldo	EMMC	Pen Bay	MMC	Others	
Belfast	04915	712	198	105	71		1,157
Searsport	04974	229	88	30	15		389
Lincolnville	04849	147	51	94	31		332
Morill	04952	137	58	22	7		235
Brooks	04921	134	72	8	7		258
Stockton Springs	04981	101	91	19	28		285
Liberty	04949	56	21	14	18	2	129
Searsmont	04973			18			

III. Financial Capability of Applicants and Financial Impact of Project

		56	19		18		119
Freedom	04941	51	20	5	11		159
Thorndike	04986	46	28	9	2		145
Frankfort	04438	36	79	3	9		149
Monroe	04951	35	17	2	1		63
Bucksport	04416	28	461	2	12		781
Union	04862	19	10	276	59	25	397
	Grand Total	1,787	1,213	607	289	27	4,598

Central Maine Medical Center

Central Maine Medical Center is a level 2 trauma/tertiary hospital located in Lewiston, Maine. Table 26 presents the hospitals with a significant market share of CMMC's service area.

Market Share CMMC Service Area *Table 26*

Central Maine Medical Center	8,754	24.35%
St. Mary's Regional Medical Center	6,437	17.90%
Maine Medical Center	4,636	12.89%
MaineGeneral-Augusta	4,293	11.94%
Mid Coast Hospital	2,377	6.61%
Stephen's Memorial Hospital	2,182	6.07%
Franklin Memorial Hospital	1,797	5.00%
Parkview Adventist Medical Center	1,213	3.37%
MaineGeneral - Waterville	1,030	2.86%
Bridgton Hospital	1,026	2.85%
Mercy Hospital	962	2.68%
Rumford Hospital	955	2.66%
Others	295	0.82%
	35,957	100.00%

Table 27, presents the zip codes that comprise CMMC's service area. The shaded cells are part of the corresponding hospitals service area.

Service Area for CMMC (90%) *Table 27*

	Zip	CMMC	St. Mary's	MMC	MaineG-Augusta	Mid-Coast	Stephens	Other	Grand Total
Lewiston	04240	2,104	2,676	276	39	56	3		5,266
Auburn	04210	1,563	1,164	210	19	22	10		3,064
Sabattus	04280	299	248	39	4	7	1		617

Turner	04282	283	126	39		2			460
Greene	04236	280	135	19	3	2	2		446
Rumford	04276	53	70	63	13	5	28		959
Lisbon	04250	225	116	43	1	60	2		492
Poland Spring	04274	210	122	58		1	23		435
Mechanic Falls	04256	195	97	28	1	3	43		375
Lisbon Falls	04252	192	95	65	2	124	1		574
New Gloucester	04260	156	80	155	3	5	1		474
Buckfield	04220	148	65	27	3	2	26		279
Leeds	04263	141	53	14	2	1			222
Winthrop	04364	140	66	71	379	3			725
Minot	04258	139	69	28	2	2	4		244
Livermore Falls	04254	124	75	38	8				473
Monmouth	04259	120	58	26	40	4			265
Mexico	04257	119	28	38	5	1	6		407
Litchfield	04350	119	73	39	36	20			328
Dixfield	04224	104	35	17	2	3	1		398
Oxford	04270	102	90	113	4	3	348		707
Jay	04239	101	76	66	5	1	1		555
Farmington	04938	97	47	100	17	1			1,010
Gray	04039	93	35	386	2	2	2		676
South Paris	04281	85	74	101	8	5	524		830
Lewiston	04243	81	23	3	1				111
Norway	04268	80	60	100	5	1	476		760
Bridgton	04009	77	20	132	1	3	19		617
Livermore	04253	76	30	32		4	2		194
Augusta	04330			347	2,559				

III. Financial Capability of Applicants and Financial Impact of Project

		73	83			26			3,891
Canton	04221	67	9	4			2		174
West Peru	04290	60	14	3			1		150
Wilton	04294	56	14	69	3	1			489
Durham	04222	49	37	93		85			347
West Bowdoin	04287	48	15	30	1	95			247
Gardiner	04345	48	44	206	721	43			1,260
Jay	04238	45	16	7			23		91
Naples	04055	40	13	121		2	4		418
West Sumner	04292	40	12	5	2		31		91
Harrison	04040	39	10	65	3	1	64		286
Brunswick	04011	34	49	510	9	1,301			2,677
Bethel	04217	34	21	43	2		172		306
Auburn	04212	33	5	2			1		43
North Monmouth	04265	33	11	3	19	2			75
Topsham	04086	30	16	200	5	460	2		954
Kents Hill	04349	30	10	13	44		1		126
Lewiston	04241	29	16	1	1				47
Auburn	04211	28	12	3					44
Bryant	04219	27	8	23	2		76		162
No. Turner	04266	27	14	7					48
Casco	04015	25	12	170		2	12		390
Waterford	04088	24	15	28		2	65		164
Fryeburg	04037	22	9	89			1		304
Hallowell	04347	22	7	36	208	10			303
Readfield	04355	22	7	15	100				174
Raymond	04071	21	15	189	1	4	2		365

Andover	04216	21	3	6	2		18		77
West Paris	04289	21	34	22	6		184		291
Grand Total		8,754	6,437	4,636	4,293	2,377	2,182	955	35,957

Parkview Adventist Medical Center

Parkview Adventist Medical Center is located in Brunswick, Maine. Table 28 presents the market share for hospitals in Parkview Adventist Medical Center's service area.

Market Share Parkview Service Area *Table 28*

Mid Coast Hospital	4,203	26.88%
MaineGeneral-Augusta	3,430	21.94%
Maine Medical Center	2,563	16.39%
Parkview Adventist Medical Center	1,852	11.85%
Central Maine Medical Center	909	5.81%
Other	2,677	17.12%
	15,634	100.00%

As presented in Table 29, Parkview's service area comprises 19 zip codes.

Parkview Hospital Service Area *Table 29*

Zip		**Mid Coast**	**Maine General - Augusta**	**Maine Medical Center**	**Parkview**	**Central Maine Medical Center**	**Other**	Grand Total
04011	Brunswick	1,302	9	510	685	34		2,775
04530	Bath	866	9	208	224	16		1,470
04086	Topsham	460	5	200	200	30		986
04032	Freeport	156	1	318	117	7		752
04079	So. Harpswell	175		108	93	11		420
04252	Lisbon Falls	124	2	65	78	192		583
04357	Richmond	124	79	56	63	17		383
04222	Durham	85		93	54	49		354
04008	Bowdoinham	132	1	50	51	11		279
04287	West Bowdoin	95	1	30	49	48		253
04250	Lisbon		1		39			

III. Financial Capability of Applicants and Financial Impact of Project

		60		43		225		502
04579	Woolwich	189		62	33	8		319
04345	Gardiner	43	721	206	32	48		1,282
04578	Wiscasset	170	6	107	30	4		503
04562	Phippsburg	116		51	28	1		208
04069	Pownal	28		55	23	14		155
04350	Litchfield	20	36	39	21	119		333
04066	Orrs Island	32		15	17	2		72
04330	Augusta	26	2,559	347	15	73		4,005
		4,203	3,430	2,563	1,852	909		15,634

St. Mary's Regional Medical Center

St. Mary's Regional Medical Center is located in Lewiston, Maine. Table 30 presents the market share for hospitals in St. Mary's service area.

Market Share St. Mary's Hospital Service Area *Table 30*

Central Maine Medical Center	8,366	18.95%	Mercy Hospital	3,380	7.66%
Maine Medical Center	6,824	15.46%	Stephen's Memorial Hospital	2,303	5.22%
St. Mary's Regional Medical Center	6,415	14.53%	Franklin Hospital	1,975	4.47%
MaineGeneral-Augusta	4,260	9.65%	Parkview Adventist Medical Center	1,710	3.87%
MaineGeneral-Waterville	3,416	7.74%	Other	5,501	12.46%
				44,150	

As presented in Table 31, St. Mary's service area comprises 50 zip codes. In comparing the number of discharges from CMMC to St. Mary's, there is a significantly larger patient population going to CMMC, overall. However, if you look at Lewiston and Auburn, exclusively the number of discharges from St. Mary's is significantly closer in size to CMMC.

St. Mary's Regional Hospital Service Area *Table 31*

		Hospital							
Zip2	Town	**CMMC**	**MMC**	**St. Mary's**	**MG - Augusta**	**MG - Waterville**	**Mid Coast**	**Other**	**Grand Total**
04240	Lewiston	2,104	276	2,676	39	17	56		5,374
04210	Auburn	1,563	210	1,164	19	10	22		3,120
04280	Sabattus	299	39	248	4	3	7		626
04236	Greene	280	19	135	3		2		449
04282	Turner	283	39	126		2	2		464
04274	Poland Spring	210	58	122		1	1		447

04250	Lisbon	225	43	116	1	2	60		502
04256	Mechanic Falls	195	28	97	1		3		379
04252	Lisbon Falls	192	65	95	2		124		582
04270	Oxford	102	113	90	4	3	3		724
04330	Augusta	73	347	83	2,559	614	26		4,005
04260	New Gloucester	156	155	80	3		5		500
04239	Jay	101	66	76	5	13	1		565
04254	Livermore Falls	124	38	75	8	12			480
04281	South Paris	85	101	74	8	3	5		850
04350	Litchfield	119	39	73	36	15	20		333
04276	Rumford	253	63	70	13	5	5		978
04258	Minot	139	28	69	2		2		247
04364	Winthrop	140	71	66	379	46	3		739
04220	Buckfield	148	27	65	3	2	2		282
04268	Norway	80	100	60	5	3	1		778
04259	Monmouth	120	26	58	40	12	4		273
04263	Leeds	141	14	53	2		1		227
04011	Brunswick	34	510	49	9	6	1,301		2,769
04938	Farmington	97	100	47	17	51	1		1,040
04345	Gardiner	48	206	44	721	117	43		1,282
04222	Lewiston	49	93	37			85		354
04039	Gray	93	386	35	2		2		713
04289	West Paris	21	22	34	6	3			295
04253	Livermore	76	32	30			4		199
04224	Dixfield	89	13	30	2	2	3		345
04257	Mexico	119	38	28	5	4	1		416
04530	Bath	16	208	25	9	5	866		1,470
04901	Waterville	20	267	24	146	2,391	7		3,762
04243	Lewiston	81	3	23	1	2			111
04217	Bethel	34	43	21	2	2			313
04009	Bridgton	77	132	20	1		3		629
04101	Portland	2	1,243	19	2	5	12		2,673
04241	Lewiston	29	1	16	1				48
04238	Hebron	45	7	16					91
04086	Topsham	30	200	16	5	1	460		986
04287	West Bowdoin	48	30	15	1		95		253
04088	Waterford	24	28	15		3	2		172
04071	Raymond	21	189	15	1		4		396
04008	Bowdoinham	11	50	15	1	1	132		279
04351	Manchester	12	53	14	189	38			308
04294	Wilton	56	69	14	3	22	1		500
04290	West Peru	60	3	14					151
04266	No. Monmouth	27	7	14					48
04062	Windham	15	926	14			3		1,623
		8,366	6,824	6,415	4,260	3,416	3,380	1,975	44,150

Bridgton Hospital

III. Financial Capability of Applicants and Financial Impact of Project

Bridgton Hospital is a subsidiary of Central Maine Medical Family (CMMF). Table 33 presents the market share for hospitals in Bridgton's service area.

Market Share Bridgton Service Area *Table 33*

Maine Medical Center	2,969	35.8%
Stephens Memorial Hospital	1,787	21.5%
Bridgton Hospital	1,350	16.3%
Mercy Hospital	1,106	13.3%
Central Maine Medical Center	691	8.3%
St. Mary's Regional Medical Center	390	4.7%
	8,293	

As presented in Table 34, Bridgton service area comprises 26 zip codes.

Bridgton Hospital Service Area *Table 34*

		Hospital						
Zip		**MMC**	**Stephens**	**Bridgton**	**Mercy**	**CMMC**	**St. Mary's**	
04009	Bridgton	132	19	319	42	77	20	609
04055	Naples	121	4	173	60	40	13	411
04037	Fryeburg	89	1	171	10	22	9	302
04040	Harrison	74	68	111	3	43	15	314
04015	Casco	170	12	93	76	25	12	388
04010	Brownfield	30	2	62	8	8	4	114
04029	East Sebago	82	1	46	29	13	4	175
04022	Denmark	23	4	46	11	14	1	99
04071	Raymond	189	2	44	86	21	15	357
04041	Hiram	76		37	26	9	6	154
04270	Oxford	113	348	31	11	102	90	695
04051	Lovell	9	9	31	3	16	3	71
04088	Waterford	28	65	24	3	24	15	159
04057	No. Bridgton	5	1	23		9		38
04047	Kezar Falls	88		16	46	8	1	159
04281	South Paris	101	524	15	10	85	74	809
04068	Porter	77		15	18	3	1	114
03813	Center Conway, NH	61		15	2	3		81
04268	Norway	100	476	12	18	80	60	746
04217	Bethel	43	172	12	3	34	21	285
04020	Cornish	93		12	34	1	1	141
04091	West Baldwin	57		9	8	2		76

04077	South Casco	28		9	13	8	2	60
04049	Limington	231		9	59	2	1	302
04062	Windham	926	3	8	524	15	14	1,490
04219	Bryant Pond	23	76	7	3	27	8	144
		2,969	1,787	1,350	1,106	691	390	8,293

Stephens Memorial Hospital

Stephens Memorial Hospital is a small hospital; however, as presented in Table 35 it is the largest provider of services in its service area.

Market Share Stephens Memorial Market Share *Table 35*

Stephen's Memorial Hospital	2,175	33.7%	Rumford Hospital	530	8.2%
Central Maine Medical Center	1,410	21.8%	Mercy Hospital	134	2.1%
Maine Medical Center	841	13.0%	MaineGeneral - Augusta	50	0.8%
St. Mary's Regional Medical Center	728	11.3%	Franklin Memorial Hospital	40	0.6%
Bridgton Hospital	546	8.5%		6,454	100.0%

Table 36 presents the 17 zip codes that comprise Stephens' service area.

Stephens Memorial Service Area *Table 36*

Zip	Town	Stephens	CMMC	MMC	St. Mary's	Bridgton	Rumford	
04281	South Paris	524	85	101	74	15	1	818
04268	Norway	476	80	100	60	12	3	754
04270	Oxford	348	102	113	90	31		699
04289	West Paris	184	21	22	34	4	13	288
04217	Bethel	172	34	43	21	12	13	302
04219	Bryant Pond	76	27	23	8	7	14	160
04040	Harrison	68	43	74	15	111		317
04088	Waterford	65	24	28	15	24		159
04255	Locke Mills	50	16	9	6	5	5	96
04256	Mechanic Falls	43	195	28	97	2		372
04292	West Sumner	31	40	5	12			90
04276	Rumford	28	253	63	70		475	947
04220	Buckfield	26	148	27	65	1	1	275
04274	Poland Spring	23	210	58	122	2		430
04238	Hebron	23	45	7	16			91
04261	Newry	19	10	8	3	1	5	46
04009	Bridgton	19	77	132	20	319		610
	Grand Total	2,175	1,410	841	728	546	530	6,454

Rumford Hospital

As shown in Table 37, Rumford Hospital is the most northern hospital in Western Maine. Rumford Hospital serves 33.9% of patients within its service area.

III. Financial Capability of Applicants and Financial Impact of Project

Market Share Rumford *Table 37*

Rumford Hospital	975	33.9%
Central Maine Medical Center	731	25.4%
Stephen's Memorial Hospital	496	17.2%
Maine Medical Center	231	8.0%
St. Mary's Regional Medical Center	227	7.9%
Franklin Memorial Hospital	216	7.5%
	2,876	100.0%

As presented in Table 38, Rumford Hospital has a discreet service area located in only 12 zip codes with a total of only 2,879 inpatient visits.

Rumford Service Area *Table 38*

		Rumford	CMMC	Stephens	MMC	St. Mary's	Franklin	Grand Total
04276	Rumford	475	253	28	63	70	35	924
04257	Mexico	175	119	6	38	28	18	384
04224	Dixfield	142	104	1	17	35	83	382
04290	West Peru	55	60	1	3	14	15	148
04221	Canton	29	67	2	4	9	59	170
04275	Roxbury	25	15	1	6		2	49
04216	Andover	18	21	18	6	3	4	70
04219	Bryant	14	27	76	23	8		148
04217	Bethel	13	34	172	43	21	2	285
04289	West Paris	13	21	184	22	34	1	275
04226	East Andover	10	4	6	2	4		26
04237	Hanover	6	6	1	4	1		18
	Grand Total	975	731	496	231	227	219	2,879

Franklin Hospital

Franklin Hospital is located in Farmington. As presented in table 39, the market is made up of 5,974 discharges.

Market Share Franklin Service Area *Table 39*

Franklin Memorial Hospital	2,629	44.1%	MG-Waterville	257	4.3%
Central Maine Medical Center	1,035	17.4%	MG-Augusta	137	2.3%
Rumford Hospital	658	11.0%	Redington-Fairview General	134	2.2%
Maine Medical Center	608	10.3%	Eastern Maine Medical Center	78	1.3%
St. Mary's Regional Medical Center	420	7.0%	Totals	5,974	

III. Financial Capability of Applicants and Financial Impact of Project

As presented in Table 40, Franklin Memorial Hospital's service area has 26 zip codes.

