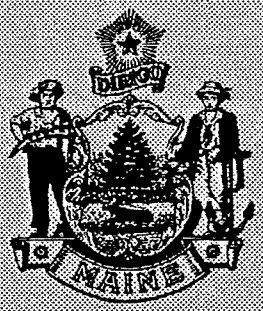
FINAL REPORT OF THE COMMISSION TO STUDY THE CERTIFICATE OF NEED LAW AND THE IMPACT OF COMPETITIVE MARKET FORCES ON AMBULATORY HEALTH SERVICES



State of Maine
1990

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114th LEGISLATURE

FINAL REPORT OF THE COMMISSION TO STUDY THE CERTIFICATE OF NEED LAW AND THE IMPACT OF COMPETITIVE MARKET FORCES ON AMBULATORY HEALTH SERVICES

December 1990

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TABLE OF CONTENTS

I. INTRODUCTION

The Commission to Study the Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services (or the "Interim Study Commission") was established through the enactment of P.L. 1989, chapter 588, section 56 (L.D. 1322) in 1989. The Commission was directed to carry out its responsibilities in two phases. We completed the first phase of our work and submitted a report to the Second Regular Session of the 114th Legislature in January of 1990.

Our report included the recommendations of both a majority and a minority of the Commission. A majority of the Commission called for changes to the laws governing both the Certificate of Need program and the hospital payment system. It also urged that certain access requirements currently applicable to hospitals should be extended to several other categories of providers. It recommended a revision of our charge to enable us to consider during the second phase of our work various methods of establishing the size of the Hospital Development Account. Finally, a majority of the Commission called for the creation of a new commission to study further certain provisions of the Certificate of Need law.

A minority of the Commission recommended the amendments to the Certificate of Need law, the extension of access requirements to non-hospital providers, and the revision of the Commission's charge as these proposed changes were reflected in the majority report. In

addition, a minority of the Commission recommended deferring any further changes of the restructuring provisions of the law governing the hospital payment system and called for an extension to any purchasers of the provisions of the Certificate of Need law relating to the acquisition of major medical equipment.

The bill reflecting the recommendations of a majority of the Commission was enacted into law as P.L. 1989, chapter 919 (L.D. 2435) during the Second Regular Session of the 114th Legislature. With the exception of the revision of our charge, the changes reflected in this legislation will become effective October 1, 1991.

In the second phase of its work, the Commission was directed "to study the current and potential impact of competitive market forces on outpatient volumes and the cost, quality and accessibility of ambulatory health services." In carrying out this study, the Commission was required to "consider the likely impact of deregulating the charges made by hospitals for outpatient services and the elimination of any continuing restrictions on the establishment of preferred provider arrangements." As indicated above, the enactment of P.L. 1989, chapter 919 (L.D. 2435) amended our charge to provide for the consideration of methods of establishing the size of the Hospital Development Account. The Commission is required to present a report on the results of the second phase of its work to the Joint Standing Committee on Human Resources. We submit this report in fulfillment of the requirements of the second phase of our study.

II. THE STUDY PROCESS

The Commission initiated the second phase of its study in May 1990 and in completing its work has conducted eight meetings. These meetings focused on the four areas identified in the Commission's charge: (1) the methods of establishing the size of the Hospital Development Account, (2) the impact of competitive market forces on outpatient volumes and the cost, quality, and accessibility of ambulatory health services, (3) the likely impact of deregulating the charges made by hospitals for outpatient services, and (4) the likely impact of eliminating any continuing restrictions on the establishment of preferred provider arrangements. The Commission considered the latter three parts of its charge as a single interrelated set of issues. As in the first phase of our work, we continued to benefit both from the consideration given to these issues in 1988 and 1989 by the Blue Ribbon Commission on Health Care Expenditures and from the fact that several of our members were formerly members of the Blue Ribbon Commission.

In the course of its meetings, the Commission heard presentations by representatives of the Department of Human Services and the Maine Health Care Finance Commission with respect to the discussion of the Hospital Development Account. In the context of our consideration of the impact of competitive market forces on ambulatory health services, the deregulation of hospital outpatient services, and the elimination of any restrictions on the establishment of preferred provider arrangements, the Commission heard presentations by representatives of Blue Cross and Blue Shield

of Maine, the Maine Bureau of Insurance, and the Health Insurance Association of America.

