**Date: September 8, 2015**

**Project**: **Merger of St. Mary’s d’Youville Pavilion with and into St. Mary’s Regional Medical Center**

**Proposal by: St. Mary’s Health System**

**Prepared by: Larry Carbonneau, Manager Health Care Oversight, DLRS**

**Richard S. Lawrence, Senior Health Care Financial Analyst, DLRS**

**Directly Affected Party: None**

**Certificate of Need Unit Recommendation: Approved**

**Proposed Approved**

**Per Applicant** **CON**

Estimated Capital Expenditure $ 0 $ 0

Maximum Contingency $ 0 $ 0

Total Capital Expenditure with Contingency $ 0 $ 0

Pro-Forma Marginal Operating Costs $ 0 $ 0

MaineCare Neutrality Established N/A

# I. Abstract

**A. From Applicant**

“St. Mary’s Health System (SMHS) proposes to merge two of its subsidiaries, St. Mary’s Regional Medical Center (SMRMC) and St. Mary’s d’Youville Pavilion (SMDYP). SMRMC and SMDYP are both Maine non-profit corporations whose sole member is SMHS, also a Maine non-profit corporation.”

“The right to appoint the Directors of SMRMC, SMDYP and SMHS rests with Covenant Health (CH), the sole member of SMHS, and the Boards of each of these entities are the same individuals. This is the management structure that was approved by the Certificate of Need Unit in 1993 when CH became the sponsor of SMRMC and SMDYP.”

“This certificate of need requests formal recognition of a corporate structure that has long existed for all practical purposes. The hospital and the nursing home are on the same campus, connected physically by an underground tunnel. The two entities share services, with hospital based services such as cardiac rehabilitation physically located in the nursing home proper. Central laundry services, food services, and provider offices are also located in the nursing home and the adjacent senior housing facility. Patient care is well integrated among the provider network, the nursing home and the hospital. The management structure of all the entities is also well integrated. The VP of Elder Care Services/nursing home administrator is responsible for all elder care services throughout the health system and reports directly to the hospital COO. All senior leaders from all entities serve on one senior leadership team. This team oversees the strategic direction and operations of all health system activities.”

“Other relevant factors associated with the merger include the following:

* There will be no change in the ownership or control of either SMRMC or SMDYP, and governance will remain the same.
* There is no capital expenditure for either the hospital or nursing home associated with the merger. There will be no incremental operating costs for either the hospital or the nursing home associated with the merger.”

# II. Fit, Willing and Able

**A. From Applicant**

“SMRMC is a non-profit charitable corporation that operates a 233 bed community hospital in Lewiston, Maine. SMRMC is state licensed and accredited by the Joint Commission. SMRMC and its affiliates provide the following health care services, among others:

* primary and specialty care physician services
* prevention and community health assessment services
* community outreach services such as school-based health centers, food pantry and annual flu shot clinics
* emergency services
* walk-in clinic services
* acute care services including surgery, intensive care, medical/surgical care, obstetrics and gynecology, and behavioral care
* full service lab, imaging and rehabilitation services for both inpatients and outpatients.”

“The medical center’s primary service area is Androscoggin County, with 74% of discharges originating from this region. The secondary service area also includes Franklin and Oxford counties. The behavioral service has been designated a tertiary referral site by the State of Maine (identified as the primary behavioral provider for Androscoggin, Franklin, Oxford, and northern Cumberland counties), and draws a significant number of behavioral patients from this region.”

“SMDYP is a 210 bed nursing facility and is a critical component of the integrated health care continuum offered by SMHS to the citizens of Lewiston-Auburn and Androscoggin County. Patients seek primary and specialty care from our network of providers; they access ancillary, emergency, outpatient services, acute inpatient and behavioral care from SMRMC; and they have come to depend on SMDYP for their rehabilitation and long term care needs. As criteria for nursing home admission have become more stringent, however, individuals are most often accessing long term care through transfer to the skilled nursing service following an acute care stay. With this evolution, patients are presenting with more complex medical conditions and higher risks for infection. Many are rehab patients who will utilize the skilled stay as a transition between acute care and eventual discharge home. Consequently, the skilled component of long term care is evolving into a much more dynamic environment requiring greater integration with the acute care hospital. There are many more admissions and discharges, and length of stay is aggressively managed. While the intermediate level of long term care continues to follow a more traditional pace, skilled nursing care is presenting much more significant management and facility challenges. The skilled nursing units now closely parallel acute care units with medically complex patients.”

“SMRMC is a subsidiary of SMHS. SMHS is also a non-profit charitable corporation and is the parent company of SMDYP, and the St. Mary’s Residences (a 128 apartment senior independent living facility). SMHS also has a distinct relationship with Community Clinical Services, Inc. (CCS), a Maine non-profit corporation that employs physicians and manages their practices. CCS also holds a designation as a Federally Qualified Health Center Look-Alike (FQHC). While CCS is an affiliate of SMHS, it is not controlled by SMHS. SMHS provides management and administrative support to each of its subsidiaries and CCS. Together, SMHS and its affiliates are collectively referred to as the “Health System.”

“Covenant Health (CH) is the sponsor and owner of SMHS and its subsidiaries. CH is a non-profit health care system formed in 1983 under the sponsorship of the Sisters of Charity of Montreal (Grey Nuns) to carry forth their century-long mission of providing value-driven, high quality health care services. CH is based in Tewksbury, Massachusetts. SMHS became a member of CH in 1992.”

“The mission of SMHS, SMRMC and SMDYP is to continue the healing ministry of the Catholic Church in the spirit of Ste. Marguerite d’Youville by providing preventative, curative, restorative and supportive services with compassion and respect for everyone. The Health System attempts to identify community needs and to respond to these needs with innovative, high quality, cost effective programs and services. SMHS has served its community with distinction for over 125 years, and is part of a health care continuum unlike any other in the state. Primary care, emergency care, acute care, long term care and prevention and wellness services are all available through SMHS and its subsidiaries and affiliates. This integrated health delivery system is a vital resource to the residents of central Maine.”

“The SMHS strategic plan articulates the organization’s commitment to creating a healthier community and a financially sustainable organization. We offer both technologically advanced, innovative care and a personalized approach to health management and promotion. We place particular focus on identified community needs, and provide high quality clinical outcomes across the full spectrum of services we offer.”

“In order for SMHS to advance its mission and to achieve success in the marketplace, the Health System must continue to pursue strategic growth opportunities. We believe that growth is best achieved by pursuing strategic goals that align with our mission, our core values, and the Triple Aim. The Triple Aim is a quality model developed by the Institute for Healthcare Improvement. The Health System embraces this quality model by focusing on its three foundational elements:

**Experience of Care, Population Health and Per Capita Cost**

“SMHS, SMRMC and SMDYP strategic initiatives are aligned with these three components of the Triple Aim:”

**EXPERIENCE OF CARE**

“Focus Area: **CLINICAL OUTCOMES**

Vision: SMHS will achieve best clinical outcomes which will receive recognition by both the public and payers.”

“Focus Area: **COORDINATION OF CARE**

Vision: SMHS patients will consistently receive the right care in the right setting at the right time through optimal care coordination.”

“Focus Area: **PATIENT/RESIDENT/FAMILY EXPERIENCE**

Vision: In partnership with our patients, residents and families, SMHS will create distinguished experiences that consistently exceed expectations.”

**POPULATION HEALTH**

“Focus Area: **COMMUNITY NEEDS”**

Vision: Consistent with our mission, SMHS will improve the health of the community through both direct care delivery and advocacy for at-risk populations.”

**PER CAPITA COST**

“Focus Area: **STRATEGIC GROWTH”**

Vision: SMHS will be recognized as the health care provider of choice within our market. Primary care relationships will serve as the principal referral source for all Health System services. In addition, we will adopt a regional approach to strategic growth of specialty services.”

“Focus Area: **INFRASTRUCTURE DEVELOPMENT**”

Vision: SMHS will have the financial resources to adequately invest in the ongoing development of the infrastructure required to support strategic objectives. Infrastructure will include human resources, information technology, medical equipment and facilities.”

“Focus Area: **FINANCIAL PERFORMANCE”**

Vision: SMHS will be recognized for strong financial performance in the region and state, which permits receipt of revenue sufficient to pay program costs.”

“All SMHS entities are in compliance with all applicable licensing, Medicare and Medicaid certification requirements and other applicable certificate or accreditation requirements.”

“Quality oversight for SMDYP and SMRMC is provided by the SMHS Board System Quality Committee. This committee is comprised of Board members, community members, providers and staff. The committee oversees the monitoring of patient care activities and ensures the continued review, evaluation and improvement of overall quality, safety and efficiency of patient care by the Corporation and its subsidiary corporations. The committee approves the annual performance improvement plans, and receives regular updates on priority quality indicators. This is a structure that integrates the quality imperative throughout the Health System, and will be retained post-merger.”