Franklin Memorial Hospital's Service Area *Table 40*

			Hospital					
Zip	Town	Franklin	CMMC	Rumford	MMC	St. Mary's	Other	Grand Total
04938	Farmington	677	97	1	100	47		999
04294	Wilton	319	56		69	14		488
04239	Jay	285	101	2	66	76		552
04254	Livermore Falls	208	124	4	38	75		472
04983	Strong	142	16		39	6		220
04966	Phillips	125	17	2	21	9		185
04970	Rangeley	100	13	1	30	4		154
04224	Dixfield	83	104	142	17	35		386
04955	New Sharon	78	20		19	7		142
04947	Kingfield	71	17		12	6		120
04221	Canton	59	67	29	4	9		171
04956	New Vineyard	48	4		11			67
04992	West Farmington	48	9		11	1		81
04253	Livermore	47	76	1	32	30		188
04940	Farmington Falls	43	6		11	3		64
04276	Rumford	35	253	475	63	70		914
04984	Temple	35	5		3	5		53
04911	Anson	33	4		15	3		264
04961	North New Portland	31	4		10	1		66
04982	Stratton	29	9		11	4		58
04352	Mount Vernon	28	8		8	4		132
04225	Dryden	22	5		2			33
04954	New Portland	22	5		5			42
04234	East Wilton	21	9		3	6		41
04227	East Dixfied	20	3	1	1	2		27
04360	Vienna	20	3		7	3		37
Grand Total		2,629	1,035	658	608	420		5,956

Miles Health Care

Miles Health Care is a full-service community health care organization located on the banks of the Damariscotta River in Damariscotta. The organization is dedicated to establishing and supporting a comprehensive network of high quality healthcare services for the people of Lincoln County, Maine. Miles is a 38-bed facility offering a complete range of medical services, including general, day, and orthopedic surgeries; obstetric care; cardiac rehabilitation; physical, occupational, and speech therapies; X-ray, ultrasound, CT scanning, MRI, and nuclear medicine; laboratory services; intensive care; and wellness, fitness, and health education programs. Miles Health Care market share for its service area is presented in Table 41.

Market Share for Miles Service Area *Table 41*

III. Financial Capability of Applicants and Financial Impact of Project

Pen Bay	3,060	25.4%	MaineGeneral - Waterville	665	5.5%
MaineGeneral-Augusta	2,841	23.6%	St. Andrew's Hospital	313	2.6%
Miles Memorial Hospital	1,794	14.9%	Mercy Hospital	165	1.4%
Maine Medical Center	1,732	14.4%	St. Mary's Regional Medical Center	147	1.2%
Mid Coast Hospital	721	6.0%	Others	609	5.1%
	10,148			1,899	
				12,047	

Miles Memorial's service area is presented in Table 42, indicating 30 zip codes comprise this service area.

Service Area for Miles Memorial Hospital *Table 42*

		Hospital						
Zip		Pen Bay	Maine General Augusta	Miles	Maine Medical Center	Mid Coast	Others	Grand Total
04543	Damariscotta	19	2	301	97	22		464
04572	Waldoboro	225	15	250	114	22		667
04553	Newcastle	7	2	162	52	18		259
04578	Wiscasset	4	6	139	107	170		493
04555	Nobleboro	15	1	112	34	13		183
04348	Jefferson	46	90	92	57	14		330
04554	New Harbor	2	1	77	28	7		119
04539	Bristol	6		66	24	6		108
04568	So. Bristol	4		51	17	7		80
04864	Warren	292	4	45	79	6		474
04538	Boothbay Harbor	1	3	45	62	41		355
04547	Friendship	75		42	32	1		151
04353	No. Whitefield	7	87	35	36	10		205
04556	No. Edgecomb	4	1	35	25	33		109
04564	Round Pond	3		31	10	3		49
04551	Medomak	5		30	23	6		66
04537	Boothbay	2	1	30	58	22		195
04573	Walpole	3		29	14	3		51
04862	Union	276	7	25	59	3		415
04574	Washington	96	33	24	20	1		196
04841	Rockland	981	2	23	125	8		1,232
04535	Alna	1		23	18	13		59
04558	Pemaquid	1		23	9	3		36
04861	Thomaston	319	3	20	62	2		422
04563	Cushing	109		19	22			158
04342	Dresden		21	14	28	59		144
04843	Camden	541	4	14	97	3		702
04330	Augusta	15	2,559	13	347	26		3,943
04579	Woolwich	1		12	62	190		313
04576	West Southport			12	14	9		70
	Grand Total	3,060	2,842	1,794	1,732	721		12,048

MaineGeneral – Augusta

III. Financial Capability of Applicants and Financial Impact of Project

In Augusta there is one hospital which is part of a system, MaineGeneral. MaineGeneral-Augusta reports its own information. MaineGeneral-Waterville reports individually. Table 43 presents the market share in MG-Augusta's service area.

Market Share of MG-Augusta *Table 43*

MG-Augusta	5,867	26.3%	Maine Medical Center	1,993	8.9%
MG-Waterville	4,819	21.6%	Inland Hospital	1,077	4.8%
St. Mary's Regional Medical Center	3,131	14.0%	Redington-Fairview General	785	3.5%
Central Maine Medical Center	2,809	12.6%	Other	1,846	8.3%
	16,626			5,701	
				22,327	

As presented in Table 44, the service area for MG-Augusta is fairly concise with only 28 discreet zip codes and 27 towns in the service area. Between the two campuses, 47.9% of inpatients in the service area go to MaineGeneral hospitals.

Inpatient Service Area for MaineGeneral - Augusta *Table 44*

Zip		MG-Augusta	MG-Waterville	St, Mary's	CMMC	MMC	Others	Grand Total
04330	Augusta	2,559	614	83	73	347		3,945
04345	Gardiner	721	117	44	48	206		1,269
04364	Winthrop	379	46	66	140	71		733
04344	Farmingdale	272	33	9	12	54		412
04347	Hallowell	208	16	7	22	36		306
04351	Manchester	189	38	14	12	53		320
04901	Waterville	146	2,391	24	20	267		3,709
04363	Windsor	136	52	4	1	33		259
04346	Randolph	131	12	5	9	30		214
04358	South China	101	157	9	3	56		390
04355	Readfield	100	20	7	22	15		176
04989	Vassalboro	94	148	1	4	60		370
04348	Jefferson	90	9	2	5	57		330
04353	No. Whitefield	87	10	2	2	36		204
04357	Richmond	79	10	13	17	56		378
04332	Augusta	65	11	2	5	9		104
04352	Mount Vernon	64	20	4	8	8		144
04917	Belgrade	52	187	4	9	43		339
04341	Coopers Mills	49	5			4		62
04963	Oakland	46	476	3	6	84		836
04349	Kents Hill	44	7	10	30	13		124
04259	Monmouth	40	12	58	120	26		267
04354	Palermo	40	40	1	2	8		111
04240	Lewiston	39	17	2,676	2,104	276		5,273
04359	South Gardiner	37	4		3	2		49
04350	Litchfield	36	15	73	119	39		331
04574	Washington	33	2	3		20		188
04976	Skowhegan	30	350	7	13	84		1,484

Grand Total	5,867	4,819	3,131	2,809	1,993		22,327

MaineGeneral – Waterville

MaineGeneral's other hospital is located 18 miles away in Waterville. Market share is presented in Table 45.

Market share MG-Waterville Service Area *Table 45*

MG-Waterville	7,157	24.2%	Inland Hospital	1,728	5.8%
Eastern Maine Medical Center	5,230	17.7%	St. Joseph Hospital	1,494	5.1%
MG-Augusta	5,076	17.2%	Franklin Hospital	1,116	3.8%
Maine Medical Center	2,148	7.3%	Acadia	886	3.0%
Redington-Fairview	2,043	6.9%	Others	2,694	9.1%
	21,654			7,918	
				29,572	

Between the two campuses, 47.9% of inpatients in the service area go to MaineGeneral hospitals. MaineGeneral-Waterville's service area is presented in Table 46.

MaineGeneral - Waterville *Table 46*

Zip		MG-Waterville	EMMC	MG-Augusta	MMC	Redington-Fairview	Inland	Grand Total
04330	Augusta	614	26	2,559	347	1	65	3,933
04901	Waterville	2,391	135	146	267	21	598	3,719
04345	Gardiner	117	1	721	206		15	1,265
04938	Farmington	51	6	17	100	3	3	1,025
04963	Oakland	476	42	46	84	4	151	839
04401	Bangor	40	3612	12	77			5,722
04976	Skowhegan	350	137	30	84	755	65	1,501
04364	Winthrop	46	5	379	71		9	732
04920	Bingham	47	18		29	122	11	242
04344	Farmingdale	33	3	272	54	1	2	412
04358	South China	157	12	101	56	2	32	391
04957	Norridgewock	125	39	9	44	148	31	433
04294	Wilton	22	5	3	69			494
04351	Manchester	38	2	189	53		7	320
04910	Albion	137	14	2	30	1	33	232
04937	Fairfield	496	34	22	62	10	104	759
04950	Madison	156	70	11	42	356	39	719
04917	Belgrade	187	7	52	43		28	341
04927	Clinton	257	34	8	40	9	70	443
04911	Anson	59	32	6	15	112	14	290
04912	Athens	33	21	1	14	69	7	154
04930	Dexter	23	185		11	1		554
04355	Readfield	20		100	15		5	176
04363	Windsor	52	4	136	33		6	252
04922	Cambridge	63	30	1	6	1	28	161

04979	Solon	21	11	1	15	44	9	110
04989	Vassalboro	148	7	94	60		51	372
04918	Belgrade Lakes	41	1	8	3		2	62
04986	Thorndike	27	28	3	2		31	151
04978	Smithfield	58	8	6	16	14	7	115
04941	Freedom	51	20		11	1	20	162
04945	Jackman	65	11	5	10	16	2	119
04962	No. Vassalboro	40	1	2	2		14	62
04953	Newport	41	151	5	13	8	11	429
04352	Mount Vernon	20		64	8		12	145
04924	Canaan	81	28	2	32	85	28	278
04967	Pittsfield	105	164		19	21	26	622
04354	Palermo	40	2	40	8		12	116
04988	Unity	91	29	1	21		62	224
04965	Palmyra	30	78	2	8	12	9	246
04942	Harmony	24	16		7	69	3	155
04958	No. Anson	40	16	3	21	104	21	226
04926	China Village	34	2	2	4		8	55
04903	Waterville	88	2	10	14		21	139
04943	Hartland	49	86	3	8	35	14	326
04971	Saint Albans	32	63	2	5	15	9	208
04987	Troy	21	32		5	3	22	106
04975	Shawmut	20			4		11	35
	Grand Total	7,157	5,230	5,076	2,148	2,043	1,728	29,572

Inland Hospital

Inland Hospital is a subsidiary of Eastern Maine Healthcare Systems. As presented in Table 47, it is the 4th largest service provider in its service area.

Market share Inland Service Area *Table 47*

MG-Waterville	6,526	34.2%	Eastern Maine Medical Center	1,373	7.2%
MG-Augusta	3,941	20.7%	Sebasticook Valley Hospital	595	3.1%
Redington-Fairview	1,799	9.4%	Acadia Hospital	289	1.5%
Inland	1,662	8.7%	Waldo County General Hospital	262	1.4%
Maine Medical Center	1,591	8.3%	Others	1,044	5.5%
	15,519			3,563	
				19,082	

Inland Hospital shows different hospital concentrations than MG-Waterville as presented in Table 48.

Inland Hospital Service Area *Table 48*

Zip		MG-Waterville	MG-Augusta	Redington-Fairview	Inland	MMC	EMMC	Others	Grand Total
04901	Waterville	2,391	146	21	598	267	135		3,718

04963	Oakland	476	46	4	151	84	42		839
04937	Fairfield	496	22	10	104	62	34		759
04927	Clinton	257	8	9	70	40	34		443
04330	Augusta	614	2,559	1	65	347	26		3,933
04976	Skowhegan	350	30	755	65	84	137		1,501
04988	Unity	91	1		62	21	29		224
04989	Vassalboro	148	94		51	60	7		372
04950	Madison	156	11	356	39	42	70		717
04910	Albion	137	2	1	33	30	14		232
04358	South China	157	101	2	32	56	12		391
04957	Norridgewock	125	9	148	31	44	39		433
04986	Thorndike	27	3		31	2	28		151
04917	Belgrade	187	52		28	43	7		341
04924	Canaan	81	2	85	28	32	28		278
04922	Cambridge	63	1	1	28	6	30		161
04967	Pittsfield	105		21	26	19	164		621
04987	Troy	21		3	22	5	32		105
04958	No. Anson	40	3	104	21	21	16		224
04903	Waterville	88	10		21	14	2		139
04941	Freedom	51		1	20	11	20		162
04345	Gardiner	117	721		15	4	1		1,063
04911	Anson	59	6	112	14	15	32		290
04943	Hartland	49	3	35	14	8	86		325
04962	No. Vassalboro	40	2		14	2	1		62
04352	Mount Vernon	20	64		12	8			145
04354	Palermo	40	40		12	8	2		116
04920	Bingham	47		122	11	29	18		241
04953	Newport	41	5	8	11	13	151		420
04921	Brooks	18			11	7	72		265
04975	Shawmut	20			11	4			35
04932	Dixmont	14			11	1	104		174
	Grand Total	6,526	3,941	1,799	1,662	1,591	1,373	19,082	

SMMC and MMC are two hospitals located 18 miles apart. Travel time between the two hospitals is estimated at 24 minutes. The Department determined that the combined service area of the two hospitals is all of the zip codes that are included in either of two individual service areas. It should be noted that all of the zip codes that are comprised in SMMC's service area are already in MMC's service area. At the level of inpatients, without regard to diagnoses, both hospitals presently draw patients from the SMMC service area. The combined hospital service area for these hospitals comprises parts of 14 of the 16 Maine counties and an area that is approximately 175 miles long from York, Maine through Bangor, Maine. It reaches towards Rumford in the West and Rangeley and Skowhegan in the Northeast. Seventeen other acute care hospitals are in this service area including:

- Four member hospitals of MaineHealth located in Norway, Belfast, Damariscotta, and Boothbay Harbor;
- Three Critical Access Hospitals in Farmington, Skowhegan, and Rumford;

- Two community hospitals in York County, located in York and Sanford;
- Three faith-based hospitals located in Portland, Lewiston and Brunswick;
- Two other community based hospitals in Brunswick and Waterville; and
- Three Secondary Care Service Hospitals located in Lewiston, Augusta and Waterville.

The discussion above provides independent evidence that SMMC and Maine Medical Center draw patients from significantly different areas of the state. Based on the methodology adopted by the Department, since the service areas overlap, SMMC and MMC are competitors. It is important to note that more specialized care is undertaken at MMC than at SMMC. The patients in the service areas, as indicated in the maps in Attachment A and the data above, indicate that there are 17 hospitals that compete for patients in this area.

The information provided above, as well as the information provided by the applicant, indicate that there are significant opportunities for patients to choose where they receive services. There appears to be little possibility of a negative impact on patient choice.

Gains and Efficiencies

The implementation of the Definitive Agreement will likely produce gains in the cost efficiency of services provided by SMMC.

The integration of planning functions contemplated by the agreement will permit MaineHealth and SMMC to avoid, or minimize, redundant investments in new services. This is a minor advantage; however, because as the prior analysis shows there are very little redundant activities occurring.

The inclusion of SMMC in MaineHealth's clinical programs should permit such programs to achieve better economies of scale by increasing the number of patients available for these programs.

The opportunities for integration of administrative functions should, according to information provided by the applicant, produce administrative cost savings. These savings are projected at $1 million over the first two years and a cumulative $5 million in six years.

The parties have agreed to an administrative savings condition. Based upon this condition MaineHealth and SMMC should achieve administrative expense savings for SMMC of at least $1 million. The financial model presented in the application estimates savings of no less than $602,208 in the first and second years for a total of $1.204 million. The agreement by the parties appears to be $204,000 less than projected by the applicant in the COPA application. There is a possibility that the projected impact by the Bureau of Insurance for impact on insurance premiums may be modified by this difference.

As a target, the applicants have agreed on a goal of $5 million of savings in the 6 years following the date upon which SMMC becomes a member of MaineHealth. In order for the Department to monitor this, the applicants have agreed that after 18 months MaineHealth will submit a report to

the Department, describing the savings to date and the progress towards achieving this target. The report will include an analysis of which savings have been, or can be, achieved in information technology, employee benefits, finance and accounting, and other sectors. This apparently is not considering the $2 million in technology expenditures that will occur due to this agreement. The Department may thereafter modify the conditions of the certificate of public advantage to incorporate the plan proposed by MaineHealth.

The applicants have agreed that at 48 and 66 months, following the date upon which SMMC becomes a member of MaineHealth, MaineHealth will report to the Department the savings in administrative expenses achieved. The failure to achieve savings for SMMC of at least $2 million for the initial 48 months, following the date upon which SMMC becomes a member of MaineHealth, if not substantially justified, may be treated as an "unanticipated circumstance" within the meaning of M.R.S.A. §1845 (3)(b). This is slightly above the $1.84 million of savings in a 36 month timeframe indicated in the financial module. The Department will accept this condition due to the mutual agreement between the parties.

The supervisory conditions incorporated in this Certificate of Public Advantage provide further assurance of the likeliness that these savings will be realized. This is indicated by the following condition approved by the applicants.

A. Limitation on Operating Margin

1. Target. During the term of the certificate, SMMC will set its annual consolidated budgeted operating margin at a level less than or equal to 3% of its total operating revenue.

2. Notification. During the term of the certificate, if SMMC's budgeted consolidated operating margin exceeds 3% of total operating revenue, SMMC will notify the Department within 60 days thereafter, and provide an explanation for the reasons therefore

3. Report. At 24 months, 48 months and 66 months following the date upon which SMMC becomes a member of MaineHealth, SMMC will report to the Department the extent to which its consolidated operating margin during the period of the certificate, averaged to an annual basis, has conformed to the target. At 48 months following the date upon which SMMC becomes a member of MaineHealth, if the average annual consolidated operating margin has exceeded the targeted level, and is not substantially justified by factors beyond the control of SMMC, the occurrence may be treated as an "unanticipated circumstance" within the meaning of 22 M.R.S.A. §1845(3)(b).

