NATIONAL AHEC EVALUATION

SUBMITTED TO THE

AHEC PROGRAM OFFICE
BY THE
KATAHDIN AREA HEALTH EDUCATION CENTER

MARCH 11, 1988

Note: These data include only professionals registered and residing in the State of Maine. Geographic distribution based on place of residence.

I. HEALTH MANPOWER DATA

The geographic distribution of primary care providers (other than physicians) and other health professionals in the nine county KAHEC service area is summarized in Tables I (number of professionals by county) and II (provider to population ratios). The KAHEC service area encompasses over eighty percent of Maine's land area, and forty-one percent of the population.

A.) Physician's Assistants: There are 153 Physician's Assistants (PAs) registered with the Maine Board of Medicine. Ninety-three (61%) of these PAs practice within the KAHEC service area; however, 31 of these professionals (33%) are located in the greater Bangor area of Penobscot county.

The ratio of providers to population in the nine counties varies from 1:2,269 to 1:14,900. Overall, in the KAHEC service area the ratio is 1:5,166 (1:5,516 when Penobscot county is excluded) compared to a state ratio of 1:7,661. The relative preponderance of PAs in the KAHEC service area reflects a reliance upon these professionals to extend physician services in manpower shortage areas.

With regard to Nurse Practicioners, 33% of all NPs are located in the KAHEC service area (their distribution by county is not known at this time). The provider to population ratio in the nine counties (1:5,651) compares less favorably with the state as a whole (1:4,561).

B.) Occupational Therapy: There are 301 Occupational Therapists licensed in the State of Maine (264 OTR; 23 COTA; 14 OTS). Of these, 63 (20% of all registered members) reside in the nine county KAHEC area. Forty-one percent of these KAHEC area professionals, however, practice in the Bangor area. Consequently, only 12% of all Maine OTs practice in the area when Penobscot county is excluded.

The provider to population ratio in the nine county area (1:7,624; 1:9,241 when Penobscot is excluded) greatly exceeds that of the state as a whole (1:3,894). In Piscataquis county (population 18,150) there is not a single provider. In Washington and Franklin counties there is only one registered professional for 34,400 and 29,100 people respectively.

C.) Physical Therapy: There are 486 licensed Physical Therapists in Maine. One hundred and fifty-two (31% of total) practice in the KAHEC area. Of this number, 49 (33%) are located in Bangor, with the remainder (21% of all licensed PTs) distributed throughout the service area.

The provider to population ratio in the KAHEC area (1:3,160; 1:3,319 when Penobscot is excluded) is greater than the state as a whole (1:2,412) and ranges from 1:2,214 (Hancock county) to 1:6,786 (Somerset county).

D.) Speech and Audiology: Of 268 registered Speech and Audiology Therapists in Maine, 90 (34%) are in the KAHEC area. However, 42 of these professionals (47%) practice in the greater Bangor area. When excluded, 48 professionals (a mere 18% of the state's total) practice in the remainder of the KAHEC service area.

The provider to population ratio of these professionals in the KAHEC area (1:5,337; 1:7,598 excluding Penobscot county) is above that of the state (1:4,374). Piscataquis county has no provider for a population of 18,150 persons, and Oxford county has only 3 professionals in a population of 50,400 (ratio 1:16,800).

E.) Psychologists: There are 349 Psychologists registered and residing in Maine. Of these 103 (30%) are located in the KAHEC area. Bangor, however, has 54 of these professionals (52%) and the remaining 49 (14% of Maine's total) are distributed-unevenly- throughout the other eight counties.

While the state provider to population ratio is 1:3,359, in the KAHEC area overall it is 1:4,663; and when Penobscot county is excluded, reaches 1:7,274. Piscataquis county has no registered provider for a population of 18,150 persons; and Oxford has only 5 professionals (1:10,080) and Somerset 3 (1:15,833).

F.) Master's of Social Work: Of 1,934 registered/licensed social workers in the State of Maine, 251 have a MSW. Of these individuals, 84 (33%) are in the KAHEC area (27% of these in Bangor), with 61 MSWs (24% of State total) practicing outside of Penobscot county.

The statewide provider to population ratio (1:4,670) is exceeded by the KAHEC area (1:5,718), and is greater than 1:10,00 in Washington (1:11,466), Piscataquis (1:18,150) and Oxford (1:16,800) counties.

G.) Substance Abuse Counselors: There are only 182 registered substance abuse councilors in Maine. Sixty-eight (37%) are in the KAHEC area, with 22 of these (32%) in the Bangor vicinity.

The provider to population ratios vary substantially, from no provider in Piscataquis county (population 18,150), 1:10,080 (Oxford county) to 1:2,980 (Waldo county).

These data serve to underscore the fact that the nine counties served by the Katahdin Area Health Education Center are underserved in terms of primary care providers and other health professionals. Even within the KAHEC service area a severe maldistribution of these professionals is evident. The concentration of providers is greatest in Penobscot county, and the Bangor "metropolitan" area specifically. The underrepresentation of all health professionals in the KAHEC service area becomes even more apparent when this geographic distribution is considered.

II. Fiscal Resource Base

MARCH 10 DATE: 1987-1988 FISCAL YEAR

1. Personnel Source: One-half of salary and fringe benefits for J.Ross from February, 1988 thru September, 1989. NIH New Investigator Research Award (7R23 HD 18751-04).	13,644
2. Equipment Source: University of Maine	5,600
3. Mobil Medical Van	14,000
4. Continuing Education Source: Eighty hours consultation, programming with VACHEP, 2 persons at $25/hr.	4,000
5. Nursing	7,378
6. Space	14,000
7. Student Housing	13,400
TOTAL:	72,022

III. Minority Student Data:

In this, our first operational year, the KAHEC is working with representatives of Maine's Native American communities to develop a youth leadership program. As currently envisioned, this program would be integrated into the Native American's Summer Youth Camp. Mr. McCllean Hall has agreed to serve as technical advisor to the planning committee to develop the leadership program utilizing a Native American model.

This program is expected to be offered over a two week period in August of this year. It specifically targets Native American youth of both gender who are seventh and eighth graders. It will include approximately 110 Native American youth representing the Penobscot, Passamaquoddy, Micmac and Maliseet communities of Maine. The KAHEC is working closely with representatives of all these communities, as well as the Superintendent of Maine Indian Education, in developing this program (see attached description).

IV. Student/Trainee Data: January proposal looks good at this point.

V. Continuing Education: To date, the KAHEC has offered three interdisciplinary workshops:

1. June 1987: Calais, Maine (Downeast Region). "AIDS: Medical and Psychosocial Perspectives". 127 participants.

2. September, 1987: Presque Isle, Maine (Aroostook Region). "AIDS: Medical and Psychosocial Perspectives". 143 participants.

3. January, 1988: Calais, Maine (Downeast Region). "Understanding Family Systems". 43 participants.

See attached program evaluation forms and comments, including summaries of participants by discipline.

The following programs are in preparation for the 1987-1988 fiscal year:

Downeast Region:
1. Developmental Disabilities
2. Child Sexual Abuse
3. Suicide
4. Immobility

Aroostook Region:
1. Developmental Disabilities
2. Chronic lung disease
3. Women's Health

Penquis Region:
1. Women's Health
2. Suicide
3. AIDS-targeted to students of University of Maine system.

VI: Organization and Governance:

The Katahdin Area Health Education Center is governed by a volunteer board of directors. Seats on the KAHEC board have been designated in the by-laws as follows:

6 Representing regional councils
1 Maine Indian Health Coalition
1 Franco-Americans in Northern Maine (ACTFAM)
1 Maine Ambulatory Care Coalition
1 Central Maine Indian Association
1 Maine Consortium for Health Professions Education
1 Maine Department of Human Services
2 Participating Educational Institutions
1 At-Large Representative

The current composition of the KAHEC board is in the process of change from the developmental to the full operational stage. Current representatives of the KAHEC board, as well as KAHEC Regional Councils, have been attached.

VII. Technical Assistance: Research: Library/Learning Resources Development:

1. Technical assistance: To date, the KAHEC staff has provided approximately 450 hours of technical assistance to the following health, health related programs and professionals:

To the Washington County Vocational Technical Institute and a coalition of community interest groups, assistance in the development of a multiple entry/multiple exit nursing program in the Downeast Region.

To the Washington County Health and Social Service Consortium, assistance in the development of a regional educational training newsletter.

To the Castine Community Hospital, assistance in developing a plan for a change from an in-patient to an ambulatory care delivery system.

To the Harrington Family Health Center, assistance in planning services to the migrant labor force Downeast.

To the Limestone Ministerial Association, assistance in developing a program of migrant health services in Aroostook county.

To the Ashland Health Center, assistance in acquiring the services of a Physician's Assistant.

To the Greenville Community Hospital, assistance in acquiring the services of a medical technician.

To the Cary Medical Center, assistance in developing a model, rural clinical training program for occupational therapists.

To the department of Public Administration, assistance in developing a proposal for summer internships for French speaking University of Maine students to provide service in health related agencies.

2. Research on Health Manpower Issues: KAHEC activities to date include:

Surveys of nursing manpower needs in the Downeast Region among institutions and community based agencies. Includes a survey of nursing professionals in the region regarding the demand for upgrade, career ladder academic programming.

An allied health manpower needs assessment in the Aroostook Region among institutions and community based agencies.

An assessment of health manpower issues/needs among Maine's Native American communities.

3. Library/Learning Resources:

The KAHEC has been compiling an informational resource base of non-traditional academic programming available to interested persons. To date, we have been able to respond to six requests for information relating to health professions programs.