**“Quality highlights for SMDYP include the following:**

* SMDYP’s 2014 year end rate of rehospitalization within 30 days of admission was 11.1 per 1000 patient days. This compares favorably with the 15.7% rate of rehospitalization in American Health Care Association’s member centers.
* CMS called upon skilled nursing facilities in its “Initiative to Improve Behavioral Health and Reduce the Use of Antipsychotic Medications in Nursing Home Residents” to reduce the use of antipsychotic medications by 15%. SMDYP exceeded that target with a reduction of 29%. SMDYP has reduced the use of PRN (when necessary) medications and scheduled anti-psychotic medications from 19.7% in 2012 to 14.0% in 2014. This success is evidence of the effective alignment between SMRMC behavioral services and SMDYP.”

**“Compliance/Satisfaction**

* SMDYP has been a four or five star facility, as defined by CMS’ Five-Star Quality Rating System, since its inception in 2009. We have consistently achieved five-star ratings in RN staffing throughout the entire time.”

**“Education and Training of Staff**

* In 2012, SMDYP developed and implemented a best practice Elder Care Specialist education curriculum and certification program through the Maine Health Care Sector Grant. This grant, funded by the American Recovery and Reinvestment Act through the US Department of Labor and the Maine Department of Labor was developed with the goal of expanding clinical and training capacity in high demand allied health occupations in particular the Certified Nursing Assistants (CNAs). SMDYP has also supported our rehabilitation staff to become certified. SMDYP currently employs 14 full time elder care specialist CNAs, and 6 certified rehabilitation registered nurses.
* On January 30, 2013 SMDYP opened a new state of the art Specialty Care Rehab Suite. This Suite was designed as a 14-bed rehabilitation unit specializing in the treatment of individuals with medically complex conditions and is a companion program to our CARF accredited Transitional Rehabilitation Center.”

**“Specific Quality Initiatives:**

**“Pressure Ulcer Prevention**

SMDYP has a very active and comprehensive Ulcer Prediction and Prevention Management.”

Program which includes:

* Updating our resources to current best practice.
* Conducting a standardized risk assessment (Braden Scale) on all admissions within 2 hours of admission, then weekly for 4 weeks, and with any significant change.
* Inclusion of a new wound care protocol and weekly wound rounds with the medical director and dedicated wound nurse.
* Adding new protocols under assessment by the nurse to include a suspected area of pressure to be offloaded for 30 minutes then reassessed with 2 nurses (aka 4-eyed assessment).
* Review of each new pressure ulcer, and completion of a Root Cause Analysis.
* SMDYP has been successful at reducing the prevalence of facility acquired pressure ulcers from 1.3 per 1,000 pt days in 2011 to 0.51 in 2013.”

**“Rehospitalization Reduction**

SMDYPhas developed a very specific action plan for reducing re-admissions to acute care settings within 30 days of SMDYP admission. This action plan includes:

* The use of InterACT ® (Interventions to Reduce Acute Care Transfers) 3.0 tools and the BOOST® (Better Outcomes for Older Adults Through Safe Transitions) Risk Assessment 8P.
* The InterACT Stop and Watch tool for all staff and the modification of a similar tool for patients and families.
* Standardized hospital transfer log
* Care pathways were introduced for nursing staff to assist them with patient care interventions and decision making including urinary tract infection, lower respiratory infection, fever, mental status change, dehydration, CHF.
* SMDYP has collaborated with Central Maine Medical Center and Androscoggin Home Care and Hospice on consistent transfer documentation. In addition, SMDYP is working with the Maine Health Care Association and was the recipient of the 2011 Quality Award for Innovation with this project, as well as the LeadingAge Innovation of the Year Award in 2012.”

**“Quality highlights for SMRMC include the following:**

* Data is submitted to the Maine Health Data Organization and used for public reporting by The Maine Health Management Coalition (MHMC), a member of the Robert Wood Johnson Foundation’s Aligning Forces for Quality© Initiative. The MHMC is a charitable organization whose mission is to bring the [people who get care, pay for care, and provide care](http://www.getbettermaine.org/foundation-board) together in order to measure and improve the quality of health care services in Maine. By publicly reporting quality information on Maine doctors and hospitals, the MHMC hopes to empower the public to make informed decisions about the care they receive.
* **Get Better Maine report**, supported by MHMC, scores care related to effective care, safe care and patient experience. Scoring is presented as low, good, better, best performance. For data in period April 1, 2013 – March 31, 2014 we have performed at the Good – Best category in all metrics.

Scores for:

Stroke = Best

VTE (venous thromboembolism) = Better

SCIP (surgical care improvement project) = Best

Falls with injury = Good (previously scored as Low)

Overall Patient Satisfaction Scores = Better

* Data submitted to CMS, reported on Hospital Compare”

[Hospital Compare](http://www.medicare.gov/hospitalcompare/search.html) is part of the Centers for Medicare & Medicaid Services (CMS) Hospital Quality Initiative. The [Hospital Quality Initiative](https://www.cms.gov/HospitalQualityInits/downloads/HospitalOverview.pdf) uses a variety of tools to help stimulate and support improvements in the quality of care delivered by hospitals. The intent is to help improve hospitals’ quality of care by distributing objective, easy-to-understand data on hospital performance, and quality information from consumer perspectives.

Patient experience data currently reported on Hospital Compare is from period Jan 2013 – Dec 2013. St. Mary’s performed at or above the national average in 9 of the 11 patient experience metrics.

* Timely and Effective Care reports performance primarily around core measures for period of April 2013 – March 2014. Performance in all applicable measures is at or above national average in 25 out of 30 metrics.
* 30 day outcomes measures unplanned readmissions within 30 days of a previous inpatient hospital admission. The 30 day mortality rate reflects those patients who die, for any reason, within 30 days of admission to the hospital. The measurement period reported on Hospital Compare is from July 1, 2010 – June 30, 2013. St. Mary’s rates are “no different than the National Rate” with the exception of unplanned readmission after discharge which reflects a “better than National Rate” score.
* Surgical Complications is no different than National Rate. Data reported are for those patients discharged between July 1, 2011 thru June 30, 2013.
* Healthcare Associated Infections reports that St. Mary’s rates are no different than National Benchmark with the exception of Clostridium difficile in which St. Mary’s performed better than the US Benchmark. Data reported is for period of January 1, 2013 – December 31, 2013.
* Medical Imaging measures the hospital’s use of imaging tests for outpatients to assess patient safety, follow up and stewardship. St. Mary’s performed at or better than the national average in 4 out of 5 metrics during reporting period July 1, 2012 – June 30, 2013.
* Medicare spending per beneficiary shows whether Medicare spends more, less, or about the same on an episode of care for a Medicare patient treated in a specific hospital compared to how much Medicare spends on an episode of care across all hospitals nationally. St. Mary’s ratio is less than the National Average which means that Medicare spends LESS per patient for an episode of care initiated at this hospital than it does per episode of care across all hospitals nationally. This reporting period reflects patients discharged between January 1, 2013 – December 31, 2013.
* [The Leapfrog Hospital Survey](http://leapfroghospitalsurvey.org/) is the gold standard for comparing hospitals’ performance on the national standards of safety, quality, and efficiency that are most relevant to consumers and purchasers of care. Hospitals that participate in the Leapfrog Hospital Survey achieve hospital-wide improvements that translate into millions of lives and dollars saved. Leapfrog’s [Hospital Safety Score](http://www.hospitalsafetyscore.org/)® assigns A, B, C, D and F grades to more than 2500 U.S. hospitals based on their ability to prevent errors, accidents, injuries and infections. The Hospital Safety Score is calculated by top patient safety experts, peer-reviewed, fully transparent and free to the public. Metrics are reported in the following categories: safety problems with surgery, staff follow steps to make surgery easier, infections and safety problems, right staffing to prevent safety problems and hospital uses standard safety procedures. St. Mary’s grade for measurement periods 7/1/2010 – 6/30/2012 was an A.”

“In addition, the Health System has received the following quality recognition:

* American Hospital Association Foster G. McGaw Award for Exceptional Community Service
* Practice Green Health Partner for Change Award – Environmental Excellence
* Chest Pain Center Accreditation – Society for Chest Pain Centers
* Leapfrog Grade “A” Hospital Safety Score
* Commission on Cancer/American College of Surgeons Accreditation with Commendation to St. Mary’s Center for Cancer and Blood Disorders
* National Accreditation Program for Breast Centers/American College of Surgeons to St. Mary’s Breast Health Program
* Aetna Institute of Quality Orthopedic Care designation to St. Mary’s Center for Joint Replacement
* Blue Cross Blue Shield Distinction Center + for Hip and Knee Replacement Awarded to St. Mary’s Center for Joint Replacement
* HeathGrades 5-Star Recognition for Hip Replacement
* Leading consumer magazine recently recognized St. Mary’s Regional Medical Center for top safety rating in the state for surgery (re-admissions, infection rates, anesthesia reactions, etc.
* CARF International Three-Year Accreditation for Inpatient Rehabilitation Programs and Skilled Nursing Program
* Maine Health Care Association Innovation Award
* Beacon Hospice Honors St. Mary’s d’Youville Pavilion for Commitment to Excellence in End-of-Life Care
* LeadingAge 2012 Innovation Award for Best Practices to Reduce Rehospitalization Rates”

**B. Certificate of Need Unit Discussion**

1. **CON Standards**

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

1. **CON Unit Analysis**

St. Mary’s d’Youville Pavilion (SMDYP) is dually licensed for 210 skilled and nursing care beds. The facility is located at 102 Campus Avenue in Lewiston, Maine. The administrator is Philip T. Hickey. The facility’s most current license was issued on November 19, 2014 and is valid from December 1, 2014 to November 30, 2015.