III. RECOMMENDATIONS

A. Hospital Development Account.

As part of its discussion of methods for establishing the size of the Hospital Development Account, the Commission reviewed the projects whose approval since 1984 under the Certificate of Need program had resulted in debits against the Account. The Commission then identified the subset of these projects that had been approved either on an emergency basis or through an administrative review, as variances to the originally approved Certificate of Need.

The Commission recognizes the importance of the existing statutory provisions for both emergency and administrative reviews. Emergency situations may arise from time to time that may require the Department of Human Services to act upon projects within a highly compressed review period. Similarly, an administrative review may be warranted in the context of a request for a variance on an earlier approved project, if the reasons for the request arise out of circumstances not under the control of the applicant and not known at the time of the issuance of the Certificate of Need and if the magnitude of the variance request is relatively modest.

The approval of a project on either an emergency basis or through an administrative review process, like any other approval, causes a reduction in the balance that would otherwise be available in the Hospital Development Account. Such a reduction may, in turn, have the effect of making it impossible for the Department of Human Services to approve some other meritorious project. In recent years, the impact on the Development Account of projects approved as emergencies or variances has been substantial. In the most recently completed payment year cycle, for example, projects with an impact on the Development Account of $2.4 million have been approved as either emergencies or variances. One project, by itself, received a variance of $929,140, more than doubling the size of the original impact of this project.

Because of the implications that the approval of emergencies and variances has both for establishing the size of the Development Account and for other projects that may be competing for the limited funds credited to the Development Account, the Commission believes that the Department of Human Services should refine further those portions of the Certificate of Need program relating to the review of both emergency projects and requests for variances on projects that have already been awarded a Certificate of Need. Specifically, the Commission recommends that the Department of Human Services, in consultation with the Maine Health Care Finance Commission, establish through a rulemaking proceeding a dollar threshold that would trigger a full public review, rather than an administrative review of a variance request.

This threshold should reflect both quantitative and qualitative considerations. Quantitative considerations might include an absolute dollar amount or a ceiling on the percentage increase in costs reflected in a given variance request. Qualitative considerations might consist of the exemption from full public review of a variance request arising out of unforeseeable and uncontrollable cost increases. The Department of Human Services and the Maine Health Care Finance Commission should report to the Joint Standing Committee on Human Resources no later than March 15, 1991 on the threshold that they have developed.

B. Market Forces, Outpatient Deregulation, and Preferred Provider Arrangements.

The Commission has reviewed the most current publications discussing the impact of market forces on the development, delivery, and purchase of outpatient health care services. In addition, the Commission's staff has interviewed a variety of individuals in order to assemble the most recent information available on this topic. These individuals included consultants, academics, representatives of industry associations, and government officials. Their comments reflected state, regional, and national perspectives.

The information that we have been able to compile has been consistent but not particularly helpful to our effort to assess the impact of market forces on outpatient services. Virtually no empirical work has been either completed or published on this subject. For the most part, the publications that discuss the

impact of market forces in health care are almost entirely theoretical.

As the result of legislation enacted in 1989, the Maine Health Care Finance Commission has initiated the collection of certain outpatient health care data from non-hospital sources and will be developing a uniform method for the reporting of hospital outpatient data. Within a few years, these data collection efforts will enhance the ability of policymakers to assess the impact of market forces. In the absence of data from Maine or any other jurisdiction, we have not been able to complete an assessment of the impact of market forces on the development, delivery, and purchase of outpatient health care services.

During our discussions of this topic, it became clear that several different points of view were represented within the Commission's membership. Because of the absence of data, we were unable to subject these points of view to the testing that would be required as part of the assessment of their respective merits. As a result, we have not reached a consensus about what changes, if any, to recommend with respect to the continued economic regulation of outpatient hospital services and the existing statutory framework governing preferred provider arrangements.

C. Establishment of Study Commission.

With the submission of this report on the second phase of our study, we will have addressed each of the specific issues outlined

in our charge from the Legislature. During the course of our study, however, we have identified other more general concerns that arise from the myriad of changes affecting our health care delivery and payment systems. We believe that these systems require continuing attention if we are to maintain and improve access to high quality services at an affordable cost.