KAHEC SERVICE AREA: NUMBERS OF PROFESSIONALS

	Projected Population July 1, 1986	Physicians Assistants	Nurse Practioner	Occupational Therapists	Physical Therapists	Speech Pathology & Audiology	Psychologists	Master's of Social Work	Substance Abuse Councilors
State Total	1,172,200	153	257	301	436	268	349	251	182
Aroostook	87,950	10		10	27	16	15	22	10
Washington	34,400	4		1	6	4	4	3	6
Hancock	44,600	12		4	21	6	9	12	5
Penobscot	138,400	31		26	49	45	56	23	22
Piscataquis	18,150	8		0	5	0	0	1	0
Waldo	29,800	2		0	12	6	6	10	10
Franklin	29,100	9		1	11	5	5	5	3
Oxford	50,400	7		7	14	3	5	3	5
Somerset	47,500	10		5	7	5	3	5	7
AHEC Service A. Total	480,300	93	85	63	152	90	103	84	68

Sources:

1. Maine Department of Human Services: Maine Vital Statistics, 1986
2. Maine Board of Registration in Medicine: Medical Directory, 1986 - 1987
3. KAHEC Proposal 1987
4. Maine State Licensure Board: February 1988
5. Maine Department of Professional and Financial Regulation; Board of Examiners in Physical Therapy, December 1987
6. Maine Department of Professional and Financial Regulation: Board of Examiners in Speech and Audiology, December 1987.
7. Maine Department of Professional and Financial Regulation; Board of Examiners in Psychology, December 1987
8. Maine Department of Professional and Financial Regualtion; Board of Examiners in Social Work, December 1987
9. Maine Department of Professional and Financial Regulation; Board of Examiners in Substance Abus December 1987

TABLE II: KAHEC SERVICE AREA: PROVIDER TO POPULATION RATIOS

PROVIDER IN RATIOS	PA's	N.P.	O.T.	P.T.	S & H	Psy	MSW	SAC
STATE	7661	4561	3894	2412	4374	3359	4670	6441
AROOSTOOK	8795	-	8795	3257	5497	5863	3998	8795
WASHINGTON	8600	-	34400	5733	8600	8600	11466	5733
HANCOCK	3717	-	11150	2124	7433	4956	3717	8920
PENOBSCOT	4465	-	5323	2824	3076	2471	6017	6291
PISCATAQUIS	2269	-	0	3630	0	0	18150	0
WALDO	14900	-	3311	2483	4967	4967	2980	2980
FRANKLIN	3233	-	29100	2645	5820	5820	5820	9700
OXFORD	7200	-	7200	3600	16800	10080	16800	10080
SOMERSET	4750	-	9500	6786	9500	15833	9500	6786
KAHEC SERVICE AREA TOTAL:	5166	5651	7624	3160	5337	4663	5718	7063
Less Penobscot Counte	5516	-	9241	3319	7598	7274	5605	7433

BO YERXA
MONTHLY ACTIVITY REPORT
FEBRUARY '88

I. CLINICAL TRAINING

Site Development

During February I expanded outreach activities into Hancock and Charlotte Counties in search of appropriate clinical training sites, especially for medical students, residents (for EMMC residency program) and OT/PT students. Specific meetings included:

- Charlotte County Hospital, St. Stephens, where Administrator Seymour Kaufman indicated a willingness to explore with his medical staff their interest in serving as an OB rotation for the EMMC residents in conjunction with Calais Regional Hospital (concern was expressed re liability vis-a-vis the international boundry). They average 14-16 births per month. Mr. Kaufman gladly shared names of his staff who could familiarize us with professional associations and health professions ed programs in N.B.

- Maine Coast Memorial Hospital, Ellsworth, where Administrator Richard Fredricks was most cordial and supportive of working with the KAHEC. Mr. Fredricks will try to facilitate my entre to his medical staff to assess their interest in taking on medical students and/or residents. He indicated that his PT department had supported training of PT students in the past and encouraged my exploring same with the new head of the hospital's PT department. He indicated his "strong support and interest" in working with the KAHEC to expand PN/ADN/RN ed programs into Hancock County, as his facility has supported locally-based CNA/PN training previously and sees an "ongoing need."

- Blue Hill Memorial Hospital, Blue Hill, where Administrator Ronald Pond was both enthusiastic and inspiring in his support for linking health professions ed programs with small hospitals. This hospital has only 24 beds, but has 18 active medical staffers and 25,000 outpatient visits per year! BHMH has been affiliated for over a decade with Brown University Medical School and gets 2-4 fourth-year medical students (4 wk. rotations) and 6-10 second/third year family practice residents (6 wk. rotations) each year, an activity that Mr. Pond believes has a direct correlation to BHMH's not having to undertake costly physician recruitment activities. He believes that there may be interest on the part of his medical staff in taking a few more students/residents, especially in the winter months. He will specifically explore with Dr. Robt. Walker (who catches ± 450 babies a year) his interest in working with EMMC residents on an OB/FP rotation. Mr. Pond does have on-staff PTs, is setting up some SNF swing-beds and is open to doing some training with PT students.

- Castine Community Hospital, Castine, where friendly but somewhat overwhelmed John Cole (BSPH, MSN, CNC) was functioning as an administrator. This 12-bed hospital is running at 25% occupancy and provides about 7,000 outpatient visits per year. It has two certified FPs as medical staff with a certified PED coming in April. It also has a PT on staff.

The hospital owns two distance clinics (Orland, Penobscot) that staff docs utilize. The whole operation is losing money and undertaking a "serious" long-term planning process to see exactly how best to maintain medical services in the local area. Despite some institutional constraints, Mr. Cole was most sensitive to the KAHEC concept and encouraged me to follow up with his staff regarding clinical training possibilities.

Student/Clerk Support

The most pressing need for student support at this time remains identification of housing with 43 student-months required in Washington County alone during the 6/88-5/89 cycle. Initially, about $200/student-month had been budgeted to support this activity. The AHEC program office, not without some merit, has determined that this should not be utilized in effect as a monthly rental stipend, but that some type(s) of institutional arrangements should be developed so that the provision of housing will be ongoing even after the loss of federal support monies. This does, however, present some practical problems in a poor, rural area with a paucity of institutional infrastructure(s).

Several avenues have been explored but no firm (contractual) commitments made. They include:

- Preceptor support - Both Dr. Hogan (Calais) and Dr. Blythe (Lubec) have indicated an availability of space sufficient for a small (2-3 room) apartment above their (respectively) house and office, which would need furnishing/equipping.

- Hospital support - Calais Regional Hospital Administrator Ray Davis indicated that, since staff cannot be found to startup the CON-approved 16-bed SNF and/or 5-bed psyc units, he could probably provide a room on an ad hoc basis. I will be meeting with this hospital's auxillary to ascertain their willingness to join KAHEC in a community drive to identify volunteer "hosts".

- University support - I met with UMM President Frederic Reynolds who indicated that UMM once provided a gratis room to a medical student (from Japan) interning locally, and that they "should be able" to again. He felt that a room might be available 5-6 months out of the year and directed me to work on this effort with his (not too enthusiastic, I think) Dean of Students. Perhaps his cooperation will be forthcoming if KAHEC could support/match a fund-raising drive/scholarship program for UMM students interested in health careers (of which they offer almost nothing).

Migrant Health

As the proposed mobile migrant health clinic seems to offer the KAHEC per se no clinical training opportunities this season, see misc.

II. CONTINUING AND EXTENDED EDUCATION

ADN Program

The development of an extended multiple-entry/multiple-exit ADN program satellited from EMVTI remains a high priority for the Downeast region. An

institutional needs survey was sent out to 2 hospitals, 4 community-based agencies, 6 nursing homes and 7 rural/Tribal health centers. Regional Advisory Council/board member Priscilla Staples collaborated on an interest survey for LPNs and diploma RNs, which will go out to all LPN/diploma RNs in the region in March. Adapted, this will also be mailed by WEET and JTPA staff to their clients for return to KAHEC. Combined, this should yield adequate data for any/all proposals. I met on several occasions this month with the WCVTI Dean of Adult Ed, as well as with the EMVTI Nursing Program Director and UMM's Director of Community Programs. I have also met with several community members interested in working/organizing informally in support of this effort. I confess to some anxiety regarding the funding uncertainties associated with this, as it is a visible KAHEC-identified activity.

Continuing Ed

The financial report on the Family Systems Workshop indicated expenses of $481.70, income of $1,105, with the balance of $623.30 to be split with V.A. CHEP. The evaluations by the 42 attendees were quite favorable (with the exception of 3-4 highly trained and Certified Substance Abuse Counselors). This points up the need to be very clear in identifying appropriate target audience in brochures/mailings.

Planning activities continue with: Washington County Childrens' Task Force regarding a 1 or 2-day conference on child sexual abuse to be held in Machias/Calais in June; with MCHPE re a 1-day conference on preventing developmental disabilities to be held in Machias/Calais in May (13?), and with UNE/MSW program re a 1-day workshop on Community Organizing in Small Towns and Rural Areas to be offered in Oct/Nov.

A request by me (for KAHEC) for trainers/resource persons for workshops/seminars was carried in the Me. NASW newsletter this month. I have gotten several responses.

Distance Ed

We need to decide what to do with the draft booklet on nontraditional/external degree programs I have developed. My initial suggestion is that we confirm accuracy with programs described, cheaply print a few hundred copies, and announce KAHEC's availability to do a basic 1-2 hour workshop with it as a handout.

The KAHEC is also tapping into the Canadian distance ed network. I have been requesting (but not always receiving) four copies of all materials.

III. HEALTH CAREER AWARENESS/ASPIRATIONS

Career Ed Initiative

I have been reviewing material from the Maine Career Education Consortium and Cooperative Extension Service's pilot "eighth-grade career and educational planning initiative" and suggest that KAHEC consider utilizing this approach with some of its target communities.

ICLAD

I participated in the first quarterly meeting of the Institute for Community Leadership and Development, a Cooperative Extension-initiated

activity intended to expand/coordinate a variety of leadership development activities. I am one of four board members (including UNE's Dean Morris) with a particular interest in youth leadership development and aspirations.

Native American Youth Project

There has been very little visible action in this area, with the committee's last formal meeting nearly three months ago. I did play telephone tag with Mac Hall, who was running a youth wilderness activity at Hopi for much of February. I have not been aware of any board-initiated leadership in this area, an area which received considerable verbal support last year.

I am aware that a meeting was held (that no KAHEC staff were invited to but several KAHEC board did participate in) where there was a proposal advanced to have KAHEC funds support next summer's Inter-Tribal Youth Project Camp, a proposal which has some merit.

Perhaps reassignment of this effort to another (now that there are others) KAHEC staff person (Ross? Bolduc?) with my playing an appropriate back-up role would be helpful in regaining some momentum and progress in this key area.

IV. MISC.

Migrant Health/Mobile Health Clinic

Together w/Ross, met with reps from Harrington Health Center regarding possible use of UNE-donated mobile clinic (trailer).

They indicated an intent to set trailer up in the parking lot of their new (five exam room) health center due to: a) their board's perception that serving migrant directly in their health center would be "too confusing", and b) there will be no Rakers' Center this year. I had been led to believe by previous principal players (WHCA and PTLA staffers) that the Health Center had agreed to be the principal organizers of the Rakers' Center in '88. Administrator Molitor was very clear that she did not intend to coordinate any but health services (if they received grant support to do so), but she did see merit in the Rakers' (one-stop service) Center concept and was willing to participate in a planning meeting that would seek to secure a site on or near the Barrens and to identify agencies/staff committed to maintaining such an effort. Subsequent to this meeting, Keith Small of WHCA offered to utilize his mailing list from last year's center and word-processor to initiate contact with appropriate agencies to convene said meeting.

I made a formal, written request to Wayne Ross, Director of MVTI, to take the truck and trailer into their automotive shop for a comprehensive evaluation and appropriate overhaul. As a backup, I will approach the UNE mechanic, who has dealt with the unit over the past 6-8 years to do some moonlighting as needed to get it into shape. (The KAHEC may find it prudent to solicit a donation of a truck at some point in the future.)