CONU utilized the Medicare.gov website and DLRS files to summarize SMDYP most recent survey. This survey revealed the following ratings:

|  |  |
| --- | --- |
| **St. Mary’s d’Youville Pavilion** | |
| **Nursing Home Compare Ratings** | |
| **Category** | **Ratings** |
| Overall | Above Average |
| Health Inspections | Average |
| Staffing | Much Above Average |
| Quality Ratings | Average |

SMDYP scored “Average” or above in all four categories rated by CMS with an overall rating of “Above Average”. The last recertification survey was conducted on 10/20/2014. Three deficiencies were identified during the survey. All of the deficiencies were Level 2 (minimal harm or potential for actual harm). The average number of health deficiencies identified during a recertification survey in Maine is 3.8 and the average number of health deficiencies in the United States is 6.8.

Inspectors determined that the nursing home failed to:

1. Conduct initial and periodic assessment in a comprehensive, accurate, standardized and reproducible manner, accurately describing each resident’s functional capacity.
2. Ensure assessment accurately reflects the resident’s status.
3. The facility must use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.

All deficiencies were corrected by 11/10/2014.

Survey data for this facility can be accessed at medicare.gov or at DHHS DLRS and is on file at CONU.

St. Mary’s Regional Medical Center is located primarily across Campus Avenue from SMDYP although some services of the hospital are located on the eastern side of the street alongside the nursing home including outpatient services located in the same building. Lee Myles is the CEO and listed as the administrator. The most recent validation survey conducted at St. Mary’s hospital was completed on 10/25/2012. Certain issues were cited including employee records and patient rights issues as well as incomplete paper work on a number of operating room procedures.

The commissioner can rely on data available to the department regarding the quality of health care provided by the applicant as allowed at M.R.S. 22 §337(3).

**Deeming of Standard**

As provided for at 22 M.R.S. § 335 (7)(A), if the applicant is a provider of health care services that are substantially similar to those services being reviewed and is licensed in the State, the requirements of this paragraph are deemed to have been met if the services previously provided in the State by the applicant are consistent with applicable licensing and certification standards.

1. **Conclusion**

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

# III. Economic Feasibility

1. **From Applicant**

“Provided below is the financial analysis that demonstrates the financial feasibility of the proposed merger. The 2015 budget was used as a base, and the impact of moving to the hospital affiliated peer group was assumed to be effective as of 1/1/2015 (see note below).”

“The following assumptions were included in the analysis:

1. Merger will result in $250,000 in drug cost savings effective 7/1/2015. As merged entities SMRMC will be able to purchase drugs for SMDYP at hospital prices – under significant discounts from those provided to SMDYP as a separate facility.
2. Patient revenue and other operating income increase by 1.5% annually in 2016 and 2017.
3. Salaries, employee benefits and other expense increase by 2.0% annually in 2016 and 2017.
4. Supply expenses do not increase due to more use of group purchasing.
5. Provider tax increases due to SMDYP revenue increase.
6. Capital purchases are made at a level maintaining depreciation content.
7. No new debt in 2015-2017 and interest expense based on current amortization schedules.
8. HANF status effective 1/1/2015.”

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |



“Eliminations noted in the financial analysis include the following:

|  |  |  |  |
| --- | --- | --- | --- |
| INTERCOMPANY TRANSACTIONS BETWEEN SMRMC AND SMDYP | | | |
|  |  | 2015 |  |
|  |  | Budget |  |
|  |  |  |  |
| SMRMC OOI - Sold to SMDYP | |  |  |
|  | Planning/Marketing | 33,799 |  |
|  | Human Resources | 85,003 |  |
|  | Finance | 104,193 |  |
|  | Administration | 240,361 |  |
|  | Rent Recovery | 40,740 |  |
|  | Housekeeping | 386,378 |  |
|  | Maintenance | 159,818 |  |
|  | Performance Improvement | 1,404 |  |
|  | Education | 24,928 |  |
|  | Materials Management | 29,760 |  |
|  | Pharmacy (IVs) | 90,684 |  |
|  | IS | 38,018 |  |
|  | Security | 3,513 |  |
|  |  |  |  |
|  |  |  |  |
| SMDYP OOI Sold to SMRMC | |  |  |
|  | Patient Meals | 3,111,816 |  |
|  | Nourishments | 115,350 |  |
|  | Interdept Meal | 94,188 |  |
|  | Laundry | 637,684 |  |
|  |  |  |  |
|  | Total | 5,197,637 |  |
|  |  |  |  |

In summary, the projected net income in years 1, 2 and 3 adequately demonstrates the overall ability of the merged entity to support operations and cash flow needs.”

“Note: SMDYP has requested to be recognized as a Hospital Affiliated Nursing Facility for purposes of Maine Care reimbursement. This request was made to Herb Downs, Director of the

State Division of Audit, on March 10, 2015. SMDYP fits the definition of “Hospital-Affiliated Nursing Facility” as set forth in the MaineCare Benefits Manual, Ch. III, Section 67 (Principles of Reimbursement for Nursing Facilities), Principle 13, because SMDYP has “ambulatory care services and nursing facility beds located within the same building” at 102 Campus Avenue. The SMRMC outpatient cardiac rehab program is located within the SMDYP. In addition to the cardiac rehab unit being housed at SMDYP, the SMRMC has a portable x-ray machine located at SMDYP. Hospital staff goes to SMDYP and perform the x-ray, which is then billed as a hospital service. Finally, the hospital performs lab services at SMDYP when hospital staff goes to SMDYP to draw blood for testing billed by the hospital.”

**B. Certificate of Need Unit Discussion**

1. **CON Standards**

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

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

1. **CON Unit Analysis**

All nursing homes eligible for MaineCare are classified in one of three peer groups in accordance with the MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities. In accordance with Principle 86.1 these three peer groups are:

1. Hospital based nursing facilities (excluding governmental institutions).
2. Non-hospital based facilities with 60 or fewer beds.
3. Non-hospital based nursing facilities with more than 60 beds.

As stated by the applicant, SMDYP has applied for Hospital affiliated status with MaineCare. If approved, this would impact MaineCare reimbursement by increasing the direct care and routine upper limit components of the MaineCare per diem rate as follows:

|  |  |  |
| --- | --- | --- |
| **Peer Group** | **Direct Care**  **Upper Limit**  **Daily Rate**  **(Per Resident/Per Day)** | **Routine**  **Upper Limit**  **Daily Rate**  **(Per Resident/Per Day)** |
| Over 60 | $78.49 | $73.65 |
| Hospital Based | $86.32 | $101.04 |
| **Increase** | **$7.83** | **$27.39** |
| **% Increase** | **9.98%** | **37.19%** |

The applicant provided a pro-forma cost report that projects changes to reimbursement in the event SMDYP is classified as a hospital affiliated nursing facility. This is currently on file at CONU. Based on the latest “as filed” 2013 cost report SMDYP’s total allowable rate is $201.96 per day. With 49,403 state resident days their total MaineCare reimbursement is $9,977,238 (49,403 x $201.96). The 2015 pro forma cost report prepared by the applicant projects total MaineCare reimbursement of $11,405,840 (47,028 x $242.53) an increase of $1,428,602.

CONU’s calculation of the total allowable rate differed from the applicant. The difference was related to the calculation of the routine cost cap. CONU’s final allowable rate is $261.43 for a

total reimbursement of $12,294,530 ($261.43 x 47,028) an increase of $2,317,292. Future reimbursement will ultimately be determined by DHHS Rate Setting based on this pro forma cost report and will be subject to audit settlement by DHHS Audit.

The applicant determined that the main source of savings attributable to this project is a savings of $250,000 in drug costs over a 12-month period. Anticipating a start date of July 1, 2015 as a hospital-based nursing home they projected savings in calendar year 2015 of $125,000.

The standard for this portion of the review is whether the applicant can show the financial capacity to support the project. In light of its budgeted forecast it is clear that St. Mary’s can financially support the nursing home operations.

**Changing Laws and Regulations**

CONU is not aware of any imminent or proposed changes in laws and regulations that would impact the project, except for federal health care reform as part of the Affordable Care Act (ACA). The impact of health reform has not been determined.

**Deeming of Standard**

As provided for at 22 M.R.S. §335 (7)(B), if the applicant is a provider of health care services that are substantially similar to those services being reviewed and is license in the State, the applicant is deemed to have fulfilled the requirements of this standard if the services provided in the State by the applicant during the most recent 3-year period are of similar size and scope and are consistent with the applicable licensing and certification standards.

The applicant has operated a 210 bed dually licensed SNF/NF in the Androscoggin County area. If this application were to be approved the applicant would still be operating the same number of SNF/NF beds. The operations would be of a similar size and scope.

1. **Conclusion**

Certificate of Need Unit staff recommend that the Commissioner determine that the applicant has met their burden to demonstrate: (1) the capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and (2) the applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules.