Although providers, payors, and several agencies of state government can be expected to devote considerable effort over the next several years to the development and implementation of policies designed to sustain and enhance our health care system, these individual efforts may fall short of providing a statewide continuing focus on the status of our health care system. For these reasons, we recommend that the Legislature establish a commission to examine the status of Maine's health care system.

This commission should be structured broadly with respect to both its membership and its charge. The issues to be considered should include, but not be limited to:

1. The development of a continuum of care;

2. The maintenance of an appropriate balance between a reliance on economic regulation and market-like forces;

3. The changing face of health care in rural areas; and

4. The obstacles impeding access to services.

This commission should be provided the personnel and financial resources that are commensurate with the significant issues that it will be expected to address. In order to avoid needless duplication of effort, however, this commission should be encouraged to use existing sources of data whenever possible and to coordinate its efforts, when practical, with any ongoing efforts intended to address similar issues. The commission should be required to submit a report and any recommendations to the Legislature and the Governor in a timely manner.

D. Elimination of Third-Party Payor.

Under current law, a major third-party payor is defined as a third-party payor that, with respect to an individual hospital:

1. Is responsible for payment to the hospital of amounts equal to or greater than 10% of all payments to the hospital, as this amount is determined by the Commission; and

2. Maintains a participating agreement with the hospital.

In addition, current law provides that the Department of Human Services will be deemed to be a major third-party payor with respect to any hospital participating in the Medicaid program. Finally, the law provides that any payor responsible for payment under the

Medicare program will be deemed to be a major third-party payor with respect to any hospital participating in the Medicare program.

Under current law, a major third-party payor is required to make periodic interim payments to hospitals on a basis that is no less frequent than bi-weekly. Any major third-party payor may, however, make more frequent interim payments on its own initiative. Major third-party payors have been subject to this requirement since the hospital payment system was implemented in 1984.

The passage of the 1989 amendments to the hospital financing statute has resulted in significant changes to the payment system administered by the Maine Health Care Finance Commission. One of these changes was intended to encourage more negotiations over price between payors and hospitals. Under the original hospital financing statute, services could not be offered to particular payors at discounts from regular charges except with the approval of the Commission. Under the revised statute, beginning in the fall of 1991, all hospitals, except those few that have elected to participate in the total revenue system, will be free to offer services at discounts from regular charges without seeking the approval of the Commission.

The revised statute contemplates that payors and hospitals will engage in discussions encompassing all aspects of the purchase of services. Under current law, however, major third-party payors would be unable to negotiate about the frequency of payment since they would be required to make at least bi-weekly payments. In

contrast, all other payors would be free to negotiate the frequency of payment. We do not believe this different treatment of payors is consistent with the spirit of the amendments that otherwise encouraged the furtherance of negotiations between payors and hospitals. Rather, we believe that discussions about the frequency of payment should, like those relating to price and quality assurance, be the responsibility of private payors and hospitals. For this reason, we recommend that the requirement that major third-party payors make interim payments on a bi-weekly basis be repealed as it affects private payors. With the elimination of that requirement, the separate statutory category for "major" payors becomes superfluous and can be removed from the health care financing law altogether. Accompanying this report is draft legislation to accomplish that change.

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2/11/91

AN ACT TO LIMIT MAJOR THIRD-PARTY PAYOR STATUS TO GOVERNMENTAL PAYORS

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 M.R.S.A. §382, sub-§9, as enacted by P.L. 1983, c. 579, §10, is repealed.

Sec. 2. 22 M.R.S.A. §382, sub-§10 as enacted by P.L. 1983, c. 579, §10 is repealed.

Sec. 3. 22 M.R.S.A. §386, sub-§7, as enacted by P.L. 1983, c. 579, §10, is amended to read:

7. Audits. The commission may, during normal business hours and upon reasonable notification, audit, examine and inspect any records of any health care facility to the extent that the activities are necessary to carry out its responsibilities. To the extent feasible, the commission shall avoid duplication of audit activities regularly performed by ~~major third-party~~ payors.