MOSAIC

Consistent with previous commitment, I have continued activities associated with editing an issue of The Maine MOSAIC, focusing on culture

and health. Claire has been very helpful on this, an activity I've little experience in. I believe we will have a decent product.

Education and Training Newsletter Survey

At the urging of the Washington County Health and Social Service Consortium and the support of my Council, I sent out a brief survey of interest in initiating some type of regional newsletter noting local education and training activities.

Assorted Meetings

Staff Meeting (Orono)
DE Regional Council (Ellsworth)
Fringe Benefits (Bangor)
Mental Health/State Plan (Bangor)

Administrator
Henrietta D
Goodall Hospital
Sanford

HOSPITALS' PRICING PUZZLE

By David Burda

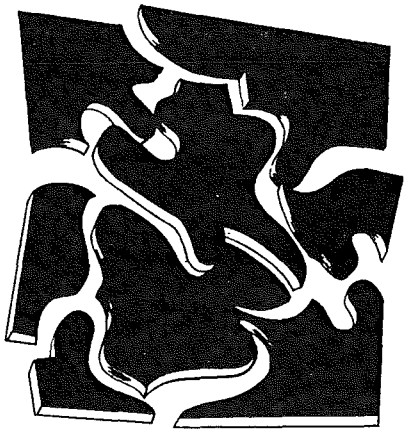
Higher labor costs and the rising costs of treating patients and staying competitive are driving up hospital expenses, healthcare economists say.

Increasing hospital costs, in turn, have resulted in higher hospital charges, which are partly responsible for above-average healthcare inflation and expenditures, the economists said.

Cost-containment mechanisms have done little to address the primary sources of hospital costs and the subsequent rise in hospital bills, they said.

"Hospitals' costs of doing business have increased. If, at the very least, they are providing the same quality of care, they have to charge more to stay in business," said Mark Pauly, executive director of the Leonard Davis Institute of Health Economics at the University of Pennsylvania, Philadelphia.

Upward trends. The median gross patient revenue per adjusted admission in 1987 was $4,349, or 11% more than in 1986 and 26% more than in 1985, said Health Care Investment Analysts, a Baltimore-based investment research firm. The figures are based on data from 3,700 hospitals.



The increase in hospital charges contributed to a 6.9% rise in prices for hospital services in 1987, the economists said. During the same period, prices for medical care rose 5.8% and overall inflation rose 4.4%, the Bureau of Labor Statistics said.

It's not surprising that prices for hospital and medical care are rising faster than the consumer price index, said Richard Clarke, president of the Healthcare Financial Management Assn., Oak Brook, Ill. "Prices for hospital services are following the direction of hospital costs," he said.

If the cost of medical care were increasing at a slower rate than the consumer price index, it would signal that hospitals are cutting back in care by eliminating medical treatment and technology, and that hasn't happened, Mr. Clarke said.

No windfalls. While hospitals' revenues are increasing, statistics show that providers aren't enjoying windfall profits. Hospitals' average net patient revenue margin during the first nine months of 1987 was 0.4%, according to a quarterly economic report released earlier this month by the American Hospital Assn., Chicago.

Total net margin, which includes other sources of revenue, was 4.9%, the AHA report said.

"Profit margins (show) that hospitals are not enjoying a windfall," said

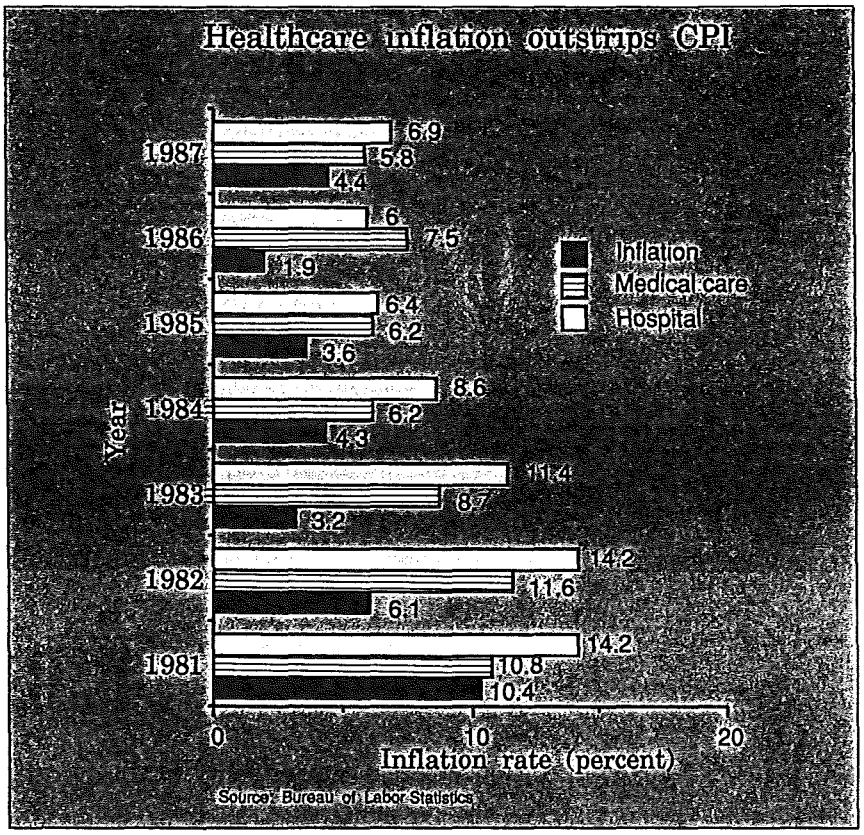
Annual hospital marketing budgets

Expenditures	% of hospitals
Less than $25,999	7%
$26,000-50,999	7%
$51,000-$100,999	11%
$101,000-$200,999	16%
$201,000-$350,999	10%
$351,000-$500,999	6%
$501,000-$999,999	5%
$1 million or more	4%

Annual hospital paid advertising budgets

Expenditures	% of hospitals
Less than $26,000	16%
$26,000-$50,999	12%
$51,000-$75,999	7%
$76,000-$100,999	8%
$101,000-$150,999	9%
$151,000-$200,999	6%
$201,000-$300,999	5%
$301,000-$400,999	4%
$401,000-$500,999	2%
$501,000 or more	5%

Source: American Society for Hospital Marketing and Public Relations, 1986



Henry Bachofer, an AHA vice president and head of the association's Office of Health Care Financing and Data Analysis.

Hospital charges have increased because hospital expenses are rising, the economists said. They added that hospitals either can't or haven't controlled some expenses.

Labor costs. Higher labor costs are a major contributor to hospitals' expenses and, consequently, to price increases, said William Schwartz, M.D., a healthcare economist and professor at the medical school at Tufts University, Boston.

Wages in the healthcare industry tend to reflect those earned by similar employees in other industries, Dr. Schwartz said. When other industries boost wages, hospitals must increase their wages to avoid losing personnel. Consequently, hospitals add to their costs but don't boost the amount of services they provide, he said.

"Labor costs will grow even faster because of the shortage of nurses, whose wages have been depressed," Dr. Schwartz said.

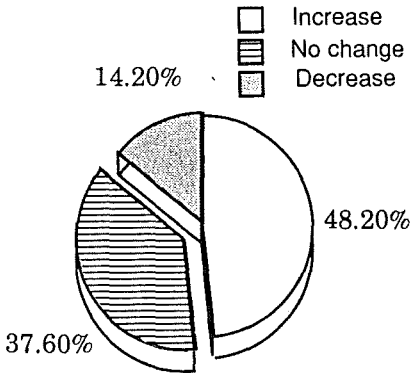
For example, the average hourly salary paid to registered nurses at 214-bed Memorial Hospital, Cumberland, Md., has increased 21.7% to $11.60 from $9.53 in the two years, said Donald McAneny, president and chief executive officer.

That component of hospital costs will continue to soar, Mr. McAneny said, adding, "We've not seen the end of the escalation in nurse salaries."

AHA data show that hospital labor expenses rose 9.1% in the first nine months of 1987, compared with the same period in 1986. That's the highest rate of increase since 1983.

Nurses earned an average of $12.70 per hour in April 1987, said a survey of 719 hospitals released by the AHA last month. That's only 4% more than the average hourly rate reported in a 1985 AHA survey. However, the larger wage increases for nurses reported in the past 10 months haven't shown up yet in hospital labor cost statistics.

Changes in hospital nursing budgets 1986 to 1987



Source: American Hospital Assn.

Hospitals also have had trouble controlling the amount of uncompensated care they provide. Rising costs for uncompensated care boost hospitals' costs and, consequently, their charges, HFMA's Mr. Clarke said.

In 1986, the latest year for which data are available, hospitals provided $7 billion in uncompensated care, or 11% more than in 1985 and 151% more than in 1980, AHA said.

Patient costs. Hospitals have had little control over the cost of treating patients. That problem is exacerbated because "hospitals are treating sicker patients who consume more hospital resources," AHA's Mr. Bachofer said.

The average length of stay at hospitals increased about 1% to 6.63 days for the first nine months of 1987, compared with the same period in 1986, AHA said. That increase signals a reversal of the trend toward shorter lengths of stay, which was encouraged by economic incentives in Medicare's prospective pricing system, economists said.

The case-mix index also shows hospitals are treating sicker patients.

At Pennsylvania State University Hospital, Hershey, for example, the

Healthcare purchasers are taking a tough stand on value, costs

Healthcare is becoming a buyers' market, at least for some employers.

Driven by a demand for value, employers are beginning to control the healthcare services they will buy and the amount they will pay for them.

For big-ticket procedures, such as organ transplants, some companies have begun regulating the providers their employees may use. For example, Honeywell Corp., Minneapolis, and Caterpillar, Peoria, Ill., limit employees to specific medical centers for organ transplants.

Houston-based Tenneco saves an estimated $300,000 annually by contracting directly with selected providers for heart transplants and cancer treatments.

The measures are an aggressive attempt by employers to minimize healthcare costs. The strategy has merit, said James D. Mortimer, president of the Midwest Business Group on Health, Chicago. Healthcare costs "are not uncontrollable," he said.

His group recently received $200,000 from the John A. Hartford Foundation, New York, to develop a model healthcare purchasing system for employers. By developing long-term purchasing arrangements between employers and providers, purchasers can control costs and get better value for their money, Mr. Mortimer said.

Companies also are collecting data on healthcare providers to help them make better-informed buying decisions. The St. Louis Area Business Health Coalition, which includes Anheuser-Busch Cos. and McDonnell Douglas Corp., recently published a survey of inpatient claims data to help prospective purchasers choose the best hospitals for their employees' healthcare.

The coalition, which has collected the data annually since 1983, published the report as "a community resource" for future negotiations with healthcare providers, said Jim Stutz, the coalition's executive director.