# IV. Public Need

1. **From Applicant**

“SMDYP is a key component of the health care infrastructure in greater Androscoggin County. The facility consistently operates at over 90% occupancy. The occupancy level exceeded 96% in 2014. The need and demand for this nursing facility has been solidly established within the market place. All the services affected by the project will continue to be accessible to all residents of the area. The SMHS mission statement clearly articulates the organization’s commitment to “providing preventive, curative, restorative and supportive services with compassion and respect for everyone.”

“The SMHS strategic plan speaks to the organization’s commitment to creating a healthier community and a financially sustainable organization. We offer both technologically advanced, innovative care and a personalized approach to health management and promotion. We place particular focus on identified community needs, and provide high quality clinical outcomes across the full spectrum of services we offer.’

“Key areas of clinical focus include:

* Primary care with emphasis on prevention, chronic disease management, geriatrics, emergency and urgent care
* Women and children’s services
* Musculoskeletal services including orthopedics, physiatry, rehabilitation and post-acute care
* Mental health and substance abuse services”

“The merged facilities will be well positioned to meet the full spectrum of health care needs required by our community, and to positively impact the health status of those we serve.”

“Distinguished patient, resident, and family-centered care is our hallmark. We provide experiences that promote healing, minimize anxiety, acknowledge vulnerability, respect unique identity, and express compassion, understanding and kindness.”

“With the merger of SMDYP with and into SMRMC, SMHS will continue to enhance the seamless continuum of health services offered through the system. Integrated case management will allow for smooth and efficient transfer of patients back and forth between the hospital and the nursing facility, and vice versa. This will be a great benefit to both patients and their families.”

“The merged facilities will also be able to better manage the demands associated with minimizing 30 day readmissions and will be better equipped to deliver bundled episodes of care as required through accountable care organizations. See in this regard, the Rehospitalization Reduction action plan for reducing readmissions to acute care settings within 30 days of SMDYP admission, described in section II of this application.”

“SMDYP and SMRMC already enjoy the advantages of a shared quality model, with the St. Mary’s Board System Quality Committee well established and providing oversight for quality and outcome measures throughout the Health System. The merger will further solidify this focused organizational attention on system-wide performance improvement.”

“While considerable integration exists between SMDYP and SMRMC pre-merger, we anticipate there will be an opportunity for a significant cultural shift with the formal merging of the entities. Employees will no longer identify with individual entities, and they will begin to reorient towards more system level thinking. No matter where an individual accesses services throughout our Health System, they should receive the same level of personalized, high quality care. The proposed merger will create a corporate culture that will allow this concept of seamless, well integrated service delivery to flourish.”

**B. Certificate of Need Unit Discussion**

1. **CON Standards**

Relevant standards 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.

1. **CON Unit Analysis**

In order to determine public need, CONU analyzed demographic and service use trends in SMDYP service area (Androscoggin County, Maine). CONU utilized the Older Adults with Physical Disabilities: Population and Service Use Trends in Maine, 2012 Edition, prepared by the Muskie School of Public Service and the U.S. Census Bureau’s website located at <http://quickfacts.census.gov>.

Androscoggin County Maine is approximately 497 square miles in size and is included in the Lewiston-Auburn Metropolitan Statistical Area. The population is estimated to be 107,940 in 2014.

Approximately 16,731 persons, or 15.5% of the population is 65 or older. This population is the primary consumer of nursing services. Between 2010 and 2022 this segment of the population is expected to grow by 38.9%. In addition the majority of the population growth in Maine over the next ten years will be in the 65-and-above age group. This growth is at a faster rate than New England or the rest of the nation. With the projected increase in the 65+ population it is likely that there will be a continued need for SNF/NF services over the next ten years.

This proposal does not involve the addition of new services. SMDYP has served the Lewiston/Auburn area for many years. Based on the latest DHHS nursing home occupancy reports SMDYP has an average occupancy of 97.62%. Androscoggin County as a whole, has a 96.11% average occupancy rate demonstrating a need for nursing home services in the area. Meeting the needs of the 65-and-above age group by maintaining nursing homes services will have a positive impact on the health status indicators of the population to be served.

The services affected by the project will be accessible to all residents in the area.

The applicant states that the merger of SMDYP into SMHS will enhance the continuum of health services offered through the system. Integrated case management will make the transfer of patients from the hospital to the nursing home and vice versa more efficient. SMDYP and SMHS will continue to benefit from a shared quality model. It seems reasonable to infer based on the proximity of the nursing home to the hospital and the shared services that the community believes that they are already the same entity so making them in fact part of the same entity would not change the perception of the community on the relationship between hospital and nursing home.

1. **Conclusion**

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

# V. Orderly and Economic Development

1. **From Applicant**

“The merger of SMDP with and into SMRMC is consistent with the orderly and economic development of health facilities and health resources for the State because it will continue the needed health services that have been provided by these two facilities for over a century. In addition, as the financial analysis demonstrates (with HANF reimbursement assumed in the baseline numbers), there will be no additional cost to the State in years 1, 2 and 3 of implementation.”

“As noted previously, a significant cost saving opportunity associated with the merger relates to nursing home pharmacy expenses. The merger is expected to result in approximately $250,000 in annual drug cost savings effective July 1, 2015. As merged entities SMRMC will be able to purchase drugs for SMDYP at hospital prices – at significant discounts from those provided to SMDYP as a separate facility. Some other benefits to SMDYP being part of SMRMC include the following:

* We will have one less set of filings we need to submit for things such as
* Form 990, Return of Organization Exempt from Income Tax
* Form 941, Employer’s Quarterly Federal Tax Return
* Form 941ME, Filing for Maine Income Tax Withholding
* Maine Unemployment Tax Return
* Form W-3, Transmittal of Wage and Tax Statements
* Form W-3ME, Reconciliation Of Maine Income Tax Withheld
* We will have a reduction in the number of contracts between SMRMC & SMDYP for shared services.
* We will be able to work with third party payers to negotiate one contract that covers both the hospital and the nursing home rather than separate ones for each.
* We will be able to reduce our costs for maintaining facility credentialing with each of the payers, as it will be one set of applications versus two.
* Employees will be able to easily float from the hospital to the nursing home and vice versa to provide for the most effective utilization of resources. Currently employees must:
* be hired in both companies in order to float, which causes employees to have two W-2s and causes us to have to manually track and calculate overtime across companies.
* We will be able to more easily create bundled-pricing arrangements with payers and employers that incorporate both acute and subacute services.”

“All other operating costs are expected to remain constant, with any increases related to annual inflation and/or revenue growth. These costs would be incurred with or without the merger. Overall supply costs do not increase given the opportunities for more group purchasing following the merger.”

“One of the greatest advantages of a health care continuum controlled by one fully integrated health system is that the likelihood of patients “getting the right care, in the right setting, at the right time” is optimized. This ensures patient access to the most clinically appropriate and cost effective level of care. The SMRMC behavioral service is a particularly valuable asset to SMDYP as more residents present with challenges related to mental health/dementia.”

“It is also important to note that the Health System, the community and the State have received numerous pre-CONU application savings in addition to those referenced throughout this submission. The Health System has continually streamlined systems in order to enhance synergies and operational results which have benefitted our residents and greater community through efficient patient centered and system coordinated care plans.”

**NOTE:** On June 12, 2015 members of the CONU staff led by Program Manager Larry Carbonneau, CPA met with representatives of the applicant in person and telephonically in accordance with 22 MRSA §335 (6B) for a pre-release Technical Assistance Meeting. At this meeting the applicant was notified that the preliminary analysis had determined that based on the information provided by the applicant and responses received from the public that it was the determination of the CONU that the applicant had not met its burden to demonstrate that the application was in the best interest of the state to approve. A response to this meeting was received on June 30, 2015. The entirety of their response has been included in the record. THE CONU has included most of the written response here.

**“Background and Fulfillment of CON Criterion – Subsection 7(D)(1) of Section 335”**

“We understand from our recent meeting that our filings to date are deemed to fulfill virtually all of the approval criteria set forth in Section 335 of the CON Act. At the same time, you offered us the opportunity to provide some additional information and data in order to foster a favorable recommendation regarding the following provisions of subsection 7(D)(1) of Section 335:”

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

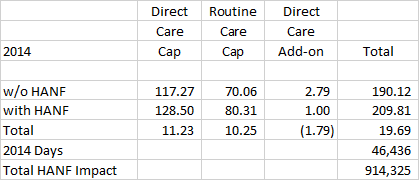
*(1) The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;*

“You have made note of the annual savings of $250,000.00 or more in the cost of purchasing pharmaceuticals for nursing home residents post-merger. You have also called attention to the anticipated additional reimbursement that DYP is expected to realize as a “hospital affiliated nursing facility” (HANF) under the MaineCare Principles of Reimbursement for Nursing Facilities (“NF Principles” or ‘Principles”). You have advised that these and other economic impacts will be further considered as you frame the Preliminary Analysis, and have invited further comments and submissions to assist you as you carry out this further analysis. Against this background, we offer the following for your consideration.”