The Department was not presented any information regarding gains in efficiencies for patients. Indeed, the applicants go to great lengths to indicate how little will change in clinical settings.

III. Financial Capability of Applicants and Financial Impact of Project

Reduction in Competition

There was no evidence presented by the applicants or the public, in the record, indicating that there will be any disadvantages attributable to reduction in competition among covered entities or other covered entities. The Department does not see any disadvantages attributable to this reduction in competition from the agreement.

The applicants did not describe, or suggest, that the agreement was designed to increase the ability of SMMC or MaineHealth to negotiate optimal payment or service arrangements. The applicants did not state that they presently have experienced any situations where insurance companies or service payers have attempted to direct patients to other hospitals in order to get preferred rates. Rather the applicants have concentrated their discussions regarding the ability to affect administrative savings and provide SMMC with needed capital.

Impact on Pricing

There was no evidence presented by the applicants or the public, in the record, indicating that there will be any adverse impact on patients in the pricing of health care services. The Bureau of Insurance estimates no impact on private health insurance premiums in the SMMC service area or statewide. Additionally, no comments were received from the insurance industry. The Department does not see any disadvantages attributable to an impact on pricing from the agreement.

v. Conclusion

CON RECOMMENDATION: CONU recommends that the Commissioner determine that MaineHealth and Southern Maine Medical Center have 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.

COPA RECOMMENDATION: CONU recommends that the Commissioner determine that the definite agreement demonstrates: (1) the likely gains in the cost efficiency of services provided by the hospitals or others; (2) the extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents or other health care payers to negotiate optimal payment and service arrangements with hospitals or health care providers; (3) the extent of any disadvantages attributable to reduction in competition among covered entities or other persons furnishing goods or services to, or in competition with, covered entities that is likely to result directly or indirectly from the cooperative agreement; and (4) the extent of any likely adverse impact on patients or clients in the price of health care services.

IV. Public Need

A. From Applicant

i. CON From Applicant

"Public Need – SMMC has determined that to meet the economic and clinical challenges it faces, it can best do so by gaining full access to the programs, resources, experience and expertise of MaineHealth. The benefits of membership will enable SMMC to achieve its mission."

"In this section, 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 change in SMMC ownership, which requires CON review. As a result, this application addresses the need for the "project" in the context of the need for the change in ownership."

"During the 1990's, there was significant consolidation of health care providers into systems. While every system evolved for different reasons, most systems have set goals to improve efficiency, lower costs, improve quality and outcomes and integrate the disparate and fragmented elements of the current system into a more coordinated system."

"As part of its strategic planning process, SMMC identified a number of significant challenges in the environment which it must address if it is to continue to meet the health care needs of the communities it serves and to improve the health of those communities. Those challenges include:

- Continuing to provide excellent health care to all regardless of ability to pay in an environment of revenues from private and public payors not keeping pace with the costs of delivering those services;
- Difficulty in recruiting and retaining physicians as the national shortage of physicians intensifies;
- Increasing difficulty in accessing the capital necessary to invest in new and replacement technologies and facilities and in information technology and to provide working capital, information systems and facilities/offices to support the recruitment and retention of physicians;
- National, regional and local shortages of health care professionals."

"From this strategic planning process, SMMC concluded that the best way to move forward was to become a member of a health care system, one that shared SMMC's non profit values and its vision that healthcare is best delivered as locally as possible. SMMC's Board, Management, Medical Staff and Community Corporators ("owners") concluded that MaineHealth best met SMMC's criteria for selecting a health care system. Further, SMMC identified a significant

number of benefits from membership in MaineHealth which would address the challenges identified above and would strengthen SMMC's ability to meet the health care needs of the communities it serves and to improve the health of those communities."

"Because MaineHealth is committed to improving the health of all of the communities in its eleven county service area, it welcomed the opportunity to demonstrate to SMMC how by joining MaineHealth, the two organizations could make significant progress in achieving this vision."

"SMMC has identified the following benefits from joining MaineHealth:

- **Commitment to Preserving SMMC's Hospital Services.** The Definitive Agreement provides that MaineHealth is committed to maintaining existing health care services in York County as part of the health care delivery system. MaineHealth acknowledges that it intends for SMMC to be the primary provider of hospital and health care services for York County residents within the MaineHealth integrated delivery system for so long as SMMC is a member of MaineHealth. MaineHealth also acknowledges that the existing level and array of health care services provided by SMMC is appropriate in relationship to current standards of quality, cost, volume, access and reimbursement; that SMMC's participation as a member of MaineHealth is predicated upon the understanding that SMMC will continue to provide, in York County, at least those core services which are appropriate to a community health care system; and that any changes to the level and array of health care services at SMMC will not occur unless first initiated by and approved by SMMC with input from the SMMC medical staff as part of the strategic planning and budgeting process.
- **Support for SMMC's Physician Recruitment and Retention Plan.** Under the Definitive Agreement, MaineHealth acknowledges SMMC's plan for recruitment and retention of qualified physicians to meet the needs of the community served by SMMC, and has agreed to assist SMMC in its efforts to secure the administrative and financial resources needed to implement SMMC's physician recruitment plans.
- **Funds for an Ambulatory Electronic Medical Records System.** Under the Definitive Agreement, MaineHealth agrees to provide financial support totaling at least $2,200,000 over a period of three years for an ambulatory electronic medical record system for SMMC and its employed physicians.
- **Funds for New Physician Facilities.** Under the Definitive Agreement, at SMMC's request, MaineHealth will provide up to 100% of the debt financing to cover the total direct cost of as many as four medical office buildings as needed with an aggregate of approximately 60,000 square feet of space in communities within the SMMC services area.
- **Access to MaineHealth's Borrowing Group.** SMMC 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, SMMC will have greater access to capital and access to a lower cost.
- **Continuation of SMMC's Community Representative Board.** SMMC will remain a hospital governed by SMMC's Board of Directors, and no new member may serve on

the Board of Directors unless nominated by SMMC's Board. This will insure the SMMC's Board will be responsive to the local community needs.

- **Full Participation in MaineHealth's Quality, Health Status Improvement and Clinical Integration Programs.** As a member of the MaineHealth system, SMMC will participate as all other members do in the development and implementation of quality improvement programs, as well as educational/networking clinical support.
- **Access to MaineHealth's Management Resources.** As a member of the MaineHealth system, SMMC will have access to shared administrative resources including but not limited to: legal, financial, strategic planning, program development and human resources.
- **Access to MaineHealth's Administrative Integration Programs.** As a member of the MaineHealth system, SMMC 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. These programs provide significant opportunities for cost savings for SMMC."

"As a result, SMMC'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 will be enhanced significantly."

Positive Impact of Project on Health Status and Quality

"MaineHealth's mission is "Working together so our communities are the healthiest in America". As is described in detail in "Section VI State Health Plan", MaineHealth is leading the development in Maine of health status improvement and clinical integration initiatives. SMMC is already a participant in a number of MaineHealth's initiatives, including:

- 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;
- 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;
- Raising Readers – a health and literacy project that provides books to all Maine children from birth to age five at their well child visits;
- 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 experience 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;

IV. Public Need

- 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")."

"As a member of MaineHealth, SMMC will be expected to continue to participate in these programs and will as appropriate, become a participant in the following additional MaineHealth initiatives:

- 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;
- 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;
- 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;
- 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."

"All of these initiatives have identified measurable outcomes. SMMC's leadership will significantly extend the geographic coverage and depth of these initiatives in York County."

Quality and Safety

"Exhibits IV-A and IV-B include SMMC's 2008 Patient Safety and Risk Reduction Plan and its 2008/2009 Quality Assessment and Improvement Plan. The mission of the Patient Safety and Risk Reduction Plan is:

> "To reduce medical errors and hazardous conditions by utilizing a coordinated and continuous approach to the improvement of patient safety through the establishment of systems that support
>
> - Effective responses to actual occurrences and hazardous conditions ranging from "no harm" events to sentinel events;
> - Ongoing proactive reduction in medical and/or health care errors;
> - Integration of patient safety priorities in the design and redesign of all relevant organizational processes, functions and services"."

"This plan sets forth the structure SMMC will use to analyze risks to patient safety and disseminate that information throughout the organization to improve patient care.
The Quality Assessment and Improvement Plan sets forth the following objectives:

1. To promote an organizational commitment to quality and patient safety and to stimulate an active leadership role in the initiation, performance and maintenance of all organizational performance improvement activities.
2. To provide a framework for improving the performance of organization wide systems and processes through a planned, systematic approach of plan, design, measurement, assessment and improvement.
3. To incorporate the important organizational functions into strategic planning and quality improvement activities and to make determinations regarding priorities for improving systems and processes.
4. To consider the continuum of care and the flow of patient care when organizing improvement activities of those processes which are cross-disciplinary and cross-service.
5. To facilitate collaboration with Medical Staff and other disciplines/services in problem solving/resolution.
6. To show measurable and sustained improvement in indicators for which there is evidence that they will improve health outcomes and identify and reduce errors.
7. To increase the probability of desired outcomes, service excellence, and patient safety by including patient, staff and other customer satisfaction information and feedback when planning and implementing quality improvement and patient safety activities.
8. To improve the framework for incorporating the findings of quality assessment activities into the reappointment/re-privileging and annual review process.
9. To provide the mechanism for an annual review of the scope and effectiveness of the Performance Improvement Plan."

"The plan sets forth organizational structure to improve quality, the quality measurement data bases and the approach to measurement and process improvement. No change in the plans or the expectation that they be implemented will result from SMMC's membership in MaineHealth. The MaineHealth Center for Quality and Safety described in Section II will provide significant support to SMMC in implementing these plans."

i. COPA From Applicant

Relevant criteria under the COPA law that should be discussed in this section are:
• The likely preservation of hospitals or health care providers and related facilities in geographical proximity to the communities traditionally served by those facilities; and • The extent of any likely adverse impact on patients or clients in the availability of health care services.

"The Applicants believe that the Definitive Agreement will facilitate preservation of SMMC and its family of health care providers and related facilities in the York County communities traditionally served by SMMC."

IV. Public Need

"Recognizing the evolving role of hospitals in our health care system, and with an eye toward trends that over time would challenge the hospital's capacity to perform their ever increasing responsibilities, SMMC's board, after an extensive study of the matter, decided that it could best perform its role in promoting the health of its communities by becoming a fully engaged member of a health care system."

"Like other hospitals in the modern setting, SMMC has assumed an active role in promoting the health of residents in its service area. In addition to its traditional function as a place for inpatient care, the hospital serves as a center for diagnostic screening and testing, for health education and the promotion of healthy life styles. It functions as the central hub for interaction among many different types of care-givers – primary care providers, specialists, mental health and home health providers – and aspires to take the initiative in deploying technologies intended to systematize the coordination of care and timely communication of health care information. It is also seeks to function as a key health planner for its communities, anticipating demands for new technologies and for service specialties and seeking to attract and retaining clinicians readily available to provide such services. Finally, as a non-profit charitable health care provider, SMMC serves as provider of last resort for those who lack either resources altogether or resources sufficient to qualify as a regular patient of a primary caregiver."

"SMMC has performed and intends to continue to perform all of these functions. But there are trends in physician supply, and a widening gulf between physician reimbursement and medical practice expenses, that pose significant challenges for SMMC's discharge of these missions."

"One such trend is the aging of the population. The demand for physician services will increase as the "baby boom" generation approaches retirement age and is covered by Medicare."

"Second, the sufficiency of a supply of physicians to meet current and expected increases in demand is in question. The average age of the active medical staff at SMMC is 49." "SMMC estimates the current gap between demand and supply at 13 physician FTE's. In addition, even to maintain the current levels of physician manpower, given expected physician retirements, SMMC estimates that an additional 17 physicians will need to be recruited to the community by 2013.[19]"

[19] Estimates of the absolute severity of the physician shortage vary, but the consensus view is that there will be significant shortages nationally if current trends continue. According to Cooper, "The Challenges of Expanding Physician Supply," Leonard Davis Institute of Health Economics, University of Pennsylvania (May 4, 2006), p, 4 (chart entitled "Demand and Effective Supply, 1929-2000 and Projected to ~2025) the demand for physicians nationally per 100,000 population in 2025 will be approximately 360 FTEs (full time equivalents), whereas the supply, assuming current trends, will be approximately 275 FTEs. (The presentation is available at http://www.aamc.org/workforce/pwrc06/cooper.pdf.) The Council on Graduate Medical Education (COGME) has recommended an annual increase of 3,000 medical school graduates by 2015 to meet rising demand and need. COGME, "Physician Workforce Policy Guidelines for the United States, 2000-2020" (January 2005). The mid-points of projected supply and demand scenarios outlined in the COGME report reflect a projected shortage of about 85,000 physicians in 2020 – equivalent to approximately ten percent of today's physician workforce. The U.S. Department of Health and Human Services, Health Resources and Services Administration ("HRSA"), Bureau of Health Professions' Report, "Physician Supply and Demand: Projections to 2020," (October 2006) projects a national shortfall of approximately 55,000 physicians in 2020. Assuming current trends, the full time equivalent

IV. Public Need

"Normal age-related retirement, however, is not the only threat to physician ranks. Private practice physicians are facing increasing costs but flat revenues. This translates to reduced physician income. Given: 1) a regional and national physician shortage in many medical specialties; and 2) opportunities for higher net income, professional enhancement through sub-specialization and reduced call responsibilities in larger practices in metropolitan areas, private practices in many parts of Maine are at a comparative disadvantage both in recruiting new clinicians to the community and in retaining clinicians within the community. SMMC is therefore concerned not only that its staff members will not be able to recruit physicians to replace those retiring, but that it will lose physicians to other opportunities even before their retirement age."

"Regulatory developments have exacerbated this concern. As a result of the promulgation of Phase II of the Stark II regulations in 2004, hospitals around the country are able to pay "fair market value" for employed physicians, calculated by utilizing the average of the 50th percentile of national compensation level for physicians with the same specialty in at least four surveys, assuming 2,000 hours of labor per year.[20] Given the size of the Maine economy, and the relatively smaller resources available in Maine for government-paid health care services, Maine-based physician practices, particularly those in smaller town and rural locations, have difficulty competing for physicians against hospitals in other localities able to pay at a rate determined by national compensation surveys.[21]"

"The Maine Commission to Study Primary Care Medical Practice made the same observations in its December 2007 Report:

> During the Commission's hearings and deliberations many people expressed concern about the supply of primary care providers in Maine. Factors impacting supply include an aging workforce; fewer students choosing to go into the medical field and in particular, into primary care; limited clinical opportunities and residencies; competition for attracting doctors in a national marketplace; and the challenges of attracting doctors to rural and remote parts of Maine.[22]"

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physician supply is projected to grow to 866,400 by 2020, while demand for physicians will increase to 921,500 due to the growth and aging of the U.S. population.

[20] 69 Fed. Reg. 16053(March 26, 2004).

[21] SMMC has experienced the recruiting difficulties directly. It has taken four years to recruit a general cardiologist to SMMC's service area. The new recruit, who has J-1 visa status, began employment on July 1, 2008. It has also taken approximately two and a half years to recruit an orthopedic surgeon to replace a surgeon who announced his retirement in 2006.

[22] Maine Commission to Study Primary Care Medical Practice, Final Report (December 2007), p. 8, reprinted at http://www.maine.gov/legis/opla/primarycarerpt.pdf This Report, p. 10, also noted:

> Recruiting challenges include competition in a national market, fewer graduates choosing

IV. Public Need

"The low level of reimbursement available to primary care physicians in Maine under publicly-financed health care programs, especially Medicaid (known in Maine as MaineCare), was cited by this Report as a particularly significant in contributing to Maine's comparative physician recruiting/retention disadvantage:

> In Maine, low Medicaid reimbursement rates amplify the problem due to the large percentage of the population in the program. One out of every five people in the state is covered by MaineCare, the State's Medicaid program. Thus, low Medicaid reimbursement rates impact Maine providers to a greater degree than it would if they practiced medicine in other parts of the nation.[23]"

"Similarly, the State's 2008-2009 Health Plan notes the interplay of these various factors in a looming physician shortage for Maine:

> New England exceeds U.S. averages on available physicians, but Maine has fewer specialty physicians and primary care physicians than every New England state except New Hampshire. The issue of physician shortages is a national discussion

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primary care, the number of doctors in Maine nearing retirement age and specific regional issues. Physician recruitment in rural areas faces particular challenges including" .. .lower earning potential, longer hours and...a general shift in desired professional setting among physicians and salary levels.

[23] The Commission made the following findings regarding the MaineCare program, its low reimbursement rates, and its impact on primary care physicians in Maine:

Findings

The Commission to Study Primary Care Medical Practice finds that:

1. Medicaid reimbursement rates through the State's MaineCare program are lower than many other comparable states.

2. Medicaid reimbursement rates have a greater impact on physicians in Maine than they may have in other states due to the large percentage of the population covered by the State's MaineCare program. . . .

3. MaineCare reimbursement rates for the work of primary care physicians are inadequate and contribute to the loss of independent ownership of primary care medical practices and affect primary care physicians' ability to practice medicine in Maine.

4. In addition to low reimbursement, MaineCare administrative requirements and restrictions hinder the ability of physicians to practice in Maine and contribute to practices closing their doors to new MaineCare.

Final Report, *supra*, p. 7.

> from which Maine is not immune. In Maine, the Maine Medical Association reports significant recruiting challenges and distribution issues that result in underserved rural areas and notes the changing expectations and employment patterns of physicians creates more need for additional workforce. For some specialties, the issue is more exacerbated. Notably, one in three surgeons in Maine is over the age of 60, according the Maine Department of Labor's 2006 Healthcare Occupations Report.[24]"

"SMMC and physician practices in its service area have experienced this phenomenon directly. SMMC has determined that whereas the median *national* effective average RBRVS conversion factor[25] reported by the physician compensation surveys was $43.84 in 2007, the PrimeCare physicians, prior to their employment with SMMC, collectively realized a composite conversion factor of $38.20. The national median conversion factor rate for the mix of physicians represented by PrimeCare is thus 15% higher than the amounts effectively earned on average by PrimeCare physicians."