The report was based on the inpatient claims experience of nine insurance carriers representing about 20 firms. The data provided a means of comparing the cost of care in certain diagnostic categories, Mr. Stutz said. However, the performance index was not weighted to account for severity of illness, he said.

Nevertheless, the study showed a wide range in hospitals' performance, such as a decline in what hospitals charged for room and board and a comparable increase in ancillary costs. While the study wasn't able to pinpoint the cause of the higher prices—whether they stemmed from increased volume or increased prices or both—such information could be useful for a purchaser when negotiating prices with a provider, he said.

—Paul J. Kenkel ■

Medicare case-mix index is 1.64, compared with 1.28 in 1984, said Howard Peterson, director of the 400-bed hospital.

Additional costs related to the treatment of sicker patients have contributed to Pennsylvania State's 9.4% annual increase in the average cost per admission during the past four years, Mr. Peterson said.

At Memorial Hospital, Cumberland, Md., the average cost per admission has increased about 3% per year since 1984 to the current $2,900 per admission, Mr. McAneny said. He attributed the higher cost to the more intensive care that sicker patients require.

Memorial's patient acuity system indicates that each patient requires 7.4 hours of nursing care per day, or 15.6% more than the 6.4 hours of nursing care required in 1984, Mr. McAneny said.

Hospitals' expenses per admission have risen about 10% annually for the past several years, Health Care Investment Analysts data show. The median expense per admission last year rose 9.8% to $3,401 from $3,098, HCIA said.

AHA statistics also show an increase in hospital expenses. Total hospital expenses rose more than 10% in the first nine months of 1987, compared with the same period in 1986, AHA said. The price of goods and services purchased by hospitals increased nearly 7% during the same period.

Uncontrollable costs are only part of the reason why hospitals are charging more for their services. Competition also has contributed to hospitals' costs of doing business, the economists said.

Competition. Two studies by researchers at the University of California's School of Public Health provide an unflattering view of hospital competition.

A study released in June 1987 showed that hospitals' costs per admission rose when there were more hospital competitors in a market. Results were compiled from the 1982 cost data of 5,732 facilities.

"In competitive markets, hospitals engaged in 'non-price' competition for patients and physicians," said James Robinson, a healthcare economist and lead researcher for the study. "Hospitals offered higher-priced services and expensive medical technologies, which increased costs."

The second study, released earlier this month, showed that length of stay increased when there were more hospital competitors in a market. Mr. Robinson based his findings on data from 500,000 patients discharged from 747 hospitals in 1982.

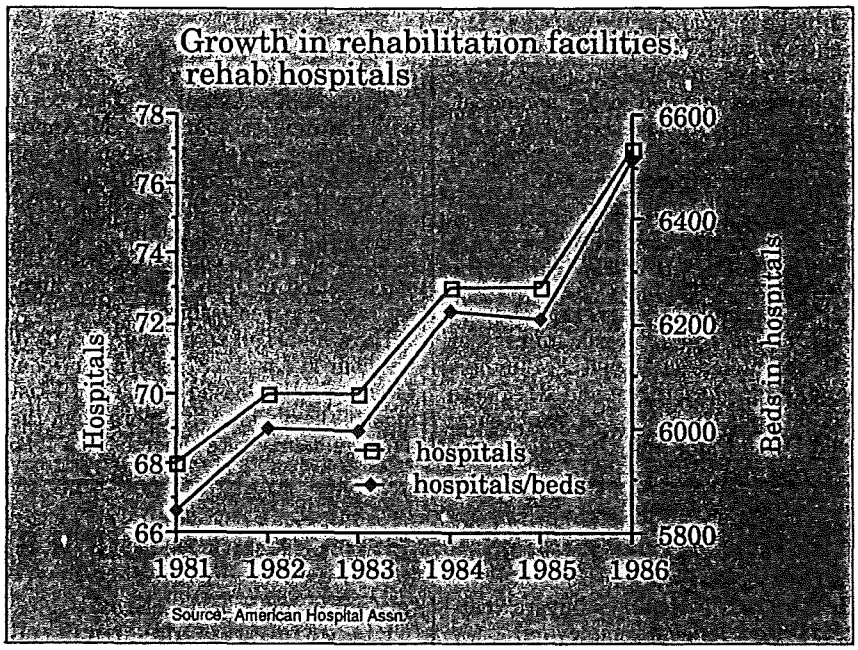
"Hospitals competed for physicians and patients based on what physicians and patients viewed as a measure of quality of care—length of stay," he said.

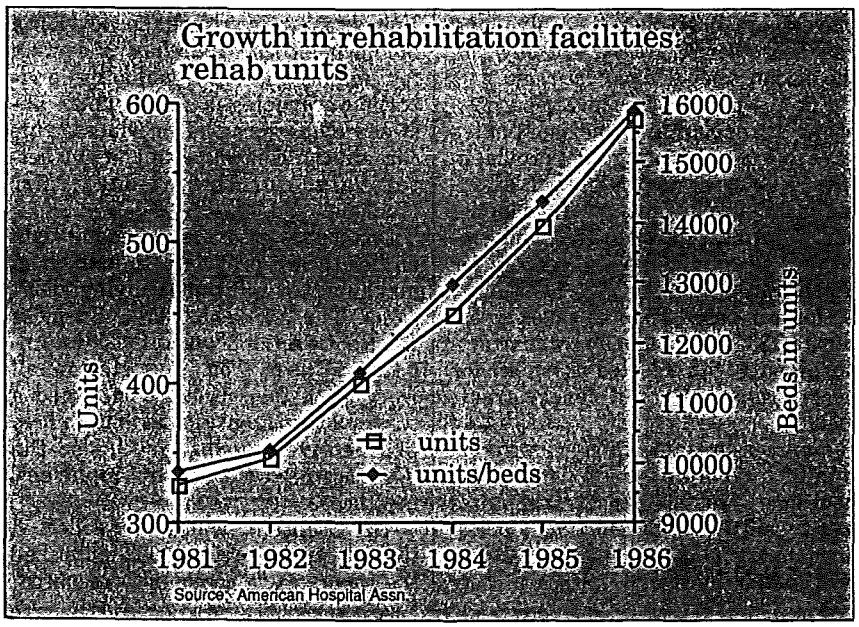
Paying for technology. Studies show that to maintain their image as high-quality providers of healthcare, hospitals have been forced by competition to buy technologically advanced equipment, regardless of whether it is needed.

"To remain competitive, many hospitals are finding that MRI (magnetic resonance imaging) is an essential service to offer," said a report released by the AHA in September 1987. The report noted that the number of mobile MRI units in operation at hospitals increased 519% to 192 from 31 between June 1986 and December 1987.

The number of lithotripters in operation increased 121% to 128 from 58 between March 1986 and May 1987, said a report released by the AHA in July 1987. Some 23% of 48 lithotripter operators said they purchased the equipment to maintain a competitive advantage, and 10% said they purchased the equipment to enhance their image as a high-quality provider.

"Hospitals have to keep up with the





latest technologies, but some hospitals maybe have been too vigorous in their pursuit of the latest medical advances," AHA's Mr. Bachofer said.

"Hospitals believe the way to get physicians and patients is through technology," said Steven Renn, HCIA's vice president.

As evidence of hospitals' infatuation with technology, Mr. Renn cites HCIA figures that show hospitals' net property, plant and equipment assets per bed have increased during the past several years. The median net property, plant and equipment assets per bed was $81,726 in 1987, compared with $71,216 in 1985.

Low-demand services. Hospitals also compete for physicians and patients by introducing new services. But economists said new services are more likely to be offered because of their profit potential than because of consumer demand.

"Generous reimbursement has fueled expansion into many non-acute-care areas," Mr. Renn said. "Hospitals hope to induce demand by opening new product lines."

AHA statistics support the economists' contentions:

- The number of beds for rehabilitation services increased 42% between 1981 and 1986.
- The number of beds for substance-abuse treatment rose 73% between 1981 and 1986.
- The number of outpatient visits increased 21% between 1984 and 1987.

Healthcare expenditures rise faster than GNP

	GNP ($ billion)	% increase	Healthcare expenditures ($ billions)	% increase	Healthcare as a % of GNP
1984	3,765	—	391.1	—	10.4%
1985	3,998	6.2%	422.6	8.1%	10.6%
1986	4,206	5.2%	458.2	8.4%	10.9%
1987	4,433	5.4%	496.6	8.4%	11.2%

Source: Division of National Cost Estimates, Health Care Financing Administration, 1987

Consumers have been paying premium prices for hospitals' new services. Prices for outpatient services rose 7% in 1987, the Bureau of Labor Statistics said.

To some extent, hospitals have been "overselling" new services, said Mr. Pauly of the Leonard Davis Institute. But, for the most part, hospitals are responding to the financial incentives created by third-party payers, he said.

Competition increases hospitals' costs in other ways, and those costs also contribute to higher prices for healthcare, the economists said.

Attracting patients, doctors. For example, hospitals are spending more money to attract patients, and those marketing costs are passed along to patients in the form of higher rates.

The average hospital budgeted $181,000 for marketing in 1987, according to preliminary results of a survey conducted by the AHA's Society for Healthcare Planning and Marketing.

Hospitals also are spending more money to recruit physicians in the hopes that they will admit patients to the hospital.

A study released in December 1987 by Jackson and Coker, an Atlanta-based physician search firm, showed that nearly all of the 114 hospitals surveyed used income guarantees to recruit physicians. Guaranteed incomes ranged from $60,000 to $180,000.

Most of the hospitals reimbursed physicians for relocation expenses, assisted them with start-up expenses and gave them free office space, the survey found.

The cost-containment illusion. Those who expected cost-containment policies to limit hospitals' expenses and, thus, their charges had unrealistic expectations, the economists said.

Cost-containment efforts by purchasers of healthcare only restrain costs for the purchasers, said Daniel Waldo, an economist in the Health Care Financing Administration's Office of National Cost Estimates. Purchasers are trying to reduce the growth of healthcare expenditures for themselves and not others, he said.

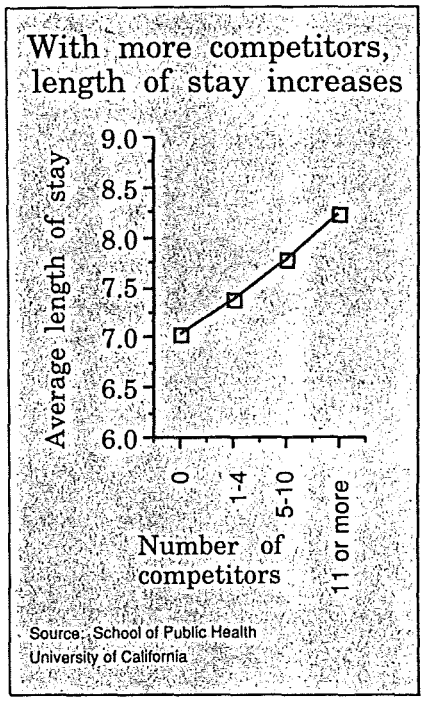
"Hospitals simply redistribute their charges from concerned purchasers to unconcerned purchasers," Mr. Waldo said.