1. **Alternative Calculation of Financial Benefit to DYP from HANF Designation**

“At our June 5, 2015 meeting, CONU staff shared a preliminary calculation of the anticipated incremental MaineCare reimbursement that might flow to DYP under the Principles if DYP were to receive designation from DHHS Audit/MaineCare as an Hospital Affiliated Nursing Facility. We perceive that staff compared: (1) our pro forma cost report filed with our Application (which assumed HANF status) with (2) our as filed 2013 cost report and suggested the differential might be around $1.4 million. If this is how the $1.4 million was derived then it also includes (A) the value of the rebasing of rates done 7/1/2014; and (B) the reduction in Mainecare days from 2013 to the days in the pro forma cost report filed with the application.”

“We believe the incremental MaineCare reimbursement flowing from HANF is closer to approximately $900,000 per year, and set forth a Table below laying this out. DYP’s direct care and routine care costs in the 2014 cost report were in excess of both the HANF and over 60 bed peer group caps. We calculate the value as the difference between the caps for the 2 peer groups. Using our case mix index we have calculated the direct care cap at $117.27 for the over 60 bed peer group and $128.50 for the HANF peer group for an increase of $11.23 per day. Similarly, with routine care the cap increases from $70.06 to $80.31 or $10.25 per day. The direct care and routine care cap increases are offset by an approximate $1.79 reduction in the direct care add-on when moved to the HANF peer group. In total our rate per day would increase by $19.69 and based on d'Youville's 2014 Medicaid days of 46,436 the impact would be $914,325. Below is a summary table:”



“This calculation recognizes that with or without HANF designation, DYP will be receiving additional reimbursement over its 2013 filing due to multiple reimbursement reforms that have resulted from the Legislative mandates for addition reimbursement to all nursing facilities (both HANF and non-HANF) as a result of its 2014 enactment of Chapter 594, Public Law 2013, LD 1776, an Act to Implement the Recommendations of the Commission to Study Long-term Care Facilities (copy attached and reviewed in detail in Sections 3 (B) and (C) below).”

**2. Additional Financial Benefits to the Merger Transaction**.

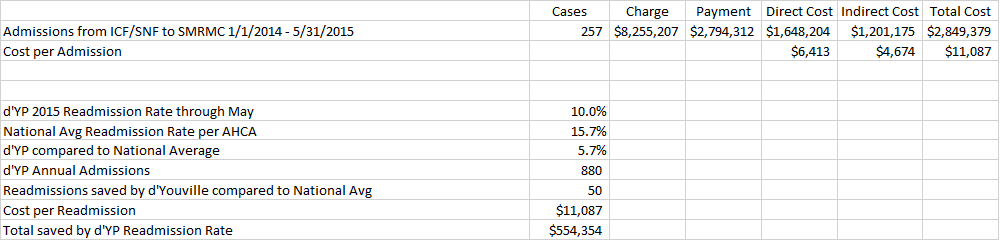
**A. “Savings Related to the Effective Management of Readmission Rates Across the Health System:** The DYP nursing leadership team has developed and implemented a nursing competencies curriculum that engages best practices from across the fields of both acute and post-acute care. Part of the goal for developing this educational program is to incorporate new and innovative training models into practice that can serve as a template and be replicated throughout the health system. This effort seeks to ensure quality outcomes for patients and residents. DYP is seeing increasingly complex patients. In addition to being part of a hospital-based system, the field of rehabilitation and nursing care is constantly evolving and patient populations are presenting with more complicated diagnoses than have been seen in previous generations. In order to ensure the best possible treatment of patients and residents, the facility recognized the need for an enhanced educational training program.”

“While developing the nursing competencies curriculum the team adhered to the principles of the Triple Aim – the concept of applying integrated approaches in order to create better patient experiences, better clinical outcomes, and lower healthcare cost for our community. This effort also enabled for the successful opening of the Specialty Care Rehab Suite with competently validated staff supporting service expansion and the capacity to address increased patient acuity. The development of this initiative has improved clinical decision making, demonstrated a reduction in facility wide re-hospitalizations and emergency room transfers; as well as an improvement in the collaboration between our direct care nursing staff and physician practice.”

“A significant outcome of this endeavor included the development of a nurse educator position in order to create a 3-year training plan modeled after nursing best practice. This position has renewed the commitment to a preceptor training for new employees to the facility and the next generation of post-acute care providers. The development of this role has allowed for collaboration within the St. Mary’s Health System to create an educational program that is cross-continuum. The education manager is a part of the health system education collaborative and is able to utilize resources from the acute care setting to develop best practices in the nursing facility for better patient outcomes overall. This initiative builds on the Elder Care Specialist program which was developed in 2012 and created as a career ladder for certified nursing assistants. The use of the competency assessment tools has also allowed for expansion of staff educational opportunities through performance appraisals.”

“As a result, DYP’s 2015 overall readmission rate of patients back to St. Mary’s Regional Medical Center is 10%, compared to the ACHA national rate of 15.7%. If DYP had performed at the national rate, this would have resulted in up to 50 additional readmissions to the Hospital.”

**The St. Mary's cost per readmission is $11,087 for a savings of $554,354 due to the close integration of DYP and St. Mary’s Regional Medical Center and their shared commitment to effective patient care management across the continuum of care.**  Details on the calculation are provided below:



**B. “Savings Related to Decrease in Medicare Average Length of Stay:** The close integration between DYP and St. Mary’s Regional Medical Center allows for the effective management of Medicare patients across the care continuum. This allowed DYP to achieve a Medicare ALOS of 22.52 in 2013, compared to other local facilities (Marshwood, Russell Park, and Montello) which had a combined ALOS of 23.55 days. The 1.03 difference in days had an impact of $244, 929 at DYP (total 2013 Medicare discharges of 573 times the length of stay savings of 1.03 days times the average reimbursement in 2013 of $415 per day equals $244,929). **Effective care management of the Medicare population by DYP and St. Mary’s Regional Medical Center will continue to have an annual impact of approximately $245,000 a year.”**

**C. “Ongoing Savings in Agency Staffing Costs**: Working closely with St. Mary’s Regional Medical Center, DYP has been able to completely eliminate agency staffing costs. Prior to developing a mechanism to share staffing resources with the hospital when experiencing staff shortages, DYP averaged annual agency staffing costs of $120,000 (with a high of $267,257 in 2006). Use of agency staff typically doubles the cost of the worker, so **approximately $60,000 in annual agency staffing costs will continue to be avoided due to the merger.”**

**D. “Savings in Information Technology Infrastructure:** The operation of DYP information technology and communications is supported by St. Mary’s Regional Medical Center. This support includes switches, firewall, wireless, security, and e-mail. The annual St. Mary’s Regional Medical Center operating budget for IT is $3,842,830 to support 2,000 workstations, for an annual operating cost of $1,921 per workstation. DYP has 150 of the 2,000 workstations, so the support DYP receives from St. Mary’s has an annual value of approximately $288,212 (150 workstations x $1,921 per workstation). Of the $288,212, approximately $75,000 of the costs are variable (fluctuating based on the number of individual workstations in use). The remaining $213,000 in costs, however, are fixed medical center costs and are part of the health system’s infrastructure. **Therefore, the net annual savings in IT costs that result from the integration between DYP and St. Mary is $213,000.”**

“By comparison, Mary Immaculate Health Care Services (a freestanding skilled nursing facility in Lawrence, MA that is also a member of Covenant Health) has an IT annual operating budget of $351,000 to cover 170 workstations, for an annual operating cost per workstation of $2,065. Through system efficiencies and economies, St. Mary’s is able to realize a savings of $144 per work station.”

**E. “Savings to St. Andre Health Care Facility:** DYP, St. Mary’s Regional Medical Center and St. Andre Health Care Facility are all members of Covenant Health. With the merging of financial operations at DYP into St. Mary’s Regional Medical Center, numerous efficiencies in financial reporting will result and St. Mary’s will now have the capacity to provide financial oversight to St. Andre’s Health Care Facility. This will allow St. Andre’s to eliminate the position of controller. **Approximately $90,000 in annual salary and benefits will be eliminated from the St. Andre’s cost structure as a result of the merger.”**

**F. “Summary of Savings:** A summary of the financial benefits that result from the merger is as follows.”

Pharmacy savings: $250,000

Hospital Readmission savings: $554,354

Decrease in Length of Stay savings: $245,000

Ongoing Agency Staff savings: $60,000

Information Technology savings: $213,000

St. Andre’s Controller savings: $90,000

**Total Savings of $1,412,354**

**G. “Significant Declines in MaineCare Patient Days:** In addition to the savings quantified above, the closer ties with the medical center have also assisted DYP in transforming its census to a more complex patient. DYP had 54,405 Mainecare days in 2012, 49,403 Mainecare days in 2013, and 46,436 in 2014. Through May 31, 2015 DYP is averaging 118.6 Mainecare patients per day. Assuming that census continues for the entirety of 2015, DYPs Mainecare days will end the year at 43,289, a 3,147 drop from 2014.”