"SMMC expects this disparity to increase over time as the proportion of its patient base covered by MaineCare, or insured by with ever higher deductibles, increases with a weakening economy, and as the proportions of its patients covered by Medicare increases with the aging of the York County population.[26] This is because MaineCare and Medicare compensate physicians at a lower conversion factor rate than privately insured patients.[27]"

"As a non-profit charitable institution, SMMC is the provider of last resort for patients who do not have a regular primary care physician to evaluate and treat them in the first instance. Such

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[24] Governor's Office of Health Policy & Finance, Maine's 2008-2009 Health Plan (April 2008), pp. 23-24.

[25] RBRVS refers to the "resource base relative value scale" – a scale widely in use as a tool to normalize and set physician reimbursement for particular services. The scale assigns a number of relative vale units for a particular physician service, depending in part on the degree of skill and time required for the procedure. The actual compensation paid to the physician for the service is the number of such relative value units multiplied by a dollar value per unit, known as "conversion factor." Physician compensation around the country can be compared by dividing physician income by the number of relative value units of service performed. The media conversion factor referred to in the text above was derived from the Medical Group Management Association's (MGMA's) 2007 physician compensation surveys.

[26] MaineCare represented 9.7% of SMMC's total charges in FY2002, and increased to 12.3% in FY2008.

[27] The demand for physician services by the Medicare population is recognized to be substantially higher than for the rest of the population, and so physicians' income, measured on a conversion factor basis, will be comparatively lower to the extent that the proportion of services delivered to Medicare patients is higher. The Association of American Medical Colleges ("AAMC"), in its 2006 report, "Help Wanted: More U.S. Doctors," observed that persons over 65 average 7 visits per year to a physician, whereas, those below 65 average approximately 3 visits per year. AAMC Report (2006), Table, p. 4. The HRSA's, "Physician Supply and Demand: Projections to 2020," (October 2006), p. 19, noted that "The United States Census Bureau projects a rapid increase in the elderly population beginning in 2012 when the leading edge of the baby boom generation approaches age 65. Between 2005 and 2020, the population younger than age 65 is expected to grow by about 9 percent, while the population age 65 and older is projected to grow by about 50 percent. . . The elderly use much greater levels of physician services relative to the non-elderly, so the rapid growth of the elderly population portends a significant increase in demand for physician services."

patients arrive in SMMC's emergency room, sometimes sicker because of delays in seeking and obtaining treatment. There is universal agreement that a hospital emergency room should not be the primary provider for such persons – a consensus reflected in Maine's 2008-09 State Health Plan[28] – but that is the trend. Over the last 5 years, the number of patient encounters at the SMMC emergency room has increased from 33,861 in FY03 to 41,555 in FY07. Over a similar period (FY02 to FY08), MaineCare's share of emergency department charges at SMMC increased from 14.7% to 21.2%.[29]"

"To respond to these concerns, beginning in 2006 SMMC formulated a medical staff development plan. Two key components of the plan are to attract physicians to practice in SMMC's service area; and to employ physicians, so that their compensation is independent of the payor mix. As employees of a 501(c) organization, employed physicians will render care to all patients, regardless of insurance status or ability to pay."

"As part of the recruitment/retention effort, SMMC has planned the construction of medical office centers in towns within SMMC's service area. The majority of physicians covered by the medical staff development plans will be office-based. The details of these plans, which are still subject to adjustment, are proprietary and confidential. To the extent necessary, SMMC will file these plans with the Department under an administrative protective order."

"These plans were developed prior to and independent of SMMC's decision to become a member of MaineHealth. In assessing the feasibility of the plan, however, SMMC recognized that the execution of such a plan would require significant working capital, both to finance employed physician compensation until receivables were paid (sometimes 6 to 9 months), and to acquire or construct physician office space and ancillary equipment. Recruitment of new physicians similarly would require capital to fund income guarantees. SMMC could not execute these plans with current capital resources without draining SMMC's capital reserves."

"The Definitive Agreement addresses these constraints. Under Section 2.7.1 of the Definitive Agreement, MaineHealth has agreed to assist SMMC in its efforts to secure the administrative and financial resources needed to implement SMMC's physician retention and recruitment plans once finalized. In addition, Section 2.7.5 of the Definitive Agreement provides that MaineHealth will furnish up to 100% of the debt financing to cover the total direct cost of as many as four medical office buildings with an aggregate of approximately 60,000 square feet of space in communities within SMMC's service area."

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[28] Governor's Office of Health Policy & Finance, Maine's 2008-2009 Health Plan (April 2008), pp. 27, 54 ("Maine – at 553 ED visits per 1000 population in 2005 – has the highest rate of emergency department visits in New England and the 4th highest in the US (the national rate was 387 visits per 1000").

[29] SMMC does not have any formal method of determining how many of these patient visits to its emergency department could have been accommodated in a physician office setting. However, SMMC does utilize a classification system that triages the level of patient acuity (1 to 5, with 1 being most acute). SMMC believes that most ED patients with acuity classification of 4 or 5 could be treated in a physician office setting. In 2005 and 2006, 43% of all ED visits were classified as level 4 or 5; in the year to date for 2008, 47% of all ED visits were classified as level 4 or 5.

IV. Public Need

"MaineHealth and SMMC structured the Definitive Agreement so as to avoid specifying a commitment for any particular number of physicians to be recruited or employed. This was in recognition of the fact that by the time of closing on the MaineHealth/SMMC Definitive Agreement, there are likely to be further changes in the supply and demand. It also reflects the recognition that MaineHealth's Maine Medical Center and its employed physicians may be able to address at least some of the physician shortage at SMMC through rotation."

"SMMC's need for affordable capital to execute its medical staff plan is now more acute as a result of developments in the last six months. In September 2008, the Boards of SMMC and PrimeCare, a multi-specialty physician group headquartered in Biddeford, Maine, agreed to a transaction by which SMMC acquired the assets of PrimeCare and the physicians became employees of SMMC on October 1, 2008."

"The employment of PrimeCare physicians will stabilize physician resources in the SMMC area for the short term. It will also ease some of the pressure on the SMMC emergency department, because as employees of SMMC, the former PrimeCare physician practices (at least those that are not full) will be open to all patients regardless of payor status."

"However, the PrimeCare transaction does not address the underlying physician shortage in SMMC service area. There are current manpower gaps remaining to be filled: 6 additional primary care physicians; 2 surgeons; and 3 emergency room physicians. As noted previously, the current age of the medical staff is such that, with expected retirements and additional demand, there is a need to recruit 17 additional physicians to the community by 2013."

"The PrimeCare transaction has also created an unanticipated capital expense for SMMC. SMMC's access to lower cost capital through its membership in MaineHealth has therefore become a more important factor in the execution of its medical staff development plan."

"One other aspect of the MaineHealth/SMMC Definitive Agreement, as it relates to SMMC's medical staff development plan, deserves mention, although its significance cannot be quantified. Both parties to the Definitive Agreement believe that SMMC's recruitment efforts will be enhanced by virtue of SMMC's status as a member of MaineHealth. Over time, the parties anticipate that there will be significant cross-fertilization among the specialists at SMMC and MMC. The Applicants believe that such a symbiosis was at work in oncology through joint ownership of the Cancer Care Center of York County. New recruits to the SMMC medical staff can expect that their opportunities for professional interaction and sub-specialization will be enhanced as a result of the fact the counterpart departments at each hospital are likely to participate jointly in the development of new protocols, programs and service enhancements."

IV. Public Need

B. CONU Discussion

i. CON Criteria

Relevant criteria 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 applicant has suggested that in order for Southern Maine Medical Center to remain a viable and sustainable healthcare resource for the people in the SMMC service area, that SMMC must become part of a larger healthcare system in order to access additional financial, operational and management resources. The applicants have stated that the benefits of joining a healthcare system include: access to capital; access to physicians and other healthcare professionals; recruitment and retention programs; and the ability to provide quality healthcare to all patients regardless of the ability to pay. By SMMC becoming a member in MaineHealth, MaineHealth will be able to fund ambulatory electronic medical records systems for all of SMMC's physicians. SMMC will also have access to MaineHealth's management resources which include legal, financial, strategic planning, program development and human resources.

Currently, SMMC is considered a preferred hospital under the state employee insurance plan, effective February 1, 2009. Other members of MaineHealth that are currently preferred hospitals under the plan are: Maine Medical Center, Miles Memorial Hospital and Stephens Memorial Hospital.

This project enhances the ability of SMMC to accomplish their physician recruitment and retention plan. The applicant believes that physician retention will become increasingly difficult as a single hospital operator because of the increasing demands from physician groups to improve revenue payments to physicians. This enhancement is achieved by employing additional physicians. SMMC will be able to ensure that a greater number of uninsured patients will have access to care. As hospital employees, physicians will be able to treat patients without regard to their ability to pay. The retention of physicians will meet the criteria to provide access to the residents of the area with physician services. If physicians have to make economic decisions as

to their patient base, more physicians will be likely to limit the number of patients they serve who are uninsured or covered by the MaineCare program.

In order to ensure that SMMC becoming a member in MaineHealth will provide anticipated improvements in quality and outcome measures, CONU recommends that the following condition be incorporated into the CON approval: Report improvements in quality outcomes as a result of this merger for a period of three years from merger date.

iii. COPA Criteria

- The likely preservation of hospitals or health care providers and related facilities in geographical proximity to the communities traditionally served by those facilities; and

- The extent of any likely adverse impact on patients or clients in the availability of health care services.

iv. COPA Analysis

At the public hearing held on this proposal on November 17, 2008, no party or member of the public expressed any opposition to the implementation of the Definitive Agreement, or to the Department issuing a Certificate of Public Advantage. This is relevant in that significant opportunity for comment from other health care providers and from local physicians was available.

The implementation of the Definitive Agreement will likely promote the preservation of hospital and medical services in the geographic proximity to the communities comprising SMMC's service area. While SMMC is not the largest provider of hospital care in this area it has a significant presence that would be difficult to replace if SMMC were unable to continue operations. SMMC and MaineHealth believe that the long term operation of SMMC would be in doubt without the agreement. The financial forecast provided by the applicants does not hint at this growing concern. However, the three year timeframe involved in the financial presentation may not be a long enough range for the development and demonstration of serious financial difficulties for SMMC. Without the agreement, SMMC would be subject to greater risks involved with the likelihood of not ensuring physician availability to the areas' residents.

The Definitive Agreement will assist SMMC in the execution of SMMC's medical staff development plan. SMMC has expressed its concerns regarding the retention of health care professionals in the area. Clearly, based on testimony at the public hearing, there has been significant concern on the part of the SMMC trustees regarding physician recruitment. The average age of SMMC medical staff is reported to be 49. It is estimated that the current gap between current demand and supply is a shortage of 13 physicians. In addition, SMMC expects an additional 17 physicians will be recruited by 2013. The applicants report that physicians face "flat line revenues" in the face of increasing expenses due to reduced MaineCare revenues. In the face of these concerns, the applicants expect that absent the agreement, there will be an adverse impact on the availability of physician services.

IV. Public Need

This physician development plan is designed to preserve and enhance the availability of medical care in SMMC's service area. There are two key components to the plan:

- Attract physicians to practice in SMMC's service area; and
- Employ physicians that agree to practice or already work in the service area.

Employment of additional physicians will offset the shift in payer mix that SMMC is experiencing. Employed physicians' compensation is independent of the payer mix. As employees of a 501(c) organization, employed physicians will render care to all patients, regardless of insurance status or ability to pay. SMMC is obligated under the Free Care Guidelines (10-144 C.M.R. Chap. 150 §1.02(c)) to provide necessary medical care to persons without insurance alternatives who qualify at below 150% of the Federal Poverty Level guidelines.

The Definitive Agreement will also provide SMMC with access to the financial, administrative and clinical resources of MaineHealth. This should strengthen SMMC ability to maintain quality community hospital care services.

The applicants and the interveners have agreed to incorporate the following three conditions which will increase the likelihood that access to care is not compromised. Accordingly, the Department should support these conditions, however it should be noted that the reports should include an analysis of the baseline conditions that presently exist at SMMC. The reports should also indicate the costs to implement these retention and recruitment plans.

1. Medical Staff Recruitment and Retention

    i. Commitment: MaineHealth will assist SMMC in its efforts to secure the administrative and financial resources needed to implement its 5-year (2008-2013) medical staff recruitment and retention plan, as modified and approved by the SMMC Board, and as provided in Section 2.7.1 of the Definitive Agreement.

    ii. Reporting: At 24 months, 48 months and 66 months following the date upon which SMMC becomes a member of MaineHealth, SMMC will report to the Department on its progress to date in achieving its medical staff recruitment and retention plan.

2. Access to Primary Care for MaineCare and Uninsured Patients

    i. Commitment: During the six years following the date upon which SMMC becomes a member of MaineHealth, SMMC will require all physicians employed by SMMC to accept patients without regard to the

patient's insurance status or ability to pay, consistent with SMMC's charity care policies. During the same period, SMMC's charity care policy will continue to provide that person(s) whose incomes are below 175% of the then current DHHS federal poverty guidelines will receive free care.

ii. Report: At 24 months, 48 months and 66 months following the date upon which SMMC becomes a member of MaineHealth, SMMC will report to the Department the number of charity care patients and MaineCare patients served by SMMC- employed physicians.

iii. Feasibility Study: At 18 months following the date upon which SMMC becomes a member of MaineHealth, MaineHealth and SMMC will submit to the Department a report analyzing the feasibility of extending the Care Partners program to eligible residents within SMMC's primary service area. The report will propose, as appropriate, a plan for improving and extending the availability of the Care Partners program to eligible residents within SMMC's primary service area. The Department may thereafter modify the conditions of the certificate to incorporate the plan proposed.

3. Emergency Department Use

i. Target: By 48 months following the date upon which SMMC becomes a member of MaineHealth, SMMC will offer the services of a primary care physician or physician extender for follow-up care to each patient discharged from SMMC's emergency department who received non-emergent ambulatory care and who does not already have a regular primary care provider.

ii. Interim Program and Report: Beginning 3 months following the date upon which SMMC becomes a member of MaineHealth, SMMC will implement a program utilizing the available capacity of current SMMC-employed primary care physicians to offer follow-up appointments with and assignments to primary care physicians for those patients discharged from the SMMC emergency department who lack a regular primary care provider. At 18 months following the date upon which SMMC becomes a member of MaineHealth, SMMC will report to the Department the numbers and percentage of patients discharged from the SMMC emergency department who were offered primary care provider access through this program, and changes in emergency department use at SMMC during the interim program.

IV. Public Need

iii. Feasibility Study: MaineHealth and SMMC will conduct a study to determine the feasibility of longer-term measures by which emergency department demand at SMMC can be re-routed to lower cost alternatives without compromise in patient care, and the practicality of benchmarks to measure the success of such a plan. At 36 months following the date upon which SMMC becomes a member of MaineHealth, MaineHealth and SMMC will report to the Department the results of their study and on changes in emergency department use at SMMC during the preceding 36 months. The report will propose, as appropriate, a plan for achieving any further re-routing of demand beginning no later than 48 months following the date upon which SMMC becomes a member of MaineHealth, and any benchmarks by which to measure the success of such a plan. The Department may thereafter modify the conditions of the certificate to incorporate the plan proposed.

The applicants have not identified any likely adverse impact on patients or clients in the availability of health care services. The applicants have stressed there is a growing concern that SMMC will not be able to ensure services are available in the service area without the completion of this Definitive Agreement.

v. Conclusion

CON RECOMMENDATION: CONU recommends that the Commissioner find that MaineHealth and Southern Maine Medical Center have met their burden to show that there is a public need for the proposed project as demonstrated by certain factors.

COPA RECOMMENDATION: CONU recommends that the Commissioner find that the definitive agreement: (1) promotes the preservation of hospitals or healthcare providers and related facilities in geographical proximity to the communities traditionally served by those facilities; and (2) the extent of any likely adverse effect on patients or clients and the availability of healthcare services is limited by the conditions approved by the applicants and recommended for inclusion.

V. Orderly and Economic Development

A. From Applicant

i. CON From Applicant

"As was described previously, there is no capital expenditure requiring CON review and no increase in operating expenses for the health care delivery system in Maine, for the State of Maine, for MaineHealth or for SMMC as a result of SMMC joining MaineHealth."

"Creating the opportunity for SMMC to join MaineHealth and take maximum advantage of the benefits described in detail in the previous section (access to capital for programs, facilities, information technology and physician recruitment; access to MaineHealth initiatives to improve health status and quality/safety; opportunities to reduce costs through economies of scale and access to specialized management support and expertise) is consistent with the orderly and economic development of the health care delivery system."

"In making the decision to join MaineHealth, SMMC evaluated two other alternatives: (1) maintain its status as a MaineHealth affiliate; (2) discontinue its MaineHealth affiliation and not be affiliated with any health care system."

"MaineHealth can offer 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). Because SMMC concluded these benefits are so significant and critical to its ability to continue to meet the health care needs of its communities and to improve the communities' health, maintaining its status as an affiliate was not the preferred alternative. For essentially the same reasons, SMMC also concluded it could not most effectively operate as a "freestanding" organization."

ii. COPA From Applicant

Relevant criteria under the COPA law that should be discussed in this section are:
• The likely avoidance of duplication of hospital or other health care resources.