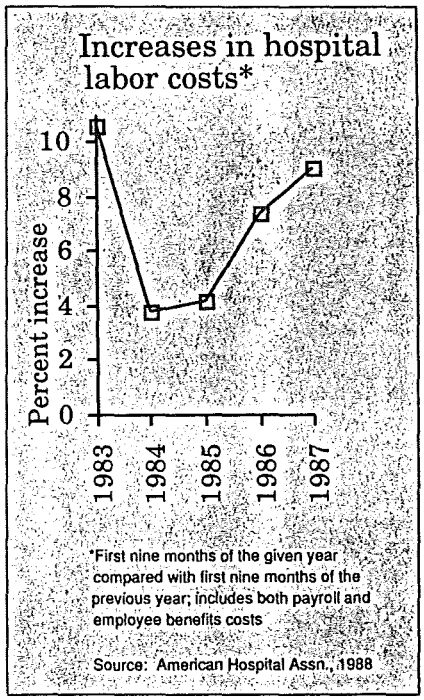
The healthcare industry is seeing a resurgence of cost-shifting, said Pennsylvania State's Mr. Peterson. "Hospitals need to get more money from the 'price payers,' the payers that haven't restricted reimbursement," he said. "You have to go where the money is."

Increased costs may force the hospital to raise its rates for the first time in four years, Mr. Peterson said.

Although the average cost per admission has been rising, Pennsylvania State's occupancy rate has increased to 87% from 77%, allowing the hospital to spread cost increases among more patients, he said.

Memorial Hospital supports the cost-containment mechanisms instituted by employers, but many companies haven't adhered to their cost-saving policies, Mr. McAneny said.





For example, many employers don't penalize workers who don't get second opinions or have hospital admissions approved in advance, he said.

Companies aren't enforcing their policies because they "don't want to be accused of denying benefits to employees," Mr. McAneny said.

Attempts to reduce unnecessary care have no effect on the real causes of healthcare inflation, which are demographics and the increasing cost of medical supplies and equipment, Dr. Schwartz said.

"Cost-containment efforts only cut current expenditures and create the illusion that healthcare costs are being controlled," he said. "After short-term savings dry up, the healthcare industry will realize it has done nothing to limit the real upward trend in costs."

Recouping losses. Other HCIA data show that hospitals are recouping their costs through ancillary, supply and drug prices.

The median markup ratio for ancillary services in 1987 was 1.7, meaning that hospitals charged $1.70 for every $1 it cost them to provide the services. The median markup ratio for ancillary services in 1986 was 1.63.

The median markup ratio for medical supplies rose to 2.04 in 1987 from 1.87 in 1986, HCIA said. The median markup ratio for drugs rose to 2.39 from 2.30 during the same period.

For insurers and patients, the result is higher healthcare bills. The average hospital charge per stay increased 19% to $4,551 in 1987, said a study released last month by Equicor, a Nashville, Tenn.-based managed-care company.

Personal expenditures for hospital services rose 7.2% to $192.6 million in 1987 from $176.6 million in 1986, HCFA data show. Total personal healthcare expenditures rose 8.6% during the same period.

National healthcare expenditures rose 0.3 percentage points to 11.2% of the gross national product in 1987. Personal expenditures on hospital services represented 4.3% of the gross national product in both 1986 and 1987.

Natural forces. Healthcare's growing share of the gross national product is a result of natural forces at work in the healthcare industry, HCFA's Mr. Waldo said. "There's nothing wrong with having a larger share of the GNP."

Healthcare represents an increasing share of the gross national product because consumers have more money available for discretionary purchases, Mr. Waldo said.

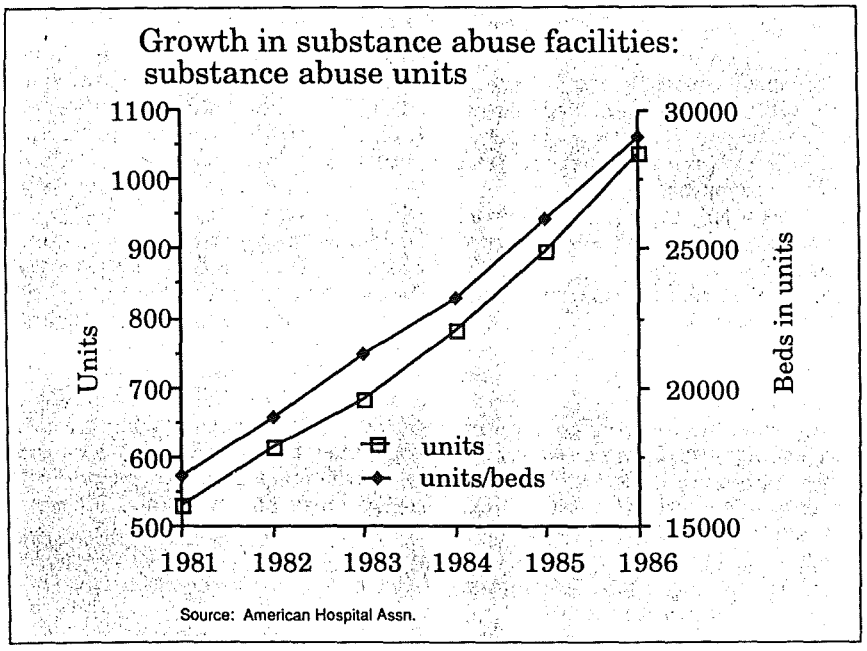
In addition, older Americans, who are increasing in number, require more healthcare services, he said.

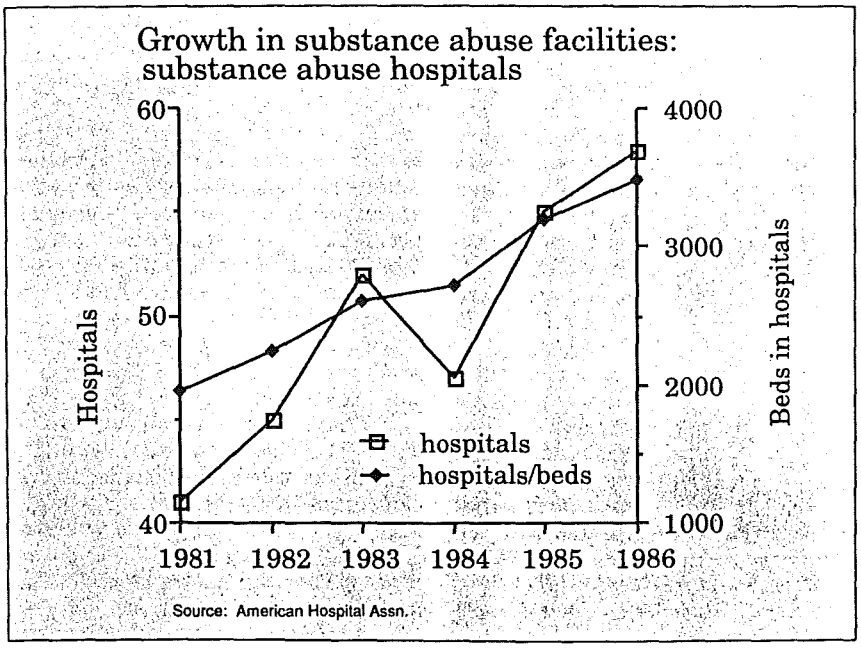
HCFA data show that people 65 and older represented 11.8% of the U.S. population in 1984 and accounted for 35% of all personal healthcare expenditures. The percentage of people 65 and older increased to 12% in 1986 and is expected to reach 13% in 1990.

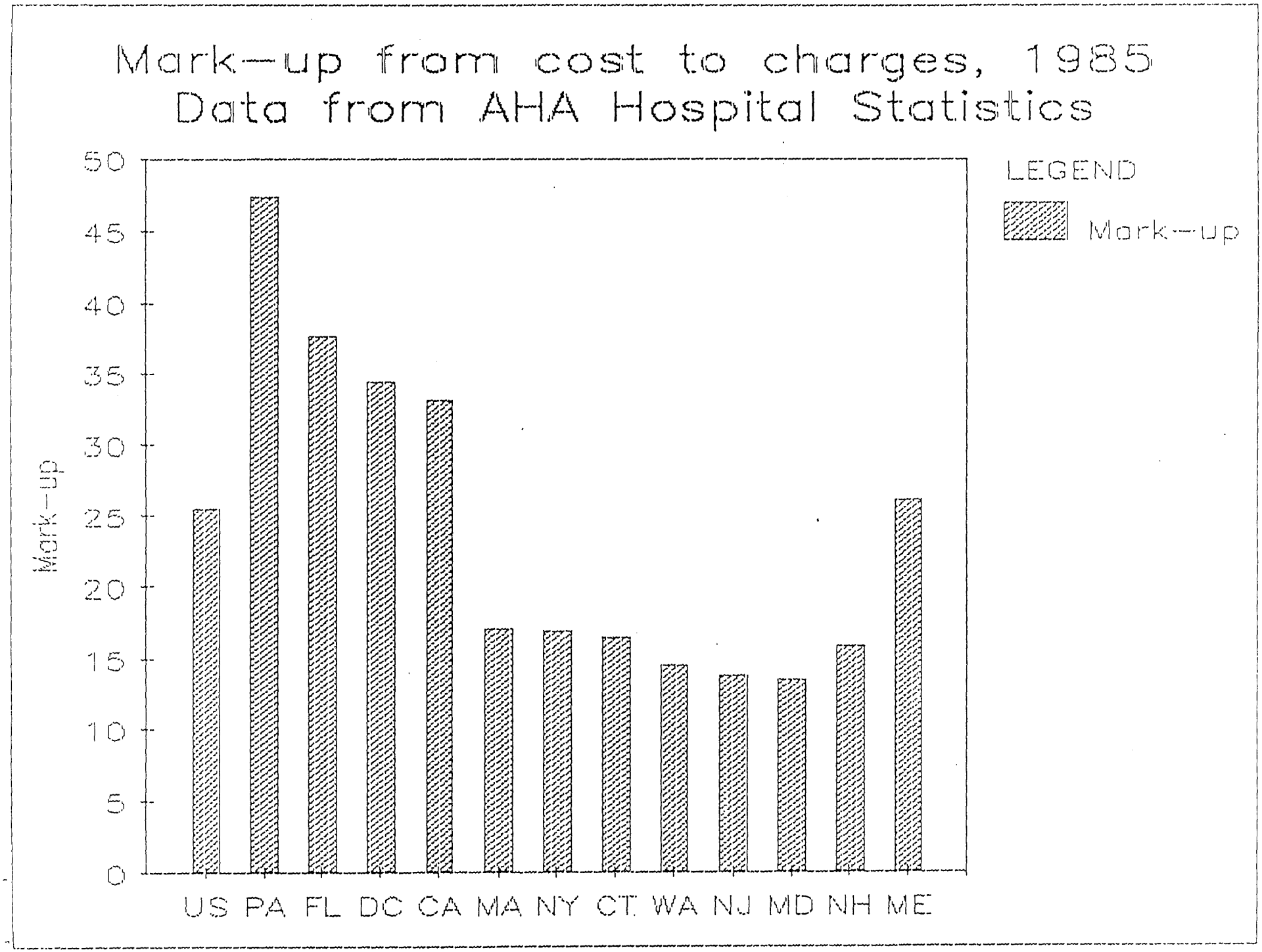
Technological breakthroughs also are contributing to healthcare's growing percentage of the gross national product, Mr. Waldo said. Innovations typically create new, more expensive medical treatments rather than make existing treatments more efficient and less costly, he said.