“These significant declines in MaineCare patient days yielded the following trends in MaineCare reimbursement, based on the applicable MaineCare daily rates

·        2012 - $10.6 million

·        2013 - $10.0 million

·        2014 - $10.3 million (includes a half year of rebasing and a half year of HANF)

·        2015 - $10.5 million (projected – includes a full year of rebasing and HANF)”

“Over the same time, 2012 to 2014 DYP increased its Medicare/Commercial Insurance census from 13,205 to 17,757. Through May 31, 2015 DYP is averaging 55 Medicare/Commercial Insurance patients per day. Assuming that census continues for the entirety of 2015, DYPs Medicare/Commercial Insurance days will end the year at 20,075, a 2,318 increase from the 2014 days.”

“In the pro forma 2015 Mainecare cost report produced for the CON Unit we calculated per diem reimbursement of $242.53 and assumed 47,028 Mainecare days for a total of $11.4 million in Mainecare reimbursement. If we had used the current projected Mainecare days of 43,289, we would have projected Mainecare reimbursement of $10.5 million.”

“The revised projected 2015 projected revenue of $10.5 million (including HANF and the 7/1/2014 rebasing) is less than the Mainecare reimbursement (without HANF and the 7/1/2014 rebasing) of $10.6 million.”

“The consolidation and integration of operations between DYP and St. Mary’s Regional Medical Center allows DYP to take more complex patients and has reduced the State's reimbursement to our facility, even after including enhanced reimbursement and a shift in peer groups.”

**3.** **The project is consistent with the orderly and economic development of health facilities and health resources for the State of Maine**.

**A. Clinical Benefits to DYP Patients from Close Hospital Affiliation with Hospital and Resulting Cost Impacts**

“The May 5 submission attached a summary document dated May 4. Part 5 of this submission provided detail on “quality and outcome measures, such as rehospitalization rates, that would be improved through the merger.” We noted that the merger will foster continued coordination of services between the Hospital and SMDYP and continued enhancement of quality outcomes.

“We attached to this filing material from Medicare.gov showing how quality and outcomes measures at SMDYP were positive and improving and ahead of Maine and national averages in several respects. Our May 4 summary document, Part 4, noted several other positive clinical outcomes.

* The percentage of SMDYP short and long-term residents with pressure sores is below both the Maine and the national average. Continuation of the Pressure Sore program noted below should continue to foster these positive results;
* The percent of residents at SMDYP who have been given seasons influenza vaccine or pneumococcal vaccine is higher at SMDYP than the Maine average or the national average;
* The percentage of short and long-term stay residents who have received anti-psychotic medication is lower than both the Maine average and national average. Again, continuation of these programs should continue to foster these results, and the coordination of behavioral services between the hospital and nursing facility will likewise improve these factors.”

“Under item 5 of the May 4 document, we noted additional benefits:

* Percentage of residents experiencing one or more falls is significantly lower at SMDYP than the Maine or national average;
* Likewise, percent of long-term stay residents with a urinary tract infection is lower at SMDYP.”
* “Our summary noted, in addition to the overall coordination, the following factors as contributing to these positive results – again as documented in the medicare.gov materials:
* Licensed nursing staff hours per resident per day are significantly higher at SMDYP than the Maine and national averages;
* CNA hours per resident per day are also higher at SMDYP.
* The merger and increased potential for staff coordination will foster continuation of these results;”

“Looking at the data in the Medicare.gov attachment to our May 5 filing, the quality of resident care at SMDYP is enhanced in several important areas. Following are examples:

* Falls with major injury – 1.3% in comparison to the Maine average of 3.7%;
* Likewise, urinary tract infections – according to Medicare.gov, our data shows 2.7% versus 6% for the Maine average;
* Pressure ulcers are similarly lower – 2.9% versus 4.2% for Maine.”

“We respectfully urge that these quality of care benefits are a direct consequence of the higher staffing ratios at SMDYP in comparison with other Maine Nursing Facilities.

* For example, Medicare.gov data show that the licensed staff hours per day for SMDYP are 2 hours and 1 minute, versus 1 hour and 32 minutes for the Maine average.
* For RN hours per resident day, SMDYP has 1 hour and 40 minutes, in comparison with 1 hour and 6 minutes for the Maine average.”

**B. Incremental Increases in MaineCare Reimbursement for Direct Care Staff Resulting from Recognition of HANF Status for DYP**

It should not be a surprise that this higher quality staff brings with it additional costs, again above the Maine averages. The anticipated recognition of DYP as an HANF would bring with it additional reimbursement for these higher staffing costs, fostering its ability to continue to generate higher quality outcomes and thereby fulfilling multiple CON review criteria as detailed below.

DYP’s aggregate direct care costs – including direct care staff of nurses, CNAs etc. totaled $9,517,841 for FY 2013. For FY 2014, DYP’s direct care costs totaled $9,807,590. Under the Principles, significant portions of DYP’s incurred and otherwise allowable direct care staffing costs were not reimbursed due to imposition of the peer group caps set forth in the Principles, Section 80.5.4.

The direct care median cost cap under the Principles of Reimbursement is established for 2013 payment years at 88.73% of the median for each peer group, and at 110% of the median for payment years 2014 and following, the latter reform mandated by LD 1776, Chapter 594.

As detailed below, these increases in the median caps for each peer group were mandated by the Legislature and signed into law last summer by the Governor to “correct chronic [MaineCare] underfunding” of Maine’s nursing facilities and to better “assure financially stable long-term care services” to Maine’s elderly “that is sustainable into the future”. See further discussion at Part 3 (C) and (D) of this filing below for the Legislative history behind these increases.

For nursing facilities that are not recognized as HANFs, the direct care median caps were as follows:

* 2013 -- $57.87 per patient day using the 88.73% of median factor; and
* 2014 -- $78.49 per patient day using the 110% factor—resulting from LD 1776.

For the HANF peer group, these direct care caps, based on these medians, are:

* 2013 -- $63.56 per patient day using the 88.73% factor; and
* 2014 -- $86.32 per patient day using the 110% factor—resulting from LD 1776.

DYP’s direct care costs were as follows:

* 2013 -- $129.25 per patient day – and $9,517,841 in total based on 73,639 patient days; and
* 2014 -- $134.45 per patient day – and $9,807,590 in total based on 72, 946 patient days.

For 2014, DYP’s MaineCare reimbursable direct care costs under alternative scenarios are:

* $ 117.27 per patient day – as a non-HANF – sufficient to cover $5,445,550 in its otherwise allowable direct care costs, and leaving a shortfall of $ 793,127 not covered by MaineCare.
* $ 128.50 per patient day – if DYP were recognized as a HANF – sufficient to cover $5,967,026 in its otherwise allowable direct care costs, and leaving a shortfall of $ 274,651 not covered by MaineCare.

To recap, for 2014, MaineCare aggregate payments to DYP for direct care costs are as follows:

* $5,445,550 where DYP not recognized as HANF
* $5,967,026 where DYP is recognized as HANF
* $521,476 is the incremental increase in MaineCare payments from HANF status.
* $274,651 is the remaining shortfall of incurred, otherwise allowable direct care costs that remain unreimbursed even with HANF status
* $793,127 would be the shortfall in unreimbursed direct care costs without HANF status.

The preceding review demonstrates that DYP has higher direct care staffing costs and with this higher quality staff, with greater involvement of professional nurses, has consistently delivered higher quality outcomes benefiting its patients and the State as a whole.

Further, attainment of HANF status will bring with it additional reimbursement to help support this higher quality staff and to continue to deliver higher quality outcomes. But even with HANF status and the additional payments that come with it, DYP would still have non-reimbursed direct care staffing costs.

Because attainment of HANF status would significantly narrow the shortfall in non-reimbursed direct care staffing costs, this factor should properly be viewed as a positive factor in fulfilling several CON approval criteria, including:

* Further enhancing DYP’s recognized status as a “fit, willing and able” provider under Section 335 (7)(A) in providing needed resources to further support its services and offset its costs;
* Further enhancing the “economic feasibility” of DYP’s services and its “capacity to support the project [the merged entities and their services] over its useful life” under Section 335 (7)(B); and
* Further enhancing DYP’s ability to continue to “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” including the reimbursement flowing from recognition of HANF status and the changes to the Principles and peer group caps under Section 335 (7)(B); and
* Being consistent with the “orderly and economic development of health facilities” under subsection 7(D)(1) of Section 335, in providing greater recognition for and additional MaineCare payments to further offset the “impact of the project on total health care expenses” attributable to DYP’s high quality services and the costs incurred to provide them.