Sec. 4. 22 M.R.S.A. §396-I, sub-§2, as repealed and replaced by P.L. 1989, c. 588, §33, is repealed and the following enacted in its place:

2. Apportionment among payors and purchasers. Based on historical or projected utilization data, the commission shall apportion, for each revenue center specified by the hospital subject to subsection 6, and for the hospital as a whole, the hospital's gross patient service revenue among the following categories:

A. The Medicare program administered under the United States Social Security Act, Title XVIII, and any payor acting as a fiscal intermediary for the Medicare program to the extent of the payor's obligations as a fiscal intermediary;

B. The Medicaid program administered by the department under the United States Social Security Act, Titles V and XIX; and

C. All other purchasers and payors, which together shall constitute one category.

Sec. 5. 22 M.R.S.A. §396-I, sub-§3, ¶A, as repealed and replaced by P.L. 1989, c. 858, §33, is amended to read:

A. Payments made by ~~major third-party payors~~ the department in accordance with its obligations under the Medicaid program, determined pursuant to paragraph B of subsection 2, shall be made in accordance with the following procedures.

(1) The commission shall require ~~major third-party payors~~ the department to make biweekly periodic interim payments to hospitals, provided that ~~any such payor~~ the department may, on its own initiative, make more frequent payments.

(2) After the close of each payment year, the commission shall adjust the apportionment of payments ~~among major third-party payors~~ to the Medicaid program based on actual utilization data for that year. Final settlement shall be made within 30 days of that determination.

Sec. 6. 22 M.R.S.A. §396-I, sub-§3, ¶B, as repealed and replaced by P.L. 1989, c. 588, §33, is amended to read:

B. For hospitals regulated according to the total revenue system, payments made by payors, other than ~~major 3rd-party payors~~ Medicare and Medicaid, and by purchasers shall be made in accordance with the following procedures.

(1) Payors, other than ~~major 3rd-party payors~~ Medicare and Medicaid, and purchasers shall pay on the basis of charges established by hospitals, to which approved differentials are applied. Hospitals shall establish these charges at levels which will reasonably ensure that its total charges, for each revenue center, or, at the discretion of the commission for groups of revenue centers and for the hospital as a whole, are equal to the portion of the gross patient service revenue apportioned to persons other than ~~major 3rd-party payors~~ the Medicare and Medicaid programs.

(2) Except as otherwise provided in this subparagraph, subsequent to the close of a payment year, the commission shall determine the amount of overcharges or undercharges, if any, made to payors, other than ~~major 3rd-party payors~~ Medicare and Medicaid, and to purchasers and shall adjust, by the percentage amount of the overcharges or undercharges, the portion of the succeeding year's gross patient service revenue limit that would otherwise have been allocated to purchasers and payors other than ~~major 3rd-party payors~~ Medicare and Medicaid. Adjustments to the succeeding year's gross patient service revenue limit shall not be made for undercharges if the undercharges resulted from an affirmative decision by the hospital's governing body to undercharge. Any such decision to undercharge must be disclosed to the commission in order that it may be taken into account in the apportionment of the hospital's approved gross patient service revenue among all payors and purchasers~~, including major 3rd-party payors~~.

Sec. 7. 22 M.R.S.A. §396-I, sub-§3, ¶C, as repealed and replaced by P.L. 1989, c. 588, §33, is amended to read:

C. Payments to hospitals on the per case system shall be made on the basis of charges established consistent with limits set by the commission under that system. The commission shall establish by rule the necessary adjustments to approved revenues in subsequent payment years for hospitals determined to have overcharged or undercharged purchasers and payors other than ~~major 3rd-party payors~~ Medicare and Medicaid.

STATEMENT OF FACT

This bill contains the statutory changes recommended in the second and final report of the Commission to Study the Certificate of Need Law and Impact of Competitive Market Forces on Ambulatory Health Services, pursuant to P.L. 1989, c. 588, §56(1)(B).

The hospital care financing system administered by the Maine Health Care Finance Commission defines certain payors as "major third-party payors" and imposes special obligations upon them. This bill removes all references to major third-party payors from the Maine Health Care Finance Commission statute. The Medicaid program, which is a major third-party payor under current law, would continue to have an obligation to make

periodic, equal payments throughout each hospital's fiscal year. Under this bill, the statute would be silent as to the method and timing of Medicare payments, which are currently governed by federal law. Hospital revenues would continue to be apportioned in the same manner as they are under current law, except that the only payors treated as separate categories would be the Medicare and Medicaid programs. The general payment provisions, formerly applicable to payors other than major third party payors, would under this bill apply to all payors except Medicare and Medicaid.

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