Because healthcare is a labor-intensive service industry, providers have to pay employees more money each year even though there is no guarantee of greater productivity, Mr. Waldo said. Consequently, the price of healthcare services must increase to provide the same amount of services, he said.

Healthcare inflation will continue to exceed increases in the consumer price index, Mr. Waldo said. "Healthcare inflation is not out of control more than anything else. The trick is learning to live with it." ■






Mark—up from cost to charges, 1985
Data from AHA Hospital Statistics
Mark—up
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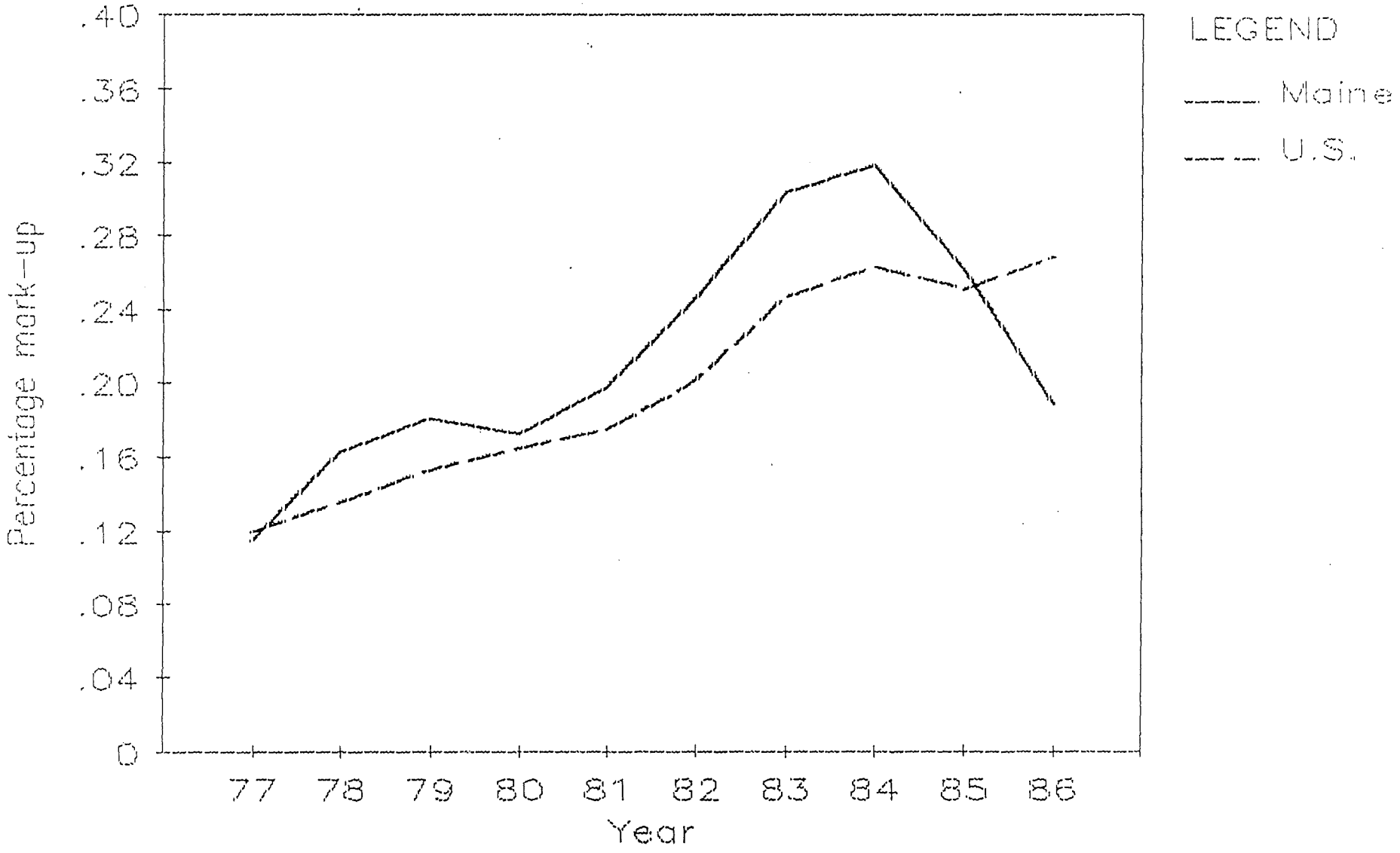
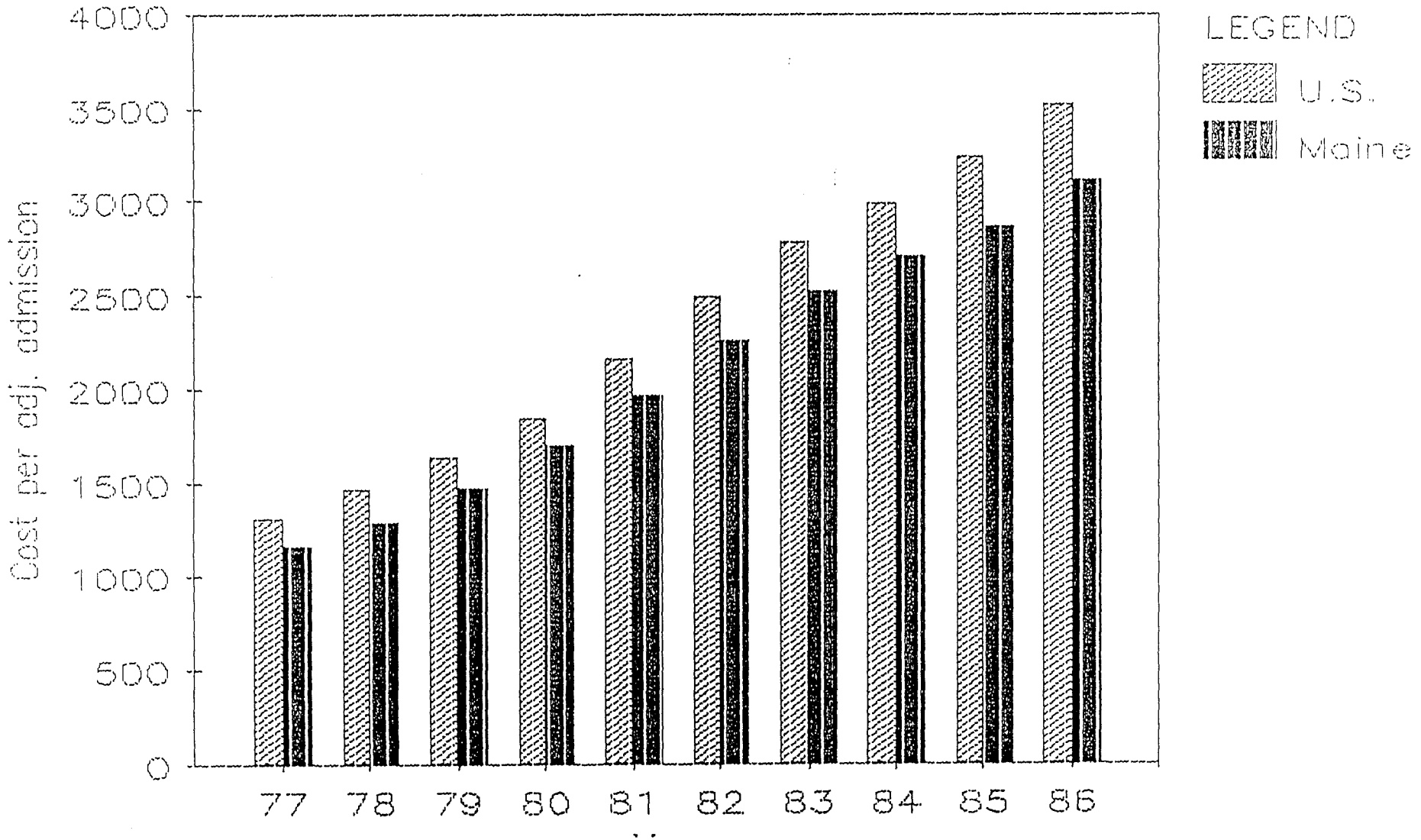
US PA FL DC CA MA NY CT WA NJ MD NH ME
LEGEND
Mark—up

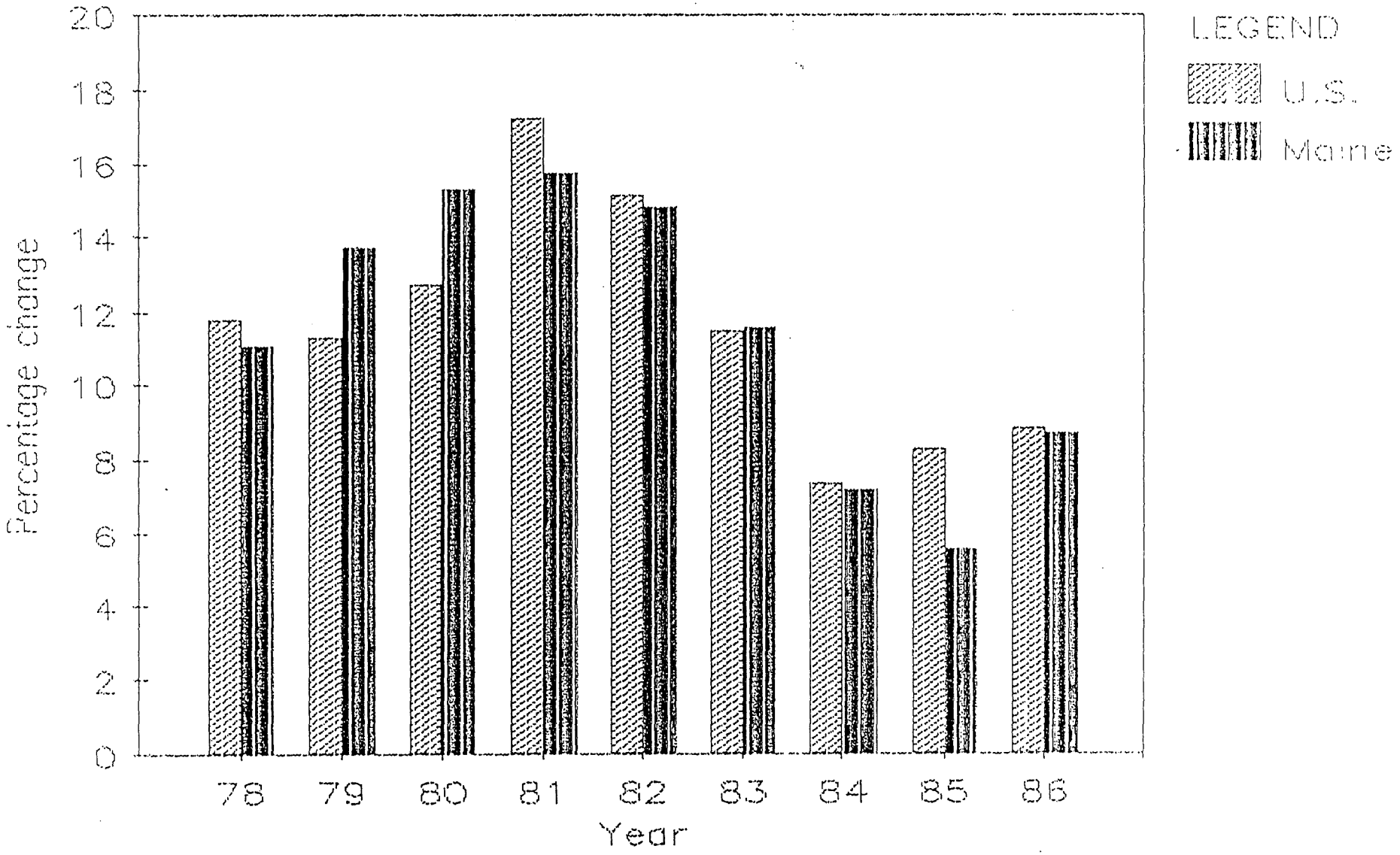
Mark--up from costs to charges
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"



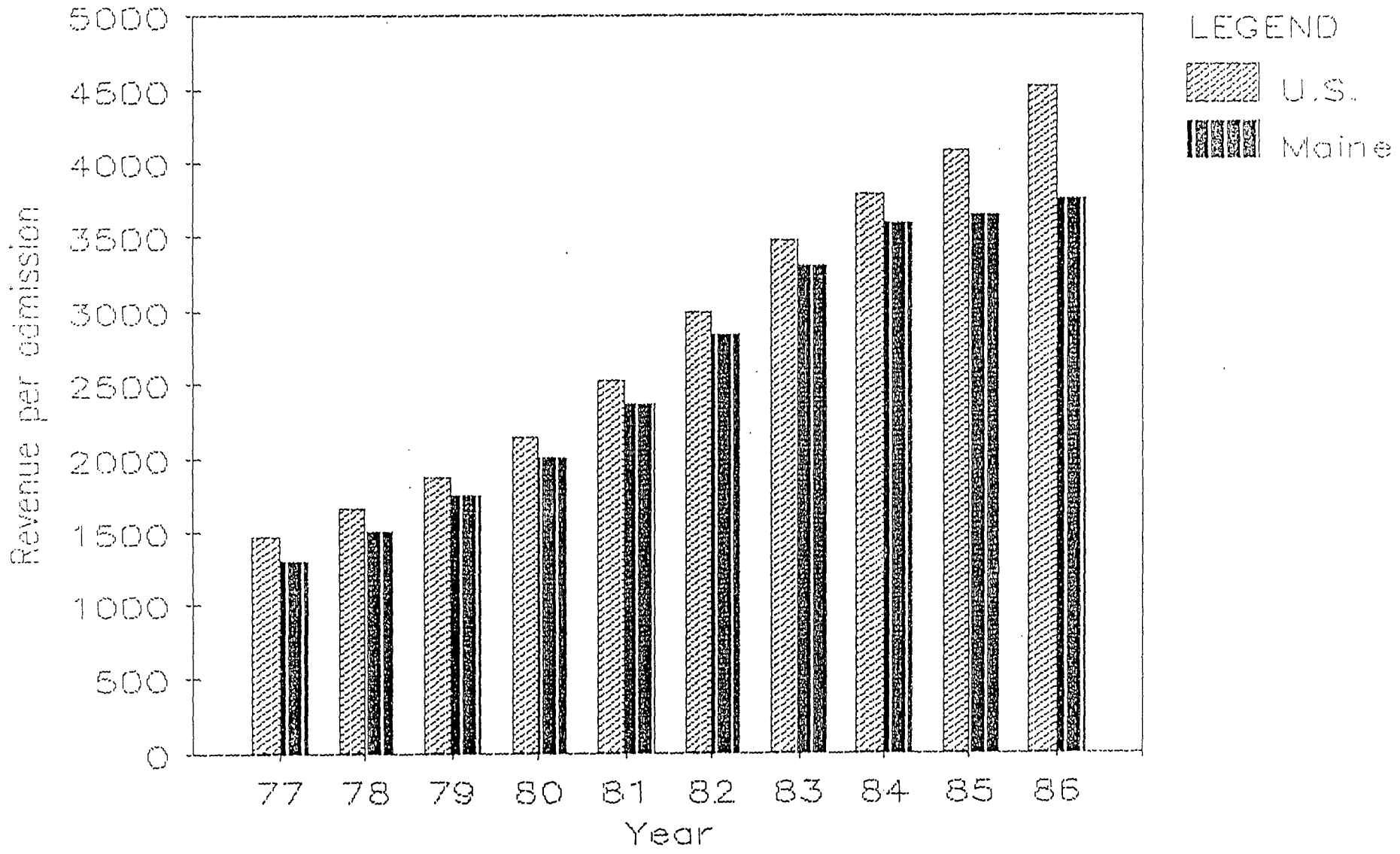
Cost per adjusted admission
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"



% change in cost per adj. admission Maine vs. US, 1977 through 1986 Data from "Hospital Statistics"



Inpatient revenue per admission
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"



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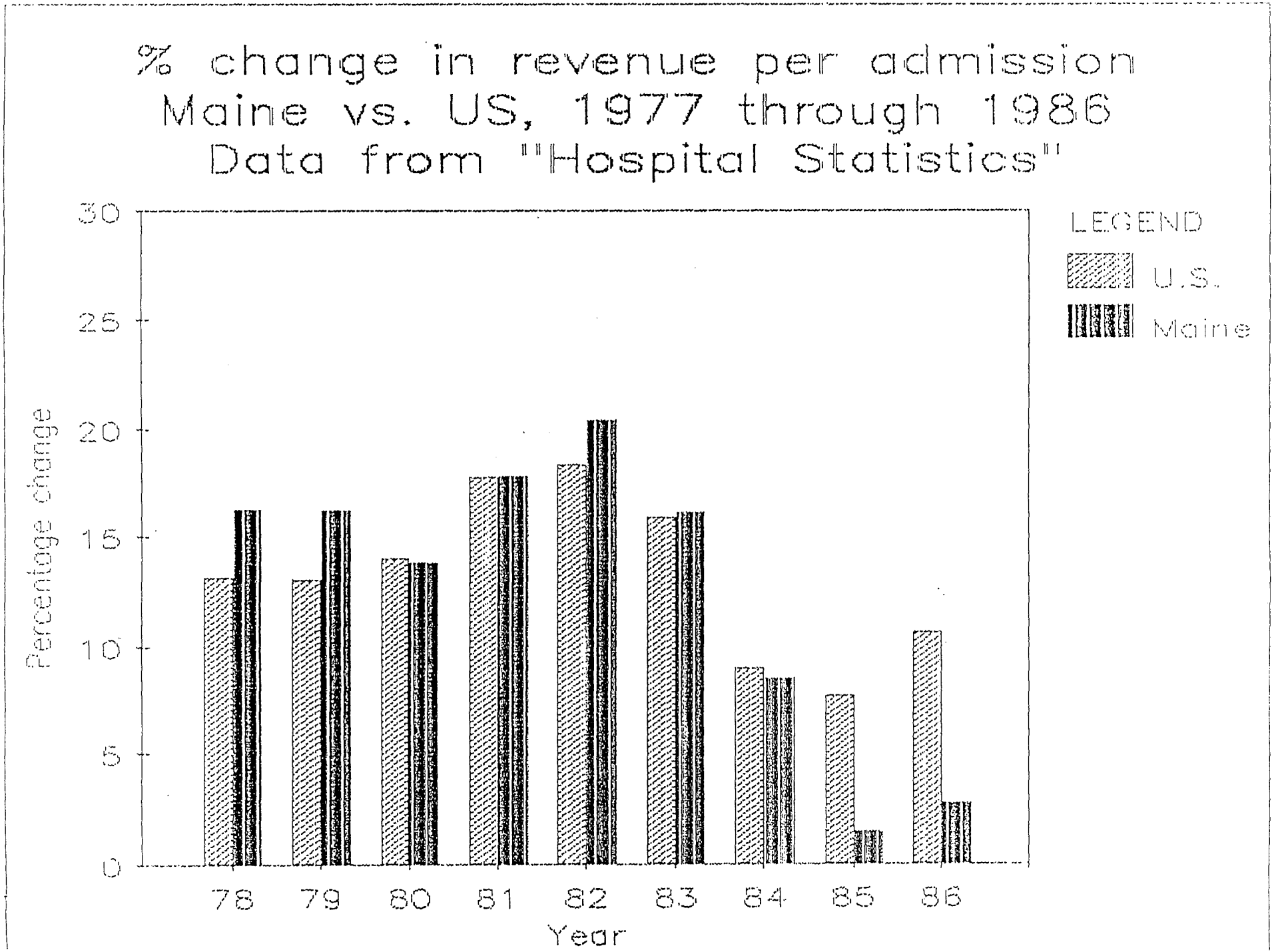
% change in revenue per admission
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"
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U.S.
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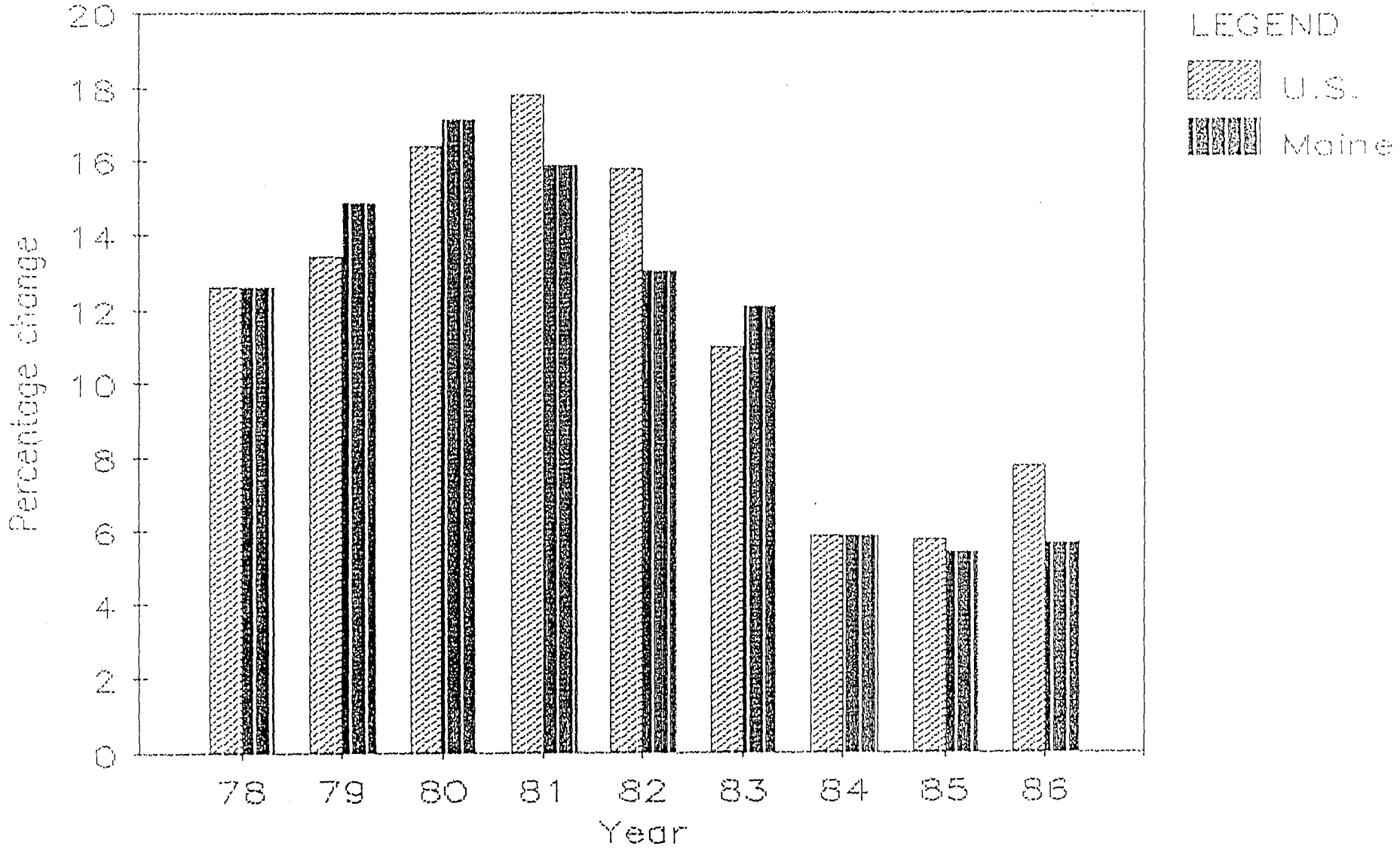
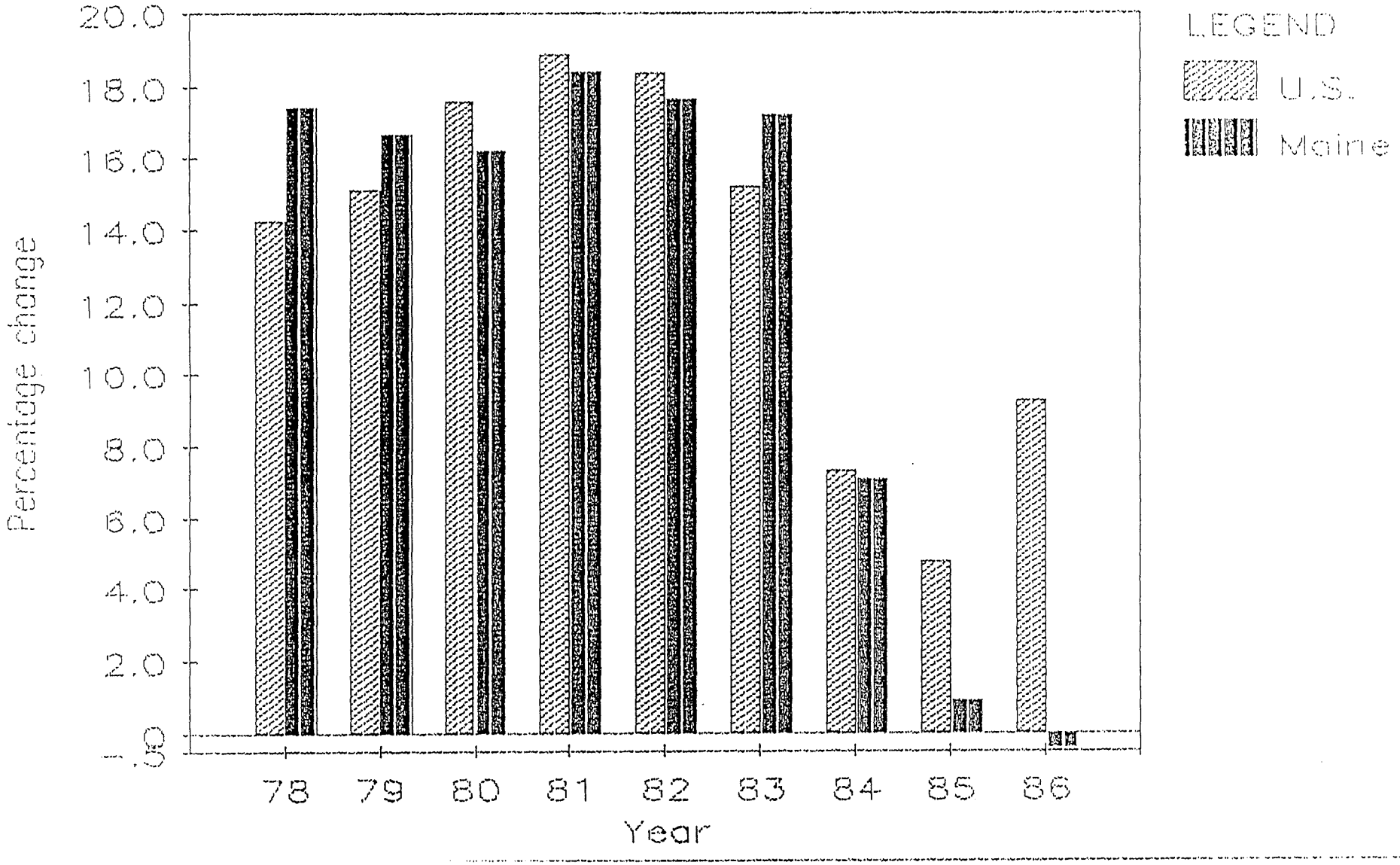
Year

7.

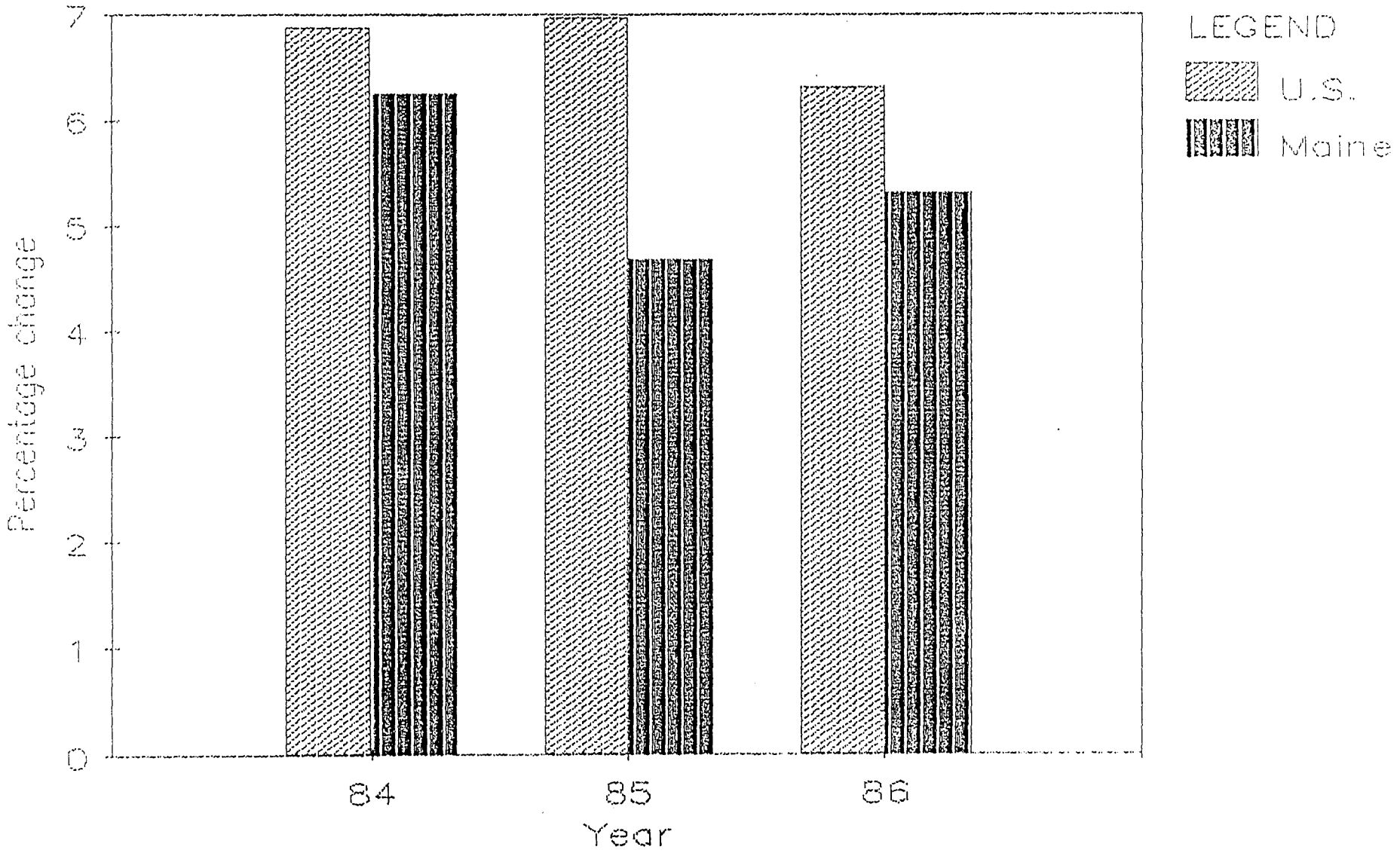
Percentage change in cost
Maine vs. US, 1977 through 1986
Data from "Hospital Statistics"