1. **All Reimbursement Benefits to DYP from HANF Designation are Benefits Mandated by the Legislature’s 2014 Enactment of Chapter 594, Public Law 2013, LD 1776 – to Correct Chronic Underfunding and Provide High-Quality Care**

Importantly, any enhanced reimbursement to DYP must properly be viewed as a benefit to DYP that was fully intended and directed by the Legislature through its 2014 enactment of Chapter 594, Public Law 2013, LD 1776, an Act to Implement the Recommendations of the Commission to Study Long-term Care Facilities (copy attached). The Emergency Preamble to this law states as follows:

***Emergency preamble. Whereas,*** *acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and*

***Whereas,***  *the people of the State of Maine need and deserve a variety of well-planned and financially stable long-term care services in home-based and community-based care settings and in nursing facilities in their communities; and*

***Whereas,***  *in order to provide high-quality care to Maine's elderly and disabled persons in a dignified and professional manner that is sustainable into the future through a spectrum of long-term care services, prompt action is needed to correct chronic underfunding and to complete a thoughtful and thorough planning process; and*

***Whereas,***  *in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety;* Emphasis Added.

As mandated by this law, several changes to the NF Principles were promulgated by DHHS through emergency rulemaking, effective August 15, 2014:

* Among the key statutory and rulemaking changes benefitting and enhancing the reimbursement for all nursing facilities are the following;
  + Rebasings will be carried out every two years, with the next rebasing in 2016, Section 1 of LD 1776, 22 M.R.S.A. § 1708(3)(F) and Section 3, subsections 1 of LD 1776;
  + Cost of Living adjustments will now be made every year, Section 3 of LD 1776, subsection 4; and
  + The cost ceiling on administrative and management costs is removed, and these costs are allowable as routine costs, Section 3 of LD 1776, subsection 3.
* The reimbursement rules governing peer group Direct Care and Routine Care cost component upper limits were likewise fundamentally reformed and enhanced by LD 1776:
  + Section 3, subsection 2 of LD 1776 increased the peer group limit for both the direct and routine cost components to 110% of the median from the prior caps of 88.73% or the median for each peer group;
  + These changes have now been incorporated into Section 80.5.4 of the NF Principles.
  + These changes increase the peer group upper limits for each peer group by 24% (110/88.73); and
  + Under the above-referenced base year provisions, these ceilings will be redetermined every 2 years thereafter, benefiting facilities in all peer groups.

These required changes to the NF Principles from which DYP is benefiting focused on the following:

* More frequent rebasings;
* Annual COLA adjustments;
* Increases to the median caps on allowable direct and routine costs.

Each was enacted into law for the express purposes – as set forth in the Emergency Preamble – of “providing financially stable long-term care services,” and to “correct chronic underfunding” in order “to provide high-quality care to Maine’s elderly and disabled persons.” These enhancements were therefore also consistent with the overriding language of subsection 7(D), requiring that the proposed project be consistent with "the orderly and economic development of health facilities [DYP among others] and health resources for the State," under policies and directives enacted into law as part of LD 1776.

1. **The Legislature’s Adopted Budget Provides Ample Funding to Fully Implement the Reforms of Chapter 594, Public Law 2013, LD 1776**

The Legislature recently completed action on the State Budget for the 2015-16 and 2016-17 State Fiscal Years. Attached are relevant excerpts from the Committee Amendments that have now been adopted by the House and Senate and were enacted into law June 30, 2015:

* Majority Committee Amendment to L.D. 1019, pp. 355 and 356 – see Nursing Facility Baseline Budget – with approximately $89 million in General Funds, $215 million in Federal Expenditure Funds, and $35 million in Other Special Revenue Funds for each of the two years;
* Majority Budget Amendment, Page 356 also contains additional funding “to fund the recommendations in Public Law 2013, chapter 594, An Act To Implement the Recommendations of the Commission To Study Long-term Care Facilities” – with $7 million in General Funds, $14 million in Federal Funds and $1.3 Million in Other Special Revenue Funds for each of the two years
* Floor Amendment, Senate B, to Majority Committee Amendment, pp. 29-30 that added an additional $1.0 million in General Funds, $2 million in Federal Funds, and $190K in Other Special Revenue Funds for each of the two years;

The approved Budget therefore provides the following:

* Funding of approximately $340 million in Baseline Funding for each of the next two years to maintain prior levels of funding for Maine’s nursing facilities;
* Additional funding of approximately $25 million for each of the next two years to fund the reimbursement reform provisions of LD 1776, Chapter 594.

The enhanced reimbursement to DYP that would flow from HANF status is less than $1.0 million, and less than one-third of one percent of the overall State Budget for nursing facilities. Moreover, there is more than sufficient “availability of state funds to cover any increase in state costs associated with utilization of the project’s services,” amply fulfilling the criterion set forth at subsection 7(D)(2) of Section 335.

Viewed from these perspectives, and tying back to the language of subsection 7(D)(1) of Section 335, requiring consideration of the “impact of the project on total health care expenses,” it is clear that any “increase in total health care expenses” flowing from enhanced reimbursement to DYP is acceptable, desirable and required as a matter of law in order to help DYP to narrow the gap between its allowable costs and its reimbursable costs and to partially “correct chronic underfunding” that DYP MaineCare services have experienced for many years.

**4. The CON Review Process Cannot Properly Operate to Deny DYP the HANF Status to Which It is Entitled Under the NF Principles**

As stated in our May 21 filing, and as discussed with you at our recent meeting, any additional reimbursement flowing to DYP from attaining HANF status under the NF Principles will not be caused by CON approval of the Merger, but rather would be the result of DYP’s being classified into the proper peer group under the Principles to recognize that certain Hospital cardiac rehabilitation services have now been housed in the DYP NF structure since July 2014. For details, see the attached March 10, 2015 filing of Joe Wood with Mr. Downs, along with the January 8, 2015 letter of Stefanie Nadeau, Director of the Office of MaineCare Services. DYP is entitled to that status under pertinent definitions in the DHHS Principles, and to the peer group classifications and reimbursement caps that go with that status.

To the extent that those nursing facilities in the HANF peer group receive more reimbursement for their direct care costs and their routine costs than facilities in other peer groups, that additional reimbursement reflects the policy and design of DHHS in promulgating the Principles, recognizing through these differentiated peer group caps that hospital affiliation brings with it relatively higher staffing costs and other costs defined as routine, as opposed to the costs of nursing facilities in other peer groups.

In all events, the determination of DYP’s entitlement to HANF status will be made by the DHHS Office of MaineCare Services, and the pendency of our filings with this other branch of DHHS cannot properly be viewed as a negative factor in this CON review. Moreover, it is speculation for the CON Unit to assume (or not assume) any facts outside of the facts which address the CON Statute and review criteria.

**B. Certificate of Need Unit Discussion**

1. **CON Standards**

Relevant standards 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.

1. **CON Unit Analysis**

SMHS seeks to merge two of its subsidiaries. SMDYP will be merged into Saint Mary’s Regional Medical Center (SMRMC). The applicant has demonstrated that it is capable of operating the nursing home as part of its hospital operations. The applicant has provided information that its close relationship with the nursing home has positively affected the outcomes of its patients. The applicant has demonstrated that at its current rates of reimbursement that it can operate the nursing facility effectively. Without considering future reimbursement rates, the impact of this proposal on these standards is minimal.

Future reimbursement rates and their impact on this proposal were brought to the fore of discussions by two events. The first of these events was the applicants March 10, 2015 requested recognition of their status as a hospital affiliated nursing facility from the Office of MaineCare Services (OMS). This letter is in the record of this application. The applicant has stated that they should be considered a hospital affiliated nursing facility based on the following language from the MaineCare Benefits Manual, Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities Principles of Reimbursement for Nursing Facilities:

“Hospital-affiliated Nursing Facility (HANF**)** is a nursing facility that is a distinct part of a hospital provider, located within the same building as the hospital unit or licensed as a hospital facility, or has ambulatory care services and nursing facility beds located within the same building or whose nursing facility beds were previously part of a hospital and relocated prior to January 1, 2005.”

The Office of MaineCare Services indicated to the applicant on May 12, 2015 that it did not consider the nursing facility as eligible for HANF status based on its current corporate configuration.

**Public Hearing**

The second instance considering the future reimbursement of the nursing facility occurred when a request to hold a public hearing on this applicant was timely received according to the provisions found at 22 MRSA §339 (2 B).

A public hearing regarding this transaction was conducted on May 14, 2015.. Public comments were welcomed through June 12, 2015. Concerns were raised by Cedars Nursing Home about the impact of SMDYP proposed change to its peer group on State funding and other providers. The complete testimony and transcript of the public hearing are on file at CONU.

Mr. John Watson, Chief Financial Officer of Cedars Nursing Home provided the following testimony:

“The reimbursement impact of granting the CON, approving the merger, and allowing d’Youville Pavilion to move from Peer Group 2 to Peer Group 3 will result in significantly higher cost to the state. How? A couple of ways according to DHHS staff: St. Mary’s annually services around 55,000 MaineCare patient days and every dollar their rate increases as a result of moving out of Peer group 2 requires around $55,000 in additional state reimbursement. Under the current rate setting method, this peer group move could require $1.2 million in additional state funding that would grow every year. Additionally, adding St. Mary’s higher costs to Peer Group 3 raises the Peer Group 3 median, requiring more funding for those already in Peer Group 3. Higher reimbursement overall, pushes the state’s funding closer to Medicare upper limits and according to DHHS staff, exceeding that upper limit mean no federal match – which means either we take more fuds back from providers or use 100% state dollars to pay for care.”

Impact on Reimbursement for other providers

**“**Also confirmed with DHHS, is the fact that moving the high costs of a hospital’s Direct Care and Routine Costs out of Peer Group 2 will lower the median for all remaining providers every time rates are rebased. This is just one of two ways to cause a reduction in funding for other providers. Another more likely way, if history is any indication, would be if state funding for nursing facilities is not adequately increased through its budgetary process to accommodate increased care delivery costs as well as the increased reimbursement caused by a Peer Group change. Then, that additional cost will come at the expense of every other provider every two years. Recently, The Aroostook Medical center (TAMC) was discreetly granted a Peer Group change that DHHS staff confirmed will do exactly what granting St. Mary’s a Peer group change would do – annually cost the state significant amounts of additional funding and reduce funding for other providers”

“Under the existing reimbursement system, the impact of a Peer Group change for d’Youville Pavilion will be felt for years to come, by both the state and other providers, especially within the budget neutral mentality of current state government.”