"As noted previously, immediately achievable operational cost efficiencies have not been a major motivation for the Definitive Agreement. MaineHealth and SMMC have estimated that they can achieve approximately $500,000 in additional cost savings for SMMC post-merger as a result of the streamlining of various operations. The MaineHealth/SMMC combination will also provide modest economies of scale for administrative expenses. As a member of the MaineHealth system, SMMC may utilize MaineHealth's existing planning staff, legal staff, and

internal audit processes. Currently, SMMC must purchase these services from external vendors."

"In addition, as a member of MaineHealth, SMMC will be able to borrow at interest rates more favorable than it has been able to achieve as a stand-alone institution. At current rates, the Applicants anticipate that SMMC's borrowing rate will be 1.5 % lower than rates currently available to it."

"Although not susceptible to quantification, the Applicants believe that their combination will produce savings from cost avoidances in the future. As noted above, SMMC's capital and operating budget are subject to approval of MaineHealth. Given the geographic proximity of the institutions – there are approximately 18 driving miles between them – the Applicants expect that many major service initiatives undertaken by SMMC or MMC will of necessity include the other within its scope, and for that reason, reflect economies of scale made possible by the inclusion of both entities and minimize duplication that might otherwise occur."

B. CONU Discussion

i. CON Criteria

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

Total projected 3rd year incremental operating costs are projected to show no additional costs from the membership, therefore no projected increase in MaineCare funds will be needed to fund this project through the 3rd year of operation (2012).

The applicants list a variety of potential savings from this project; however, the most significant and immediate savings comes from Southern Maine Medical Center being able to participate in the MaineHealth's group health insurance plan for SMMC's employees. SMMC will be required to pay a membership fee to MaineHealth as are other member organizations that belong to

MaineHealth. The fee is currently calculated on the basis of 0.045% of a member's net operating expense. This fee is projected to be $636,768 by the third year of operation (FY 2012) (Table 20 of the Financial Forecast Module). As discussed in the economic feasibility section of this application, the projected 3rd year incremental operating costs show a net difference of zero, with the membership fee being offset in its entirety by administrative savings which the applicant attributes to employee benefit savings (FY 2012) (Table 20 of the Financial Forecast Module), as a result of the application and SMMC's membership into MaineHealth. Offset savings in the amount of $636,768 is documented by the applicants by applying a reduction in insurance related costs as a benefit to SMMC becoming a member of MaineHealth. This is offset by the membership fee discussed above that reduces the total cost to $0 by 2012. The impact on health care expenditures therefore is zero based on the reviewable costs.

The applicants chose not to include approximations for increased expenditures related to physician retention and medical office buildings as well as electronic medical records. These costs will be passed on to the payers of the services. However, it is the applicants' contention that these costs are currently too subjective and speculative regarding their exact amounts and the timing of the expenditures to include in a forecast. In order for the impact to be minimal, significant additional savings need to be realized. This is accomplished by some of the conditions approved by the applicants and recommended in this analysis.

A major benefit of the proposed merger is enhanced physician retention; this is a service that is unlikely to be replaced by alternative methods of delivery. Also, the development of electronic medical records is a priority of the State Health Plan and, as such, should be considered to limit the consideration of any likely effective, accessible or less costly alternative technologies.

iii. COPA Criteria

Relevant criteria under the COPA law that should be discussed in this section are:

- The likely avoidance of duplication of hospital or other health care resources.

iv. COPA Analysis

The implementation of electronic medical records should reduce medical errors. It should also reduce duplicative medical testing. This will be accomplished by providing a platform for physicians to more efficiently share test results. Because of this improved information flow, physicians will be aware of results of the various tests run by other physicians, for an individual patient, and will be less likely to run additional diagnostics. Electronic medical records will also have the advantage of making the results from these tests more readily available to diagnostic staff. The applicants did not include discussions regarding the possibility that other health care resources will be better utilized or duplication avoided. Based on the fact that SMMC expects to recruit 30 physicians (13 currently and 17 additional through 2013) it is unlikely that duplication will occur for basic physician staffing. The applicants stressed that no programs would be discontinued because of this agreement. No information was presented by the applicants related

to the identification of duplicated health care resources. By becoming part of the same organization, the two hospitals, SMMC and MMC, will need to receive approval from the board for significant programmatic changes; this places the board in a position to monitor for duplicative services.

The applicants propose no changes regarding the changing of services provided. There is no evidence in the record from the applicants, interveners or comments from the public suggesting that there presently is much duplication of services between the two entities in the areas they provide services.

v. Conclusion

CON RECOMMENDATION: CONU recommends that the Commissioner find that MaineHealth and Southern Maine Medical Center have 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.

COPA RECOMMENDATION: The Commissioner should find that the definitive agreement is likely to result in the avoidance of duplication of hospital or other health care resources.

VI. State Health Plan & Educational Opportunities

A. From Applicant

i. CON From Applicant

Overview

"MaineHealth, as an applicant, and the proposed project, Webber Hospital Association d/b/a Southern Maine Medical Center becoming a subsidiary corporation of MaineHealth, are consistent with the intent, goals and objectives of Maine's 2008 – 2009 State Health Plan."

"The Governor's Office of Health Policy and Finance's Maine's 2008 – 2009 State Health Plan (pp. 78-80) declares that projects that meet more of the following attributes shall receive higher priority than projects that meet fewer of these attributes in the Certificate of Need review process."

The applicant is redirecting resources and focus toward population based health and prevention.

a. Applicant's Discussion on Priority

"The mission of MaineHealth is "Working together so our communities are the healthiest in America". We have made financial and human resource commitments to this mission which are 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 our clinical integration initiatives. In the next 15 years, the population in Maine over the age of 65 will double. Based on national studies we can expect 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. For the past 10 years, 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. Below are the MaineHealth budgets for these initiatives for FY 2008 and 2009."

	FY 2008	FY 2009
Clinical Integration	3,325,000	4,597,000
Health Status Improvement	2,736,000	3,055,000
Community Education	1,041,000	1,242,000
Total	7,102,000	8,894,000
% of MaineHealth Total Budget	32%	32%

"Beginning in FY 2006, MaineHealth began providing partial support for these initiatives through fund balance transfers from member organizations. At the time, a limit for such transfers was set at 0.4% of each organization's net assets. The actual amounts provided through this process increased from $385,000 in FY 2006 to $1,058,000 in FY 2007 and FY 2008 (representing 0.06%, 0.14% and 0.12% respectively of members' net assets)."

"MaineHealth has not asked for more than it thought could be well used and it has continued to be successful in securing other support through grants. As part of MaineHealth's recently completed strategic planning process, MaineHealth 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 over the next several years up to 1% of its net assets annually to support these initiatives. At present, 1% of member's net assets would represent a commitment of $7 million which would be added to commitments of dues revenue, investment income and grant support."

"Presented below are brief summaries of the major health status improvement and clinical integration initiatives supported by these resources. Exhibits VI-A, VI-B, VI-C, VI-D, VI-E and VI-F provide detailed descriptions of the initiatives and the outcomes they have produced to date to improve the health of communities we serve."

"MaineHealth emphasizes collaboration in developing and implementing clinical integration and health status improvement initiatives; all provider organizations are welcome to join us and

use our tools. Our approach is based on bringing together providers to design and implement evidence based approaches to the care of patients and on measuring results."

- "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."

"In addition to these established initiatives, MaineHealth has launched a new major initiative focusing on cancer. Goals for this new initiative include:

VI. State Health Plan & Educational Opportunities

- For the five most prevalent cancers, adopt evidence-based clinical care guidelines, identify quality metrics and reporting methodology, and provide a range of educational supports to promote consistent use of guidelines.
- Support each MaineHealth organization in attaining or maintaining the appropriate level of cancer care accreditation, including appropriate level of credentialing necessary for delivering care in accordance with desired accreditation (e.g. Board-certified surgeons, surgeons with sentinel node training.)
- Improve access to clinical trials.
- Improve access to genetic counseling services.
- Support the development of patient navigation and survivorship programs to improve patient access, engagement, and satisfaction.
- Improve the Network Registry to support increased access and data review for outcomes and quality metrics.
- Coordinate services regionally to provide maximum access to care (i.e. improve access to specialists.)"

"MaineHealth and its members are clearly committed to population based health and prevention and are redirecting resources to support those initiatives."

b. Maine CDC/DHHS Assessment

"MaineHealth states that it currently supports a great number of effective population-based health and prevention efforts. Beginning in 2006, it started transferring up to 0.4% of each member's net assets to population-based initiatives. The funds provided through this process increased from $385,000 in FY 2006 to $1,058,000 in FY 2007 and 2008. MaineHealth's stated plans are to increase the commitment to these initiatives up to 1% of members' net assets, which would result in an anticipated commitment of $7 million to these initiatives."

"There is no mention of any specific planned increase in support of population-based initiatives based on the granting of this application nor any mention of support of local public health infrastructure-related initiatives (such as the MAPP process and the HMPs)."

c. CONU Discussion

MaineHealth speaks to the resources that are ongoing projects but do not mention any new investments as a result of this membership. The applicants provide a budget for these ongoing initiatives in 2009 which represents 32% of MaineHealth's total budget. Their focus is on health status improvement initiatives and clinical integration incentives with a major focus on management of populations with chronic disease.

CONU may also consider partnerships between hospitals as a possible way to meet this priority, provided that the hospitals present evidence of the effectiveness of their proposed and/or extant public health efforts. MaineHealth provided considerable documentation in regards to the clinical and administrative integration of programs and the benefits to the communities they serve. It appears MaineHealth members are asked to support existing initiatives by contributing

additional funds as a percentage of their net assets towards such initiatives. Therefore, resources will be redirected in a more regionally efficient manner in order to focus resources on population based health and prevention as the priority requires.

2. The applicant has a plan to reduce non-emergent ER use.

a. Applicant's Discussion on Priority

"Long term reductions in use of emergency services are directly related to: (1) the development of initiatives to improve the health status of the population and control chronic disease: and (2) ensure there is convenient, timely and affordable access to physicians. As described above, MaineHealth has developed and is implementing across the region a broad base of health status improvement and chronic disease management initiatives, to address such conditions as asthma, diabetes, depression, congestive heart failure and obesity. Expansion of these programs into all of MaineHealth's eleven county service area is a priority and will be funded through the net asset transfer mechanism described above. MaineHealth has also implemented its CarePartners Program which provides primary care, referrals to specialists and care management to low income adults who are not eligible for state and federal programs. The program currently serves residents of Cumberland, Lincoln and Kennebec Counties and has demonstrated its ability to reduce emergency services utilization."

"SMMC's CON-approved Emergency Department project incorporates:

- An Urgent Care Center adjacent to the Emergency Department so that lower acuity patients can be served in a less intense setting,
- A Clinical Observation Unit to monitor patients with chronic conditions to avoid unnecessary inpatient admissions, and
- A dedicated Crisis Psychiatric Unit providing staff with a greater opportunity to treat patients while avoiding unnecessary inpatient admissions."

"These initiatives will improve the quality and appropriateness of the care provided and should contribute to appropriate use rates for ED services."

"SMMC has developed a detailed plan for medical staff recruitment and retention. Among the major reasons why SMMC is proposing to joint MaineHealth is to secure access to the resources necessary to implement this plan. By increasing the supply of physicians, access to care will be improved significantly. Such improvements to access should overtime reduce non-emergent use of emergency department services."

b. Maine CDC/DHHS Assessment

"There are two strategies that are mentioned as a result of this proposal and that are meant to reduce ED use:

- The applicant refers to the SMMC's new ED that is in development in which an urgent care center is part of;

VI. State Health Plan & Educational Opportunities

- There are expected MaineHealth supported medical staff recruitment and retention strategies."

"There is no mention of a specific plan to assure expanded primary care hours."

c. CONU Discussion

This application is not an ER project; therefore, this priority does not apply.

It is worth noting that SMMC recently received CON approval for a project that expanded their ED. In addition, SMMC's recent purchase of PrimeCare Physician Practice speaks to SMMC's commitment to reduce ED use.

3. The applicant demonstrates a culture of patient safety, that it has a quality improvement plan, uses evidence-based protocols, and/or has a public and/or patient safety improvement strategy for the project under consideration and for other services throughout the hospital, as well as a plan – to be specified in the application – to quantifiably track the effect of such strategies using standardized measures deemed appropriate by the Maine Quality Forum.

a. Applicant's Discussion on Priority

Commitment to Quality

"MaineHealth is committed to being recognized by patients, payors and providers as the benchmark for quality and safety, patient and family experience and evidence based use of resources. On a quarterly basis the MaineHealth board reviews quality performance measures for all member and affiliate organizations, including:

- National Quality Forum hospitals measures
- Performance of participants in the MaineHealth Vital Network (electronic ICU monitoring system)
- Home health clinical measures
- Long term care clinical measures"

"In 2007, the MaineHealth Board adopted the following 10 year vision for quality and safety:

> "In 2017 MaineHealth will be a nationally recognized leader in health care quality and safe patient and family centered care. We will achieve that status not because we seek national prominence for its sake but rather it will be founded on an unwavering system level commitment to quality and safety and continuously improving the health of the communities we serve. Achieving and sustaining excellence starts with our belief that every single patient in the communities we serve deserves the highest quality health care services that we can provide in an efficient and cost effective manner. We will communicate publicly our quality, safety and cost information to aid patients and their families in making informed choices when seeking health care services. The core of our success will be our boards and management teams focusing at all levels on quality and

safety as the critical elements driving strategic planning. Across the continuum of care our physicians, nurses, staff, patients and their families will collaborate to set high standards, monitor performance, openly share results and work together to continuously improve quality and safety"."

"In order to implement that vision, MaineHealth has established its Center for Quality and Patient Safety under the direction of Dr. Vance Brown, MaineHealth Chief Medical Officer. The Center will focus on:

- Board Engagement – All MaineHealth and member board members will complete a core curriculum in quality and safety developed by the Center. That training will enable every board member to better understand quality, safety and performance improvement and enable them to take a greater role in ensuring quality and safety in their organization.
- Education and Consultation – Center staff will provide support and expertise to member organizations in developing and implementing quality and safety initiatives. Ownership and responsibility for quality improvement and monitoring will remain at the local level.
- Performance Measurement and Reporting – Member organizations are overwhelmed at present by the number of organizations requesting quality and safety performance information. The Center will provide support for data collection, measurement and reporting allowing members to focus on actual quality and performance improvement.
- Accreditation and Regulatory Support – The Center will provide the support and expertise to ensure member organizations attain and maintain all appropriate licensure and accreditation standards.
- System Wide Performance Targets – Working with members, MaineHealth will identify system wide performance targets to ensure consistency and accountability for major clinical processes. Included in these efforts will be clinical decision support systems that facilitate the monitoring of performance."

"Please also refer to Exhibit IV-A: SMMC Patient Safety and Risk Reduction Plan"

"Please also refer to Exhibit IV-B: SMMC Organizational Quality Assessment and Improvement Plan 2008/2009"

b. Maine CDC/DHHS Assessment

"The applicant notes its new Center for Quality and Patient Safety that includes a planning and implementation process to adopt and follow a number of quality measures (including MQF and NQF measures) and to embrace a culture of quality throughout the organization, including its member organizations. A plan is included in the appendix."

c. CONU Discussion

MaineHealth has an active involvement with their members in monitoring quality performance measures. MaineHealth has established a Center for Quality and Patient Safety in order to

implement their vision of becoming "a nationally recognized leader in health care quality and safe patient and family centered care."

SMMC submitted their FY09 quality assessment and performance improvement plan which includes the following framework:

"A. Quality
1. Participates in State and National mandated quality initiatives
2. Compares SMMC quality data to state and national benchmarks as available
3. Evaluates quality data collected internally for improvement opportunities

B. Safety
1. Participates in regional / national safety culture surveys, such as the Agency for Healthcare Research and Quality (AHRQ) Culture of Safety Survey
2. Collects and evaluates safety data collected internally

C. Customer Satisfaction
1. Participates in the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS), a CMS survey of inpatient's perception of care.
2. Evaluates results of satisfaction surveys developed and administered internally."

Accordingly, the applicant has satisfied this priority.

4. The project leads to lower cost of care / increased efficiency through such approaches as collaboration, consolidation, and/or other means.

a. <u>Applicant's Discussion on Priority</u>

"SMMC, its physicians and patients will continue to benefit from collaboration with MaineHealth and its members in the following ways:

- SMMC participates in MaineHealth's VitalNetwork – the system's electronic twenty-four hour critical care patient monitoring service;
- SMMC participates in MaineHealth/MMC PACs system (electronic archiving and access to imaging studies) reducing the need for duplication of studies;
- Spring Harbor Hospital manages SMMC's inpatient and emergency psychiatric services which enhances coordination of services between the organizations and will enhance access for MaineCare, Medicare and uninsured patients;
- SMMC, Goodall Hospital and Maine Medical Center are members of Cancer Care Center of York County which provides access to radiation therapy and medical oncology services through a cooperative agreement."

VI. State Health Plan & Educational Opportunities

"SMMC, its physicians and patients will continue to benefit from participation in MaineHealth clinical integration and chronic disease management programs, and to realize savings from participation in MaineHealth supply chain purchasing.

In addition, SMMC will receive support recruiting and retaining physicians to assure local access to health care; receive more favorable access to capital to support implementing an Ambulatory Electronic Medical Record and developing medical offices; and will have access to MaineHealth administrative services including financial and internal audit services, legal services, planning services, program development, marketing and human resource management."

b. Maine CDC/DHHS Assessment

"The applicant notes that the current MaineHealth services SMMC benefits from will continue if the application is approved, including critical care monitoring services, emergency psychiatric services, cancer care, and supply chain purchasing, etc. Additionally, as a result of the application being approved, SMMC will receive physician recruitment and retention support from MaineHealth as well as access to a number of administrative functions and capital."

c. CONU Discussion

The applicant has supported this priority via the Financial Forecast Module submission lowing incremental operating costs through participating in MaineHealth's insurance programs. MaineHealth also demonstrates how SMMC will benefit from a collaboration of clinical integration and chronic disease management programs. This is demonstrated by showing that these clinical trials are not presently occurring at SMMC and involving those patients that hospital serves. Inclusion in these clinical advancements will serve to improve the access to new and innovative therapies. Accordingly, this project has satisfied this priority.

5. The project improves access to necessary services for the population.

a. Applicant's Discussion on Priority

"No change to the existing level and array of healthcare services provided by SMMC occurs as a result of SMMC becoming a member of MaineHealth. By enhancing SMMC's ability to recruit and retain physicians and invest in facilities and technology, membership in MaineHealth can mitigate what might otherwise be reduced access to care."

b. Maine CDC/DHHS Assessment

"There is anticipated to be no changes to access, though there could be a stabilization due to improved recruitment and retention services in the SMMC service area."

VI. State Health Plan & Educational Opportunities

c. CONU Discussion

The applicant states that while they are not improving current access to services, they are ensuring the continued availability of current services to the population as a result of SMMC's membership in MaineHealth. Based on the inclusion of the goals for the SMMC physician retention and recruitment plan this priority has been met.

6. The applicant has regularly met the Dirigo voluntary cost control targets.

a. Applicant's Discussion on Priority

"MaineHealth member hospitals and SMMC have responded positively to Governor Baldacci's request that they voluntarily hold the increases in their cost per adjusted discharge to the legislatively determined increase and hold their operating margins to less than 3.0%."

b. Maine CDC/DHHS Assessment

"The applicant states that MaineHealth member hospitals and SMMC have accomplished this."

c. CONU Discussion

While the applicant has stated that they have accomplished the voluntary cost control targets, there was no data provided to demonstrate this.

7. The impact of the project on regional and statewide health insurance premiums, as determined by BOI, given the benefits of the project, as determined by CONU.

a. Applicant's Discussion on Priority

"The Bureau of Insurance (BOI) and the Certificate of Need Unit (CONU) make this determination. MaineHealth and SMMC are happy to respond to any concern, issue, question or request for additional information to assist BOI and/or CONU in making this determination."

"MaineHealth and SMMC note that the proposed transfer of ownership involves no new capital expenditure or third year operating expense requiring a Certificate of Need as described in 22 M.R.S.A. § 329 (3). MaineHealth and SMMC believe that this project has no impact on regional and statewide health insurance premiums."

b. Bureau of Insurance Assessment

The Bureau of Insurance assessment received January 7, 2009 acknowledged the following: "The Bureau of Insurance applied an enhanced version of the assessment model that was previously developed internally with support from its consultant, Milliman, Inc., of Minneapolis, MN, in order to develop an estimate of the impact that this CON project is likely to have on private health insurance premiums in the Southern Maine Medical Center service area and in the

entire state of Maine. I have worked with you and your staff at the CON Unit, using data and support from the U.S Census Bureau, the Centers for Medicare & Medicaid Services, the State Planning Office, the Office of Integrated Access and Support (DHHS), the Certificate of Need Unit of the Department of Licensing and Regulatory Services, the Bureau of Insurance, and information submitted by the applicant through your agency to perform this assessment."

"I am not aware of any information describing potential adverse economic consequences of this specific acquisition on statewide or regional health insurance premiums resulting from possible increased negotiating power of the applicant or the acquired hospital vis-à-vis insurance carriers or self-insurance entities. Therefore, the methodology used in this assessment excludes consideration of such economic consequences. Should information become available which documents such economic consequences, this assessment may be subject to revision."

"The methodology compares the CON project's Year 3 incremental operating and capital costs (adjusted to the year ending June 30, 2008) to the estimated private health insurance average premium per person for that same year-ending period. Based on the information provided by the applicant, I estimate that there will be no impact on private health insurance premiums in the Southern Maine Medical Center service area for the project's third year of operation. I further estimate that this project, in its third year of operation, will have no impact on statewide private health insurance premiums."

c. CONU Discussion

Based on what is currently known from the Bureau of Insurance, this project is estimated to have no impact on regional and statewide insurance premiums.The applicants have met this priority.

8. Applicants (other than those already participating in the HealthInfoNet Pilot) who have employed or have concrete plans to employ electronic health information systems to enhance care quality and patient safety.

a. Applicant's Discussion on Priority

Ambulatory Electronic Medical Record

"In 2007, the MaineHealth Board approved a plan recommended by management to make available an ambulatory electronic medical record system to employed and independent physicians on the medical staffs of all MaineHealth member hospitals. The system is also being offered to physicians on the medical staffs of MaineHealth's affiliate hospitals. The plan calls for bringing 400 physicians (180 employed and 220 independent) at Maine Medical Center, Miles Memorial Hospital, St. Andrews Hospital, Stephens Memorial Hospital and Spring Harbor Hospital on to the system by 2010. MaineHealth is investing $10.4 million, its member hospitals $2.5 million and the independent physicians $2.7 million ($15 million total) to bring these 400 physicians on to the system. First year (FY 2008) implementation is underway at several practice sites."

VI. State Health Plan & Educational Opportunities

"Under the Definitive Agreement MaineHealth has agreed to provide financial support totaling at least $2.2 million to SMMC over a period of three years for an electronic medical record system for SMMC and its employed physicians."

Picture Archiving and Communications System

"MaineHealth has developed a PACS (imaging archiving and retrieval system) project for Maine Medical Center, Stephens Memorial Hospital, Miles Memorial Hospital, St. Andrews Hospital, St. Mary's Regional Medical Center, SMMC and 12 other sites."

Vital Network (Electronic ICU Monitoring)

"In 2005, MaineHealth began offering to Maine hospitals an electronic system for monitoring real time patients in intensive care units. The system is staffed at a central location by critical care trained/certified physicians and nurses. The Leap Frog Group has determined that electronic monitoring systems satisfy its quality/safety standard for care of ICU patients by Board Certified critical care physicians. The system provides continuous monitoring of selected patient conditions and has a video system which allows the VitalNetwork Staff to view the patients. Because of its capabilities, the system has proved to reduce ICU mortality and morbidity. MaineHealth was the first health care system in New England to implement the system, and has invested well in excess of $4 million in the project."

"Currently, the VitalNetwork is operational for all critical care beds (except neonates) at Maine Medical Center, Miles Memorial Hospital, St. Mary's Regional Medical Center, Waldo County General Hospital, Pen Bay Medical Center and Southern Maine Medical Center. Implementation is in the planning stages at MaineGeneral Medical Center, Mercy Hospital and Franklin Memorial Hospital."

HealthInfoNet

"MaineHealth has supported HealthInfoNet since its inception:

- MaineHealth leaders were active participants in developing the HealthInfoNet.
- MaineHealth has contributed $250,000 over two years to underwrite the project.
- Bill Caron and Frank McGinty MaineHealth's President and Executive Vice President have served on the Board of Directors of HealthInfoNet.
- MaineHealth acted as the guarantor for the initial eighteen-month engagement of the HealthInfoNet's Executive Director.
- MaineHealth is negotiating to make its proprietary MaineHealth information system available to HealthInfoNet and serve as a pilot site."

"OneMaine Health (MaineHealth, MaineGeneral and Eastern Maine Health) selected and funded HealthInfoNet as the data bank for medical records to share statewide patient information such as medications, allergies and health problems regardless of where care is delivered"

VI. State Health Plan & Educational Opportunities

b. Maine CDC/DHHS Assessment

"The applicant states it is agreeing to provide financial support to SMMC ($2.2 million over 3 years) to implement an EMR system for SMMC and its employed physicians. A PACS project has been developed by MaineHealth for its hospitals, including SMMC. MaineHealth states that is a supporter of HealthInfoNet, including participating in developing it and providing board membership, contributing $250,000 over two years to help underwrite the project, acting as a guarantor for the Executive Director, and making its information system as a pilot site for the initiative."

c. CONU Discussion

MaineHealth has demonstrated an active role in the implementation of the HealthInfoNet Pilot within the State of Maine. MaineHealth has committed to provide financial support to SMMC employed physicians on implementing physician electronic medical records. The applicant has satisfied this priority.

9. Projects done in consultation with a LEEDS certified-architect that incorporate "green" best practices in building construction, renovation and operation to minimize environmental impact both internally and externally.

a. Applicant's Discussion on Priority

"Does not apply."

b. Maine CDC/DHHS Assessment

"This does not apply to this application."

c. CONU Discussion

This project involves no new construction that would require CON approval. This priority does not apply.

ii. COPA From Applicant

"Currently, SMMC serves as teaching hospital for The University of New England College of Osteopathic Medicine, providing opportunities for students while enrolled at UNE. No change in the SMMC-UNE relationship will occur as a result of the Definitive Agreement. Under the Definitive Agreement, § 2.8, MaineHealth acknowledges the benefits to SMMC from the continuation of such relationship and agrees that any changes or termination of such relationship shall require the vote of the SMMC Board."

VI. State Health Plan & Educational Opportunities

"Currently, MaineHealth's Maine Medical Center is affiliated with the University Of Vermont College Of Medicine, and MMC serves as a teaching hospital for UVM medical students. More significantly, MMC also has an active postgraduate medical education program, with 207 physicians in 8 residencies and 10 fellowship programs. The residencies' programs last from 3 to 5 years. Historically, approximately 25-30% of MMC's residents have remained in Maine. In some specialties, such as psychiatry and geriatrics, approximately half of the residents of these programs at MMC have remained in Maine."

"Beginning in 2009, Maine Medical Center will inaugurate a joint degree program with Tufts University School of Medicine. The program will graduate 36 students a year – with 20 spots reserved for Maine students or those with close ties to Maine. The new program will allow Tufts medical students to spend their junior year and part of their senior year in rotation at MMC. The clinical part of this curriculum is designed to attract doctors to Maine, and will include programs to train physicians who intend to work in community hospital settings and rural areas. Students will receive a combined degree from Tufts and Maine Medical Center."

"No change in the MMC- residency and fellowship programs, the MMC-Vermont College of Medicine relationship[30] or the MMC-Tufts School of Medicine relationship will occur as a result of the implementation of the Definitive Agreement."

"As a member of MaineHealth, SMMC and its physicians will be in a position to derive benefits from these programs at MMC. SMMC will be offered the opportunity to serve as a site for rotation of students. Recruits to SMMC staff that also have academic interests will be in a position to participate with their colleagues in Tufts-MMC medical school program."

iii. COPA Criteria

- The likely continuation or establishment of needed educational programs for health care providers; and

- The extent of any likely adverse impact on the access of persons enrolled in in-state educational programs for health professions to existing or future clinical training programs.

iv. COPA Analysis

MaineHealth currently has a relationship with the University of Vermont Medical School and is instituting an additional program with Tufts University, located in Massachusetts. Much of Maine is served by community hospitals. The applicants state that there is a significant advantage when recruiting physicians if the physicians are trained locally. Therefore, the preservation of medical educational opportunities in Maine is very important. SMMC has an

[30] Maine Medical Center will end its affiliation with the University of Vermont in 2011 to make room for the Tufts University medical students.

agreement with the University of New England (UNE), with campuses located in Biddeford and in Portland, ME, to provide these opportunities.

The CONU makes the recommendation that SMMC provide notice to CONU of any changes to the agreement with UNE regarding the training of UNE students. This notice shall occur ninety days before the changes are to go into effect, or within 30 days of changing the agreement, whichever occurs earlier.

Training medical students in Maine should coincide with the SMMC medical staff development plan. Providing educational opportunities to train physicians in the State of Maine increases the likelihood that these trained physicians will take up residency and practice medicine in Maine. The Definitive Agreement will not have an adverse impact on the access of persons enrolled in in-state educational programs for health professionals, but will instead have a positive impact.

The condition suggested above will help ensure that there is no adverse impact on current agreements for educational opportunities for in-state educational programs.

v. Conclusion

CON RECOMMENDATION: CONU recommends that the Commissioner find that the project is consistent with the State Health Plan priorities.

COPA RECOMMENDATION: CONU recommends that the Commissioner find that the definitive agreement is likely to: (1) continue needed educational programs for health care providers; (2) have no adverse impact of access on persons enrolled in in-state educational programs for health professionals.

VII. Outcomes and Community Impact

A. From Applicant

i. CON From Applicant

No Impact on Other Providers

"Approval of this project does not negatively affect the quality of care delivered by other existing service providers. This project primarily involves the day-to-day operation of SMMC in its current form. There is no change to clinical services. The project should have no impact on other providers' volume of services, quality of care or costs."

Ensures High Quality Services

"SMMC has in place its ongoing structures to improve safety/reduce risk and improve the quality of care (see Section IV). No change in the commitment to those initiatives will occur with SMMC joining MaineHealth."

Improves the Health of the Community

"Through continued participation in MaineHealth's health status improvement and clinical integration initiatives (see Section VI), SMMC will be able to continue to impact positively the health of the communities it serves. A strengthened financial position should ensure its ability to do so."

No Impact on SMMC Existing Service Delivery, Management and Finances

"This project primarily involves the day-to-day operation of SMMC in its current form. There is no change to clinical services. The project should have no impact on service utilization. The current SMMC Board of Directors and Senior Management Team remain in place. As noted elsewhere in this application, SMMC finances should improve through cost reductions resulting from SMMC's access to MaineHealth's administrative integration initiatives, e.g., 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."

VII. Outcomes and Community Impact

ii. COPA From Applicant

Relevant criteria under the COPA law that should be discussed in this section are:
• The likely enhancement of the quality of care provided to citizens of the State; and • The extent of any likely adverse impact on patients or clients in the quality of health care services.

"SMMC is already a high-quality provider of health care services. SMMC has been so recognized for a number of years. Three times, SMMC has been rated in the top ten in the nation for patient satisfaction. Four times, SMMC has been rated as "best in nation" for out-patient care. Twice, SMMC employees have been named as Maine Caregiver of the Year. SMMC has been recognized as a preferred hospital with Blue Ribbon status under the Maine Employee Program. SMMC is accredited by the Joint Commission."

"SMMC's current affiliate status with MaineHealth has contributed to SMMC efforts at quality of care enhancement. As noted previously, in recent years, SMMC has participated in several MaineHealth-developed clinical protocols and programs such as VitalNetwork, the Cancer Care Center of York County, Acute Myocardial Infarction/Primary Coronary Intervention Project, AH! Asthma, Target Diabetes, Healthy Hearts, and the Healthier Weight Initiative.[31] These are all programs sponsored by MaineHealth or its affiliate Maine Medical Center in which SMMC had the option to participate by virtue of its affiliation arrangement with MaineHealth. As a result of the Definitive Agreement, and SMMC's accession to the full membership status within MaineHealth, SMMC's participation in these and, as importantly, future programs, is assured."

"In addition to the benefits deriving from membership, the quality enhancement efforts of SMMC and its medical staff will benefit immediately from MaineHealth's commitment of at least $2.2 million for the deployment of an electronic medical record system. This is an example of the kind of support of quality enhancements that MaineHealth makes possible for its members."

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[31] The MaineHealth VitalNetwork is an electronic intensive care unit (e-ICU) that monitors vital signs and other information for patients. The command center is staffed, 20 hours per day, by physicians and nurses who have special training in critical care and computer access to the latest medical knowledge. The system can warn attending caregivers about concerning changes in the patient's condition, and as needed provides directive for changes in care.

The Cancer Care Center of York County provides comprehensive, state-of-the-art cancer treatment in a new facility equipped with advanced technologies. The center is a collaboration of Maine Medical Center, SMMC, and Goodall Hospital, staffed by radiation oncologists from Spectrum Medical Group and medical oncologists from the Maine Center for Cancer Medicine.

These and the other identified initiatives are described above in Section III (B) re "Financial Impact."

VII. Outcomes and Community Impact

"Electronic medical records have been cited as a key strategy for the prevention of medical errors and associated morbidity and mortality. According to the analysis reported in a June 2003 edition of the New England Journal of Medicine,[32]

> Information technology can reduce the rate of errors in three ways: by preventing errors and adverse events, by facilitating a more rapid response after an adverse event has occurred, and by tracking and providing feedback about adverse events. Data now show that information technology can reduce the frequency of errors of different types and probably the frequency of associated adverse events. The main classes of strategies for preventing errors and adverse events include tools that can improve communication, make knowledge more readily accessible, require key pieces of information (such as the dose of a drug), assist with calculations, perform checks in real time, assist with monitoring, and provide decision support."

"The same point was echoed more recently in a study of communication problems among health care providers associated with the discharge of a patient from a hospital. As reported in the February 28, 2007 edition of the journal of the American Medical Association,

> Deficits in communication and information transfer between hospital-based physicians and primary care physicians are substantial and ubiquitous. The traditional methods of completing and delivering discharge summaries are suboptimal for communicating timely, accurate, and medically important patient data to the physicians who will be responsible for follow-up care. Urgent improvements are needed in the processes and formats used for transferring information to primary care physicians at hospital discharge."
> * * *
> "Research is beginning to show that poor information transfer and discontinuity are associated with lower quality of care on follow-up, as well as adverse clinical outcomes. Moore et al found that errors related to discontinuity of care occurred for about 50% of patients and that lapses in communication related to diagnostic evaluations were associated with a significantly higher risk of readmission. Van Walraven et al demonstrated a trend toward greater risk of readmission among patients who were treated in follow-up by a physician who had not received a discharge summary. Conversely, in a population-based cohort study in Canada, patients following up with the same physician who provided inpatient care had a 5% decrease in the relative risk of death or readmission. Other studies have highlighted concerns about potential adverse events related to discontinuity, including a report by Roy et al, which showed that about 40% of patients have test results that return after hospital discharge and that physicians are commonly unaware of these results, even though about 10% of them require some action."

[32] David W. Bates, M.D., and Atul A. Gawande, M.D., M.P.H, Improving Safety with Information Technology, Volume 348:2526-2534 (June 19, 2003).

> "According to the results of this review, we suggest several steps to improve communication between inpatient and outpatient physicians at hospital discharge. The delivery and perhaps quality of discharge summaries can be improved substantially through health information technology. Such technology offers the potential to quickly extract information about diagnoses, medications, and test results into a structured discharge document that can be reviewed for accuracy by the hospital physician and augmented with specific instructions to outpatient physicians about pending test results and other follow-up needs. An electronic medical record can ensure integrity and speed in the data capture process. It could be configured to deliver information through fax or e-mail to designated outpatient physicians on the day of discharge, or outpatient physicians could be allowed to access the information on their own.[33]"

"The full deployment of electronic medical records had been identified as a national health priority in an Executive Office announcement of April 26, 2004.[34]"

"The Robert Wood Johnson Foundation, a recognized leader in health care policy development, noting a consensus view that electronification of health information will produce improvements in outcome quality, recognized that the slow pace of dissemination of the technology was a matter of concern:

> Health information technology (HIT) has the potential to advance health care quality by helping patients with acute and chronic conditions receive recommended care, diminishing disparities in treatment and reducing medical errors. Nevertheless, HIT dissemination has not occurred rapidly, due in part to the high costs of electronic health record (EHR) systems for providers of care—including the upfront capital investment, ongoing maintenance and short-term productivity loss. Also, many observers are concerned that, if HIT follows patterns observed with other new medical technologies, HIT and EHRs may diffuse in ways that systematically disadvantage vulnerable patient populations, thus increasing or maintaining existing disparities in access to and quality of care. These and other concerns have led to public and private efforts that aim to increase the pace of and reduce disparities in HIT diffusion by formulating national plans for dissemination, catalyzing the development of standards to encourage interoperability and promoting public-private partnerships to develop HIT infrastructures at the local and regional levels.[35]"

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[33] Sunil Kripalani, MD, MSc; Frank LeFevre, MD; Christopher O. Phillips, MD, MPH; Mark V. Williams, MD; Preetha Basaviah, MD; David W. Baker, MD, MPH, Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians, JAMA, 2007;297:831-841.

[34] http://www.whitehouse.gov/infocus/technology/economic_policy200404/chap3.html

[35] Blumenthal D, DesRoches C, Donelan K, et al. Health information Technology in the United States: the Information Base for Progress. Princeton, NJ: Robert Wood Johnson Foundation, 2006, p 1:2.

VII. Outcomes and Community Impact

"Maine's 2008-2009 State Health Plan embraces this view. The Plan noted that "Electronic health records have long been identified as a successful strategy to improve patient care, lower the risk for medical error, and achieve efficiencies,"[36] and observed that the dissemination of such technology is "critical" to the achievement of a patient-centered medical home model of care.[37]"

" The barrier to wholesale deployment in physicians' offices is primarily financial – the upfront investment and training cost, balanced unfavorably against the perception that the investment does not yield financial returns:

> Financial barriers have a significant influence on HIT [Health Information Technology] adoption. These barriers can be best understood as "twins:" the high cost of HIT systems; and provider uncertainty regarding the value they will derive from adoption in the form of return on investment. [cit. om.] Stated another way, many providers do not perceive that there is a business case for HIT acquisition and use. They argue that the absence of a business case stems from a form of market failure within the HIT sector: current dysfunctional market dynamics and incentive structures do not work efficiently and effectively to realize the societal benefits of HIT. * * * [E]conomic incentives in the health care industry generally do not reward good performance, reducing the motivation of self-interested health care actors to acquire HIT and compete more effectively. Often, health care compensation arrangements reward poor performance. Inefficient and sub-optimal care, for example, can generate more visits, tests and procedures and thus more revenue for providers. At a minimum, this reduces incentives for physicians and others to invest in systems to improve performance. [38]"

"The commitment of MaineHealth to provide at least $2.2 million to SMMC staff physicians for the implementation of electronic medical records addresses this barrier head on."

"In addition to these direct quality enhancement measures, the assistance that MaineHealth will provide to SMMC in its medical staff development will also facilitate the achievement of quality enhancements. The Applicants believe that timely and ready access to health care often is a critical element of quality of care. This view is in accord with the State Health Plan, which noted the significant role of chronic disease in contributing to health care costs, and the importance of a timely attention to the management of chronic conditions by primary care providers in the treatment of chronic disease.[39] To the extent that the implementation of the Definitive

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[36] Governor's Office of Health Policy & Finance, Maine's 2008-2009 Health Plan (April 2008), pp. 64-65.
[37] Id., at 65.
[38] Blumenthal D, *et al., supra,* pp 5:43-44. Maine's 2008-2009 Health Plan, *supra,* noted "that only about 15% of physician practices" use electronic medical records, and the cost was one of the barriers to more extensive deployment . Id. at 64.
[39] Governor's Office of Health Policy & Finance, Maine's 2008-2009 Health Plan (April 2008), p. 39.

> Nationwide, 45% of the population has a chronic illness, and half of these people have more than one. The incidence of chronic disease is higher in older people;

VII. Outcomes and Community Impact

Agreement preserves and enhances timely access to health care for patients in York County to health care providers, as described in Section IV ("Public Need") above, it preserves and enhances the quality of care."

B. CONU Discussion

i. CON Criteria

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

ii. CON Analysis

As this application involves the membership of SMMC into MaineHealth, it does not involve the addition of a new health services or the expansion of an existing service. However, as mentioned above, with the approval of SMMC membership into MaineHealth and its health status improvement, clinical integration and quality improvement initiatives and programs the outcomes are predicted to improve over time. SMMC was asked at the Public Informational Meeting about referral and transfer agreements. The applicant responded that they currently have in place multiple agreements and they are not expecting to change as a result of their membership into MaineHealth.

CONU received no comments of opposition from other providers. CONU concludes that the project does not negatively affect the quality of care delivered by existing service providers.

iii. COPA Criteria

- The likely enhancement of the quality of care provided to citizens of the State; and

- The extent of any likely adverse impact on patients or clients in the quality of health care services.

83% of Medicare beneficiaries have one or more chronic conditions; 23% have five or more. Complications of chronic disease account for a large portion of hospital admissions and emergency room use. Many of the episodes causing these services are felt to be avoidable; that is, they could have been prevented with more adequate primary care.

However, primary care practices have been hampered by increasing clinical and administrative demands and by declining compensation relative to other specialties. As a result, fewer medical school graduates are entering primary care fields. A reimbursement system that values the essential role of primary care physicians in preventive care is one means of addressing this shortage of primary care physicians.

iv. COPA Analysis

The applicants have asserted that the implementation of the Definitive Agreement will likely lead to enhancements in the quality of care for residents in SMMC's service area who obtain services from SMMC. They believe that the quality of care will be enhanced through the successful retention and recruitment of primary care physicians as employees of SMMC or its affiliates, who will then be able to provide more timely care to residents in the service area; and through the programs to encourage non-emergent ambulatory care in a non-hospital setting. The quality of care provided to patients may improve because of additional doctors. Additionally, the pool of patients who reside in the area who are not SMMC patients may receive better care. The Department does not see any likely adverse impact on patients or clients in the quality of health care services.

Additionally, care will be improved by the deployment of electronic medical record systems that should reduce medical errors and duplicative medical testing. Quality of care will improve by SMMC participating in MaineHealth's clinical integration programs. The State Health Plan includes a priority that is directly related to this and therefore the expansion of electronic medical records is in itself considered an improvement in outcomes.

The applicants and the interveners have approved the following conditions which will serve to define the commitment of the parties to reduce utilization demands. It is recommended that the commissioner include these conditions.

Ambulatory Electronic Medical Record System Deployment

Commitment: Consistent with the objectives of Maine's 2008-2009 State Health Plan (April 2008), which identifies the deployment and use of electronic medical record systems as a state health policy objective, MaineHealth will provide financial support of at least $2.2 million for the deployment and integration of ambulatory electronic medical record systems for use by employed and non-employed members of SMMC's medical staff during the 6 years following the date upon which SMMC becomes a member of MaineHealth. This amount will not be recovered by MaineHealth or Southern Maine Medical Center as charges from patients or payers.

Target: Within 48 months following the date upon which SMMC becomes a member of MaineHealth, MaineHealth and SMMC will have at least fifty (50) physician members of the SMMC medical staff using ambulatory electronic medical records.

Report: At 48 months following the date upon which SMMC becomes a member of MaineHealth, MaineHealth and SMMC will submit a report to the Department describing the level of electronic medical record system deployment achieved, and the plan for achieving the targeted level, if not yet achieved. The failure to achieve the targeted deployment within 48 months, if not substantially justified, may be

treated as an "unanticipated circumstance" within the meaning of 22 M.R.S.A. §1845(3)(b). In order to help ensure that quality care continues and the agreement assists in reaching these goals the applicants agree to the following condition.

Quality Improvements

Commitment: During the 6 years following the date upon which SMMC becomes a member of MaineHealth, SMMC will continue its current level of participation in MaineHealth-sponsored clinical integration programs (identified in its October 24, 2008 Joint Application for a Certificate of Need and Certificate of Public Advantage, pp. 55-56), and SMMC will participate in any new clinical integration programs hereafter established by MaineHealth for all of its hospital members. SMMC will publish the results of its participation in such programs in the same manner and to the same extent as other hospital members of the MaineHealth system.

Report and Plan: At 24, 48 and 66 months following the date upon which SMMC becomes a member of MaineHealth, MaineHealth and SMMC will report to the Department on the extent of SMMC's participation in MaineHealth's clinical integration programs, and any gains in quality achieved by SMMC during the period covered by the report.

iii. Conclusion

CON RECOMMENDATION: CONU recommends that the Commissioner find that Southern Maine Medical Center and MaineHealth have 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.

COPA RECOMMENDATION: CONU recommends that the Commissioner find that the definitive agreement is likely to: (1) result in the enhancement of the quality of care provided to the citizens of the State; and (2) the extent of any likely adverse impact on patients or clients and the quality of healthcare services is limited by the condition approved by the applicants and the interveners and recommended for inclusion.

VIII. Service Utilization

A. From Applicant

i. CON From Applicant

Service Utilization

"SMMC joining MaineHealth will have no adverse impact on the utilization of services by residents of its service area. Participation in MaineHealth's health status improvement, clinical integration and quality improvement initiatives should over time positively impact utilization."

ii. COPA From Applicant

Relevant criteria under the COPA law that should be discussed in this section are:

- The likely improvements in the utilization of hospital or other health care resources and equipment.

"As noted in Sections IV and VI, the Definitive Agreement is intended to facilitate, among other things, SMMC's achievement of its medical staff development plan, and the dissemination of electronic medical information technologies. Attracting and retaining needed physicians, and compensating such physicians in a manner that does not depend on the patient's payor, will reduce pressure for the hospital's emergency department to serve as a first call option for the delivery of primary care to the underinsured and MaineCare-insured. The deployment of electronic medical information should reduce duplicative testing that can arise when previous test results were either unknown or inaccessible."[40]

B. CONU Discussion

i. CON Criteria

Relevant criterion 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.

[40] According to the American Electronic Association's newsletter AeA Competitiveness Series, Vol. 13 (December 2006) the annual savings to be garnered nationally by electronic medical records from increased efficiencies and reduced duplication of procedures is $77 billion.

ii. Maine Quality Forum Analysis

Comments received by the MQF on December 12, 2008:

"The applicants are applying for certificate of need to allow Southern Maine Medical Center to become a subsidiary corporation of MaineHealth. The CON application includes a combined application for a Certificate of Public Advantage under Maine's Hospital and Healthcare Provider Act."

"This CON application is not an application for approval of a project requiring new technology; it is submitted because of the change of ownership involved. Neither this application nor the accompanying application for Certificate of Public Advantage (COPA) requires Maine Quality Forum review. However, these comments are submitted because of the health care quality implications of the project."

"The advantages to Southern Maine Medical Center (SMMC) of joining MaineHealth include continued and possibly increased participation in MaineHealth-sponsored clinical integration, health status improvement, and quality improvement initiatives; opportunities to share administrative services; access to capital for health information technology and electronic medical records for owned and affiliated practices; and access to capital for expansion of ambulatory care space. Additional rationale cited includes "achievement of clinical…benefits from economies of scale" and "avoidance of duplication of services and improving efficiency, access, and quality" (p.14) and the possibility that recruitment of medical staff will be facilitated by this relationship. The application also states that the parties understand that "SMMC will continue to provide, in York County, at least those core services which are appropriate to a community health care system."

"Clinical services quality at SMMC is good. Data submitted to the Maine Health Data Organization for the Maine Quality Forum indicate that SMMC performs in the top 10% of Maine hospitals on 10% of these indicators and is an average performer in 90% (http://207.103.203.51/summary/summary.aspx?ProvID=200019&level=0&CompGroup=All). The documents supplied in the application reflect a commitment to quality and quality improvement throughout the organization. The energy, commitment, and record displayed by MaineHealth in the areas of clinical integration, quality improvement, and advancement of the care model are amply demonstrated as well. There is evidence that integrated care systems provide care that is high value, delivering high quality services at low cost. The integration of SMMC into the MaineHealth system should allow SMMC to completely avail itself of the quality resources of MaineHealth."

"A drawback to the application is that it does not fully explain what future array of services at SMMC it contemplates are and what services, because of complexity, expense, or risk, are not contemplated for SMMC but would be offered at Maine Medical Center, which is 18 miles distant. These include services that are already offered at SMMC, including advanced imaging, cardiac catheterization, major joint replacement, or inpatient pediatrics. For example, instead of

recruiting orthopedic surgeons partly for the purpose of continuing the joint replacement program at SMMC, would not a fully integrated system find economies (and possibly enhanced quality and safety) in concentrating these elective procedures in a single nearby center? Both the Hospital and Health Care Provider Cooperation Act and the CON rules (and the State Health Plan) emphasize minimization of duplication in resources and efficient use of facilities. There may be other areas in which system integration can lead to better deployment of resources, now or in the future. A statement of how the organizations view what are described as "core services which are appropriate to a community health care system" and how they envision allocating these services in the future would have strengthened both applications."

iii. CON Analysis

This application involves the membership of SMMC into MaineHealth. It does not involve the addition of new health services or the expansion of existing service. As mentioned above, the approval of SMMC membership into MaineHealth combined with its health status improvement, clinical integration and quality improvement initiatives and programs will not create an inappropriate increase in service utilization and is expected to have a positive impact on patient care.

CONU is concerned with the comments of Maine Quality Forum as to the lack of specificity of the application regarding the necessary services to be continued at SMMC and MMC and the expected need to run separate programs. Discussions related to additional coordination would be beneficial to ensuring reduced concerns resulting from utilization of services. It is expected that since the budgets and operations of both hospitals will be reviewed by the same board that when the need arises to reduce or reconfigure services that the combined entities will make more efficient operations.

iv. COPA Criteria

- The likely improvements in the utilization of hospital or other health care resources and equipment.

v. COPA Analysis

The implementation of electronic medical records will reduce utilization by eliminating duplicative testing. By providing physicians an electronic platform, they will be more likely to share results of tests. Results of these tests will be communicated to diagnostic staff more timely because of integrated electronic medical records.

Additionally, further improvements in the utilization of hospital resources and equipment may occur. Through the execution of SMMC's medical staff development plan, and recruitment of employed primary care physicians, SMMC could combine equipment resources in a more effective manner.

VIII. Service Utilization

The additional physicians to be employed will permit SMMC to develop programs to redirect non-acute ER visits from the SMMC emergency department to more cost-effective sites of care by providing more people with primary care physicians.

In order to provide additional assurance that clinical efficiencies are reached, the applicants agree to the following condition. The commissioner should agree to the following condition.

Clinical Efficiencies

Report and Plan: At 24 months following the date upon which SMMC becomes a member of MaineHealth, MaineHealth and SMMC will report to the Department the results of their efforts to date to identify any unnecessary redundancies in current clinical services, and describe any measures deployed to reduce or avoid such redundancies in future clinical services. The report will propose, as appropriate, a plan for pursuing additional clinical efficiencies within 48 months following the date upon which SMMC becomes a member of MaineHealth, and benchmarks by which to measure the success of such a plan. The Department may thereafter modify the conditions of the certificate to incorporate the plan proposed.

Follow-up Reporting: At 48 months and 66 months following the date upon which SMMC becomes a member of MaineHealth, MaineHealth and SMMC will report to the Department the extent to which benchmarks identified in the plan have been achieved. The failure to achieve the additional benchmarks starting with 48 months following the date upon which SMMC becomes a member of MaineHealth, if not substantially justified, may be treated as an "unanticipated circumstance" within the meaning of 22 M.R.S.A. §1845(3)(b).

vi. Conclusion

CON RECOMMENDATION: The CONU recommends that the Commissioner find that the applicants have 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.

COPA RECOMMENDATION: The CONU recommends that the Commissioner find that the definitive agreement is likely to result in improvements in the utilization of hospital or other healthcare resources and equipment by including the condition approved by the applicants and the interveners and recommended for inclusion.

IX. Funding in Capital Investment Fund

A. From Applicant

i. CON From Applicant

"MaineHealth and SMMC note that there is no new capital expenditure requiring a Certificate of Need as described in 22 M.R.S.A. § 329 (3) involved in making SMMC a subsidiary corporation of MaineHealth (Membership)."

"There are no incremental new third year operating costs associated with this project."

"The project does not involve a debit against the amount credited to the Capital Investment Fund for the current annual effective period."

B. CONU Discussion

i. CON Criteria

Relevant criteria for inclusion in this section are related to the needed determination that the project can be funded within the Capital Investment Fund.

ii. CON Analysis

The financial forecast module completed by the applicants shows no additional third year incremental operating costs. There are no qualifying additional costs to the healthcare system as a result of SMMC's membership in MaineHealth.

iii. COPA Criteria

This section does not apply to a Certificate of Public Advantage.

iv. Conclusion

CON RECOMMENDATION: CONU has determined that there are no incremental operating costs to the healthcare system there and will be no Capital Investment Fund (CIF) dollars needed to implement this application.

COPA RECOMMENDATION: No COPA determination is required for this criterion.

X. Less Restrictive Alternatives

A. From Applicant

i. CON From Applicant

This section does not apply to a Certificate of Need. The applicant was not required to comment on this section.

ii. COPA From Applicant

Relevant criteria under the COPA law that should be discussed in this section are:

- The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.

"The Applicants believe there are no practicable alternative arrangements that would be less restrictive of competition and yield a higher level of net benefit."

"For the reasons noted above, there will be no substantial diminishment of competition between MMC and SMMC for the simple reason that there is no substantial competition between the two institutions at present. The benefits that drive the Definitive Agreement – strengthening of SMMC's ability to continue to provide services at current levels and to retain its physician base – derive from membership in the MaineHealth system and access to its capital resources."

"SMMC's board and management concluded after studies that lasted over a year that membership in MaineHealth offered the best opportunity for the optimal balance of continued significant local control over health care decisions and access to the resources, technical and financial, to a larger healthcare system. Affiliate status within MaineHealth will not allow SMMC to access the capital, planning and management resources available to members of MaineHealth, and which SMMC has determined that it will need in order to maintain and improve the quality of its service offerings in the near and medium term."

B. CONU Discussion

i. CON Criteria

This section is not relative for a Certificate of Need. No analysis is required.

X. Less Restrictive Alternatives

ii. COPA Criteria

- The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.

iii. COPA Analysis

There has been no information provided by the public or the applicants that would indicate there are any less restrictive alternatives.

Although SMMC continuing on its own was not considered as an alternative, typically applicants explain why they can not maintain the status quo. When comparing generated revenues to the expenses contemplated in its retention program, electronic medical record and medical office building development programs, it appears unlikely that the modest net revenues of SMMC would allow them to reach their stated goals if they continued independently. While SMMC's current operations generate more revenue than expenses, the hospital cannot be currently described as a high performing hospital and has considerably fewer resources than MaineHealth has available. Administrative costs are higher on a percentage basis than Maine Medical Center. The applicants have provided for conditions to the certificate of public advantage that should ensure that administrative costs as a percentage of revenue are reduced at SMMC. SMMC would not be expected to achieve these operational savings while operating independently.

Short of MaineHealth changing its policies regarding affiliation and membership, it seems unlikely that any less restrictive alternatives exist. Other alternatives include the possibilities of membership with out-of-state hospital groups; however, that would most likely entail ending the long standing affiliation agreement of sustained coordination that has occurred at the affiliate level with MaineHealth. The risk of increasing competition at the local level would therefore be greater if any real opportunities existed regarding out-of-state affiliations. The President of SMMC, at the public hearing, stated that these discussions were not well developed because of the lack of interest in out-of-state affiliations by the out-of-state providers.

The Attorney General and the Governor's Office of Health Policy and Finance have supported the implementation of the Definitive Agreement with the specified conditions that have been approved by the applicants. This agreement, it is argued by the applicants, can be considered corroboration that there are no arrangements less restrictive of competition that would likely achieve a more favorable balance of benefits. The agreement to the arrangement indicates that the Attorney General's and the Governor's Office of Health Policy and Finance's position is that they agree to the agreement with the proposed conditions. Interveners have no obligations to make their agreements based on the criteria necessary for approval by the Commissioner. It is certainly true that there are no existing alternative arrangements that the parties have agreed to, that would achieve nearly the same benefits.

The applicant submits that the record contains no evidence that there will be any disadvantages attributable to any reduction of competition likely to result from the implementation of the

X. Less Restrictive Alternatives

Definitive Agreement. The Department notes that there is nothing in the record that indicates the existence of alternative arrangements that would provide a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.

iv. Conclusion

CON RECOMMENDATION: No CON determination is needed for this criterion.

COPA RECOMMENDATION: CONU recommends that the Commissioner find that there are no arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.

XI. Likely Benefits v. Likely Disadvantages

A. From Applicant

i. CON From Applicant

This section does not apply to a Certificate of Need. The applicant was not required to comment on this section.

ii. COPA From Applicant

Relevant criteria under the COPA law that should be discussed in this section are:

- Please discuss how the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition likely to result from the agreement.

"The benefits to SMMC have been outlined in Sections IV and VI above. The Definitive Agreement will accelerate the deployment of electronic medical records among SMMC-affiliated physicians and enhance SMMC's prospects for success in recruiting and retaining physicians to address the demand for hospital and medical services in its service area. It will expand access to physicians for those in the SMMC service area who are uninsured or underinsured. It will result in greater access to non-reimbursable community health initiatives, not currently available in the SMMC service area. It will increase efficiencies through the sharing of administrative and support resources. It will provide SMMC with access to lower-cost capital, and solidify SMMC role as a key member of a region-wide integrated health care system."

"For the reasons described in Section III, there are few, if any, disadvantages resulting from any reduction in competition to be weighed against these advantages. This is because SMMC and MaineHealth's member hospitals generally do not actively compete against each other for patient patronage. To the contrary, MaineHealth has actively assisted SMMC in its status as an affiliate since 1997 in the development and enhancement of health program initiatives and services, and extended to SMMC the benefits of cost savings from group purchasing."

"Accordingly, the Applicants request that the Department determine that in the aggregate the likely benefits from the enclosed Definitive Agreement outweigh any disadvantages attributable to any reduction in competition likely to result from the Definitive Agreement."

"The COPA Act contemplates that there will be periodic reporting by the certificate holders and supervisory governmental review of a cooperative arrangement, and in the case of transactions falling into the category of mergers, that the review will take place between 12 and 30 months after the implementation of the cooperative agreement. The Applicants also propose that the

Certificate of Public Advantage expire after 6 years, unless the Applicants seek and DHHS then approves an extension of the certificate."

B. CONU Discussion

i. CON Criteria

This section is not relevant for a Certificate of Need. No analysis is required.

ii. COPA Criteria

- The Commissioner shall issue a certificate of public advantage for a cooperative agreement if it determines that the applicants have demonstrated by a preponderance of the evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition likely to result from the agreement.

iii. COPA Analysis

Consideration of other information and discussion of other agreed upon conditions

In a follow-up letter, December 16, 2008, counsel for the applicants stated "There is no evidence in the record of any disadvantages attributable to a reduction in competition that likely would occur from the implementation of the Definitive Agreement." CONU agrees that there is no information provided by the applicants or third parties regarding specific claims of harm if the agreement is implemented.

The main concern for the Department is the potential harm to patients from the agreement. In the economic conditions present in the nation today, considerable economic retrenching is occurring. For-profit businesses are determining that entire segments of their operations are unwieldy and inefficient and wholesale closures of outlets are occurring. Direct comparisons of non-profit hospitals with commercial businesses can present limitations; however, hospital systems need to make reasonable returns in order to provide services. The long-term continuation of clinical programs that are ineffective, marginalized or costly is not sustainable. Based on today's economic climate, it is understandable that SMMC is motivated to become a member of MaineHealth.

Supervisory conditions

The applicants have agreed to incorporate three additional considerations into the COPA. The applicants have agreed to incorporate these as supervisory conditions. These three conditions reduce concerns regarding the likelihood of harm occurring to individuals through the approval of this agreement; therefore, it is recommended that the Commissioner include the following:

XI. Likely Benefits v. Likely Disadvantages

Report: Any report submitted by MaineHealth or SMMC under the terms of this Agreement on Conditions shall be simultaneously provided to the Attorney General and the Governor's Office of Health Policy & Finance.

Review: Supervisory review by the Department will occur at 27 months and at 54 months following the date upon which SMMC becomes a member of MaineHealth. The Department may conduct additional supervisory reviews as necessary in response to reports filed by the applicants in accordance with these conditions.

Term: The certificate will expire in 6 years.

In a certificate of public advantage, the Department may include a condition requiring the certificate holders to submit fees sufficient to fund expenses for consultants or experts necessary for the continuing supervision required under section 1845. These fees must be paid at the time of any review conducted under the agreement. Therefore it is recommended that the commissioner include the following condition: Upon providing the required review materials to the Department, at 27 and 54 months following the date of when SMMC becomes a member of MaineHealth, an amount of $5,000 should be submitted by the applicant to be used by the Department to fund expenses for consultants or experts necessary for the continuing supervision of the agreement.

CONU finds that the conditions submitted for approval by agreement of the applicants and the Attorney General and the Governor's Office of Health Policy and Finance and Policy as well as the "four" conditions included by CONU are reasonably enforceable subject to the future measurement or evaluation of the order to assess compliance with those conditions

Benefits of the agreement

Consideration of the standards for approval indicates that, by a preponderance of the evidence, the benefits outweigh the disadvantages. The following 14 benefits have been accepted by the Department.

- *Continuation of Independent Boards*
  As part of this agreement the two separate boards will continue to operate independently. At least 80% of the individuals elected to the SMMC Board must be residents of York County. This serves to not limit competition by providing for independent counsel for the two organizations.

- *Reduction of Financial Risk*
  With the addition of the agreed upon conditions and reporting, financial risks are minimized and substantial benefits may be realized. SMMC purchased a physicians group for the assumption of $15 million of liabilities.

- *Administrative Savings*
  The agreement anticipates savings of $5 million in administrative costs over the first six

years.

- *Access to Funding Resources*
  The agreement will provide SMMC the opportunity to access financial resources to execute its current plans for the deployment of electronic medical records equal to $2.2 million over three years. Additionally, the agreement calls for MaineHealth to provide up to 100% of the debt financing to cover the direct costs of up to four medical office buildings.

- *Changes to Provided Services*
  No changes to the existing level and array of health care services provided by SMMC can occur unless it is initiated by SMMC and approved by MaineHealth.

- *Physician Retention and Recruitment*
  Because of the agreement, SMMC will be better able to implement its physician retention and recruitment plan.

- *Access to Primary Care for MaineCare and Underinsured Patients*
  By increasing its employed physicians, SMMC will provide access to care to all MaineCare and underinsured patients by requiring all employed physicians to accept patients without regard to the patients' ability to pay.

- *Reduction in Emergency Department Use*
  By increasing its employed primary care physicians, SMMC will be able to implement a program utilizing the available capacity to offer follow up appointments with primary care physicians for patients who lack a regular primary care provider. This is projected to reduce emergency department use for chronic conditions.

- *Development of Electronic Medical Records*
  The agreement will allow faster implementation of electronic medical records for employed SMMC physicians.

- *Avoidance of Duplication of Limited Health Care Resources*
  The deployment of electronic medical records will allow for faster reporting of laboratory results and diagnostic tests.

- *Reduction of Medical Errors*
  Implementation of electronic medical records should reduce medical errors.

- *Continuation of Needed Educational Programs for Health Care Providers*
  The State's interest to continue educational opportunities is protected by the additional reporting requirements.

XI. Likely Benefits v. Likely Disadvantages

- *Enhancement of Quality of Care*
  The implementation of an electronic medical records system should enhance the quality of care.

- *Improvements in Utilization of Hospital Resources and Equipment*
  Implementation of electronic medical record system should reduce utilization by eliminating duplicative testing.

The following two disadvantages of the agreement have been identified:

- *Impact on Other Service Area Providers*
  Membership in MaineHealth and the savings suggested in this application may present difficulties for other health care providers in the immediate area that provide similar or new levels of benefits for their cadre of doctors.

- *Reduction of Private Practice Physician's*
  Private practice physician groups may be at a competitive disadvantage due to the support of SMMC's recruiting efforts by MaineHealth.

Following the public hearing, the Applicants engaged in negotiations with both the Department of the Attorney General and the Governor's Office of Health Policy and Finance. Conditions were agreed to by the applicants and those interveners. It is recommended that the Commissioner accept the 11 agreed upon conditions for the reasons previously stated. In addition, CONU recommends including the following three conditions as they are necessary to ameliorate any likely disadvantages. These conditions are:

1. Reporting of free care -
   Reporting of free care will demonstrate the commitment to provide continued access to services to patients regardless of ability to pay.

2. Submitting all tax returns for all entities under the control of MaineHealth -
   Submitting tax returns will show the commitment to the benchmarks agreed upon by the applicants. It will also ensure the department has necessary financial information to monitor the results of this agreement.

3. Reporting any changes to the agreement with UNE regarding training of medical students -
   Reporting these changes will allow the department to monitor the applicants' commitment to continue educational opportunities.

Likely Advantages vs. Disadvantages

The prior discussion demonstrates that there are significantly more advantages than disadvantages as a result of this proposal. The agreed upon conditions, as well as additional conditions proposed by CONU, contribute to the recommendation to the Commissioner that by a

preponderance of the evidence, the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition likely to result from the agreement.

The Attorney General and the Governor's Office of Health Policy and Finance have concluded that with the incorporation into a Certificate of Public Advantage the provisions set forth in the Agreement on Conditions, the likely benefits resulting from the membership of SMMC in MaineHealth would outweigh any disadvantages.

The opportunity existed for individuals, suppliers and payers of these hospitals to express their concern regarding the implementation of this agreement. No concerns were expressed; therefore, the record contains no evidence that there will be any disadvantages attributable to any reduction of competition likely to result from the implementation of the Definitive Agreement. Also, the record contains no evidence that managed care payers have sought to negotiate favorable terms from SMMC based on a threat to provide an incentive to patients and their physicians to patronize MMC rather than SMMC. Further, there is no evidence that the implementation of the Definitive Agreement will likely have any adverse impact on any competition with any other hospital that competes with SMMC or MMC. No evidence was provided to show that the implementation of the Definitive Agreement will likely have any adverse impact on any competition among persons furnishing goods or services to hospitals.

The conditions set forth in the Agreement on Conditions, and incorporated into this Certificate, are the product of negotiations between the Department of Attorney General, the Governor's Office of Health Policy and Finance and the Applicants. The Attorney General and the Governor's Office have supported the implementation of the Definitive Agreement with the specified conditions that have been approved by the applicant.

iv. Conclusion

CON RECOMMENDATION: No CON recommendation is required for this criterion.

COPA RECOMMENDATION: CONU recommends that the Commissioner find that the applicants have demonstrated, by a preponderance of the evidence, that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition likely to result from the agreement.

XII. Timely Notice

A. From Applicant

The Applicant did not provide any information regarding this section.

B. CONU Discussion

Letter of Intent filed:	July 11, 2008
Technical Assistance meeting held:	July 31, 2008
CON application filed:	October 24, 2008
CON certified as complete:	October 24, 2008
Public Information Meeting Held:	November 17, 2008
Public Hearing held:	November 17, 2008
Public comment period ended:	December 17, 2008

C. COPA Discussion

Letter of Intent filed:	May 21, 2008
COPA application filed:	October 24, 2008
COPA application included signed copy of Definitive Agreement:	October 24, 2008
Notice of Public Hearing published:	October 31, 2008
Additional notice by mail to persons requesting notification:	October 31, 2008
Attorney General and Governor's Office of Health Policy and Finance notified and copies of application and agreement provided:	October 31, 2008
Public Hearing held:	November 17, 2008
Public comment period ended:	December 17, 2008

XIII. CON Findings and Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available was not demonstrated by the applicant;

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

E. The applicant has demonstrated that the project is consistent with and furthers the goals of the State Health Plan;

F. 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;

G. 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; and

H. That the project need not be funded within the Capital Investment Fund.

CON RECOMMENDATION: For all the reasons contained in the preliminary analysis and in the record, CONU recommends that the Commissioner determine that this project should be **approved with the following conditions:**

1. The applicants will be required to produce the letter from the Department of Justice/Federal Trade Commission that waived the 30-day waiting period requirement from the Hart-Scott-Rodino Antitrust Improvement Act.
2. Carry out the conditions set forth in the Certificate of Public Advantage (COPA).
3. Report cost savings attributable to this merger for a period of three years from merger date.
4. Report improvements in quality outcomes as a result of this merger for a period of three years from merger date.

XIV. COPA Findings and Recommendations

CONU recommends the Commissioner issue a certificate of public advantage for a cooperative agreement because the applicants have demonstrated by a preponderance of the evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition likely to result from the agreement. CONU recommends the Commissioner make the following findings subject to the conditions specified in Attachment B.

The following benefits are likely to result from the cooperative agreement:

(1) Enhancement of the quality of care provided to citizens of the State;
(2) Preservation of hospitals or health care providers and related facilities in geographical proximity to the communities traditionally served by those facilities;
(3) Gains in the cost efficiency of services provided by the hospitals or others;
(4) Improvements in the utilization of hospital or other health care resources and equipment;
(5) Avoidance of duplication of hospital or other health care resources; and
(6) Continuation or establishment of needed educational programs for health care providers.

The following disadvantages are not likely to result from the cooperative agreement:

(1) The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents or other health care payors to negotiate optimal payment and service arrangements with hospitals or health care providers;
(2) The extent of any likely adverse impact on patients or clients in the quality, availability and price of health care services; and
(3) The extent of any likely adverse impact on the access of persons enrolled in in-state educational programs for health professions to existing or future clinical training programs.

The following disadvantages are likely to result from the cooperative agreement:

(1) The extent of any disadvantages attributable to reduction in competition among covered entities or other persons furnishing goods or services to, or in competition with, covered entities that is likely to result directly or indirectly from the cooperative agreement; and
(2) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.

The likely disadvantages may be ameliorated by the enforceable conditions included Attachment B, as well as the following conditions recommended by CONU:

1. Reporting of free care; MaineHealth and SMMC will report free care as required by 22 M.S.R.A. §1716.
2. Submitting all tax returns for all entities under the control of MaineHealth for the term of the Certificate of Public Advantage.
3. Reporting any changes to the agreement with UNE regarding training of medical students for the term of the Certificate of Public Advantage.