The applicant commented concurrently with that period and the following was their response.

SMHS response:

**“**The CON Application does not and will not determine whether St. Mary’s d’Youville Pavilion should be a HANF. That determination is made pursuant to a separate set of rules and process, by a separate branch of DHHS, and the pending CON Application should be ruled upon consistent with the criteria found in the CON Statute without reference to the reimbursement peer group status of the Nursing Home.”

“The Cedars presented its concerns regarding the St. Mary’s CON Application at the May 14 hearing. Although The Cedars is on record as not objecting to grant of the CON for the merger, it states that there is a “potentially significant impact on MaineCare reimbursement that would be caused if as a result of the merger the [Nursing Home} were to be reclassified with the hospital-based peer group under Principle 13…” As noted above, the decision by MaineCare to classify or reclassify a nursing home under the principles of reimbursement does not implicate the CON law.”

“The Cedars provided no definitive data in support for its concerns, even if the CON Unit were disposed to evaluate these concerns. In fact, it is speculative as to whether a change in peer group status to HANF for d’Youville Pavilion would have any impact on the large nursing home peer group (where Cedars is presently classified). Indeed, when The Aroostook Medical Center (TAMC) was granted HANF status last year, the peer group caps and related elements were not revised.”

“Rate setting is a complex process with multiple elements set forth in governing legislation and the Principles of Reimbursement LD 1776, Public Law Chapter 594, which the Legislature enacted in 2014, made multiple changes on how this process is to be carried out going forward. Several of these changes took effect August 14, 2014 via emergency rulemaking. Given the many moving parts in this process, it is virtually impossible to evaluate how future rates will be determined until future rebasing’s, COLA adjustments and other elements are carried out by DHHS, based on cost report data yet to be determined.”

**CONU Response to Comments:**

CONU agrees with SMHS that CONU will not approve SMDYP request to be a HANF. However, the financial impact of SMDYP moving to the hospital based peer group must be evaluated in the context of its’ potential impact on total health care expenditures and its impact on other providers in the local service area and statewide given the available resources.

We agree with comments that receiving HANF status will necessitate increased State funding. This after all is the point of this particular provision of the reimbursement rules.

This CON process utilizes financial projections provided by the applicant; CONU must evaluate the impact of this proposed transaction using these assumptions. As shown in the Economic Feasibility section of this analysis, this could result in increased reimbursement of between $1,400,000 and $2,300,000, depending on final computation by DHHS Rate Setting and DHHS Audit. The applicant suggests that this increased reimbursement could be as low as $900,000.

The applicant has quantified $250,000 in actual savings stemming from this proposal. The applicant in its response to the pre-release technical assistance meeting noted several ways that the entity currently coordinates care and services between the two entities. The applicant indicated that the proposed transaction would allow a different nursing home in Maine to eliminate the costs of a position with savings of $100,000.

The applicant in its response to the pre-release technical assistance meeting noted several ways that that the entity currently coordinates care and services between the two entities and quantified these savings at $1,100,000.

The applicant makes the argument that the legislature provided additional funding to reimburse nursing facilities. In light of the public comments included above, some consideration should be given to the fact that the legislature did allocate more funds to nursing homes. In communication with Office of MaineCare personnel, it was reported that the anticipated additional costs of this proposal can be absorbed by the state budget. This should serve to mitigate much of the concerns of the public commenters.

It is Maine’s own regulation that allows for the enriched MaineCare reimbursement for HANF’s. To deny a CON on the sole grounds of a secondary impact from a department rule is tenuous at best and should be considered in context of how the applicant meets the other related standards, but not control the determination. The two entities are already closely related and, as reviewed, provide a level of service that would be considerably more expensive to replace if, because of the lack of reimbursement, the provider stopped providing the services.

Therefore, considering 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 applicant meets the standard.

**III. Conclusion**

The Certificate of Need Unit recommends that the Commissioner find that the applicant has met its burden to demonstrate that the proposed project is consistent with the orderly and economic development of health facilities and health resources for the State.

# VI. Outcomes and Community Impact

**A. From Applicant**

“Outcomes and quality indicators will continue to be measured as they are today. As described in other sections of this application, SMHS has an established, system-wide approach to performance improvement and quality monitoring. In addition, SMDYP and SMRMC will retain their individual licenses and will thereby continue to meet all applicable licensing standards. The merger will not have any negative impact on quality outcomes moving forward.”

“SMHS, SMDYP and SMRMC are all vital community health resources. All entities are actively engaged in community health outreach, and are active participants in the community dialogue around population health. The Health System works cooperatively with other local organizations in the development of the community health needs assessment in order to clearly identify health priorities. SMHS strategic priorities align with the identified community needs. The additional integration of the Health System entities that will ensue from the merger of the nursing home with and into the hospital will have a positive impact on the community.”

**B. Certificate of Need Unit Discussion**

1. **CON Standards**

Relevant standards 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.

1. **CON Unit Analysis**

This transaction would have no adverse impact on high-quality outcomes at SMDYP. SMDYP currently serves up to 210 SNF/NF residents at any one time and would continue to do so if this transaction occurs. SMDYP is a subsidiary of SMHS. SMHS mission is to focus on identified community needs and provide high quality clinical outcomes across the full spectrum of services. This will not change as a result of this transaction. As this proposal does not increase the number of SNF/NF beds or add additional new health care services it does not negatively affect the quality of care delivered by existing service providers.

**Conclusion**

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

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# VII. Service Utilization

**A. From Applicant**

“The proposed merger will not result in inappropriate increases in the utilization of services according to the principles of evidence-based medicine adopted by the Maine Quality Forum. No significant changes in service utilization are anticipated as a result of this merger.”

“The merger will provide an opportunity for enhanced integration across the Health System. This will ensure that patients are treated in the most clinically appropriate, cost effective level of care. The ability to reduce hospital readmissions will be optimized, with the increased potential for seamless communication across the Health System.”

“The merger is not expected to have any impact on other competing health care providers in the area.”

**B. Certificate of Need Unit Discussion**

1. **CON Standards**

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

1. **CON Unit Analysis**

The Maine Quality Forum has not adopted any principles of evidence-based medicine directly applicable to the application; therefore this application meets the standard for this determination. This project will not result in any additional SNF/NF services in this area and will not result in inappropriate increases in service utilization.

1. **Conclusion**

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

# VIII. MaineCare Funding Pool and MaineCare Neutrality

1. **From Applicant**

“N/A”

1. **Certificate of Need Unit Discussion**
2. **CON Standards**

In the case of a nursing facility project that proposes to add new nursing facility beds to the inventory of nursing facility beds within the State, is consistent with the nursing facility MaineCare funding pool and other applicable provisions of sections 333-A and 334-A.

1. **CON Unit Analysis**

Since the project does not include a proposal to add nursing facility beds to the inventory of nursing facility beds within the State, this standard is deemed to have been met.

1. **Conclusion**

Certificate of Need Unit recommends that the Commissioner find that the applicant has met their burden to demonstrate that the project is consistent with the nursing facility MaineCare funding pool and other applicable provisions of sections 333-A and 334-A.

# IX. Timely Notice

**A. From Applicant**:

“SMHS filed a Letter of Intent for this project on January 29, 2015. Upon notification of CON applicability, a technical assistance conference was scheduled. This conference occurred on February 18, 2015 at SMRMC. SMHS was represented by Carolyn Kasabian, Joe Wood, John Geismar, John Doyle and Brett Seekins, and DHHS was represented by Matt Chandler, Larry Carbonneau, and Rich Lawrence. St. Mary’s representatives provided an overview of the proposed project, and CON representatives highlighted key issues to be addressed in the CON application. The technical assistance meeting was beneficial to SMHS staff, and the feedback provided has been incorporated throughout the application.”

**B. Certificate of Need Discussion**

|  |  |
| --- | --- |
| Letter of Intent filed: | January 29, 2015 |
| Subject to CON review letter issued: | February 18, 2015 |
| Technical assistance meeting held: | February 18, 2015 |
| CON application filed: | March 26, 2015 |
| CON certified as complete: | March 26, 2015 |
| Public Information Meeting Held: | N/A |
| Public Hearing held: | May 15, 2015 |
|  |  |

# X. Findings and Recommendations

Based on the preceding analysis, including information contained in the record, the Certificate of Need Unit recommends that the Commissioner make the following findings:

**A.** 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.** 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 proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

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

**E.** The project ensures high-quality outcomes and does not negatively affect the quality of care delivered by existing service providers:

**F.** 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

**G.** The project is consistent with the nursing facility MaineCare funding pool and other applicable provisions of sections 333-A and 334-A.

For all the reasons contained in this preliminary analysis and based upon information contained in the record, Certificate of Need Unit recommends that the Commissioner determine that this project should be **approved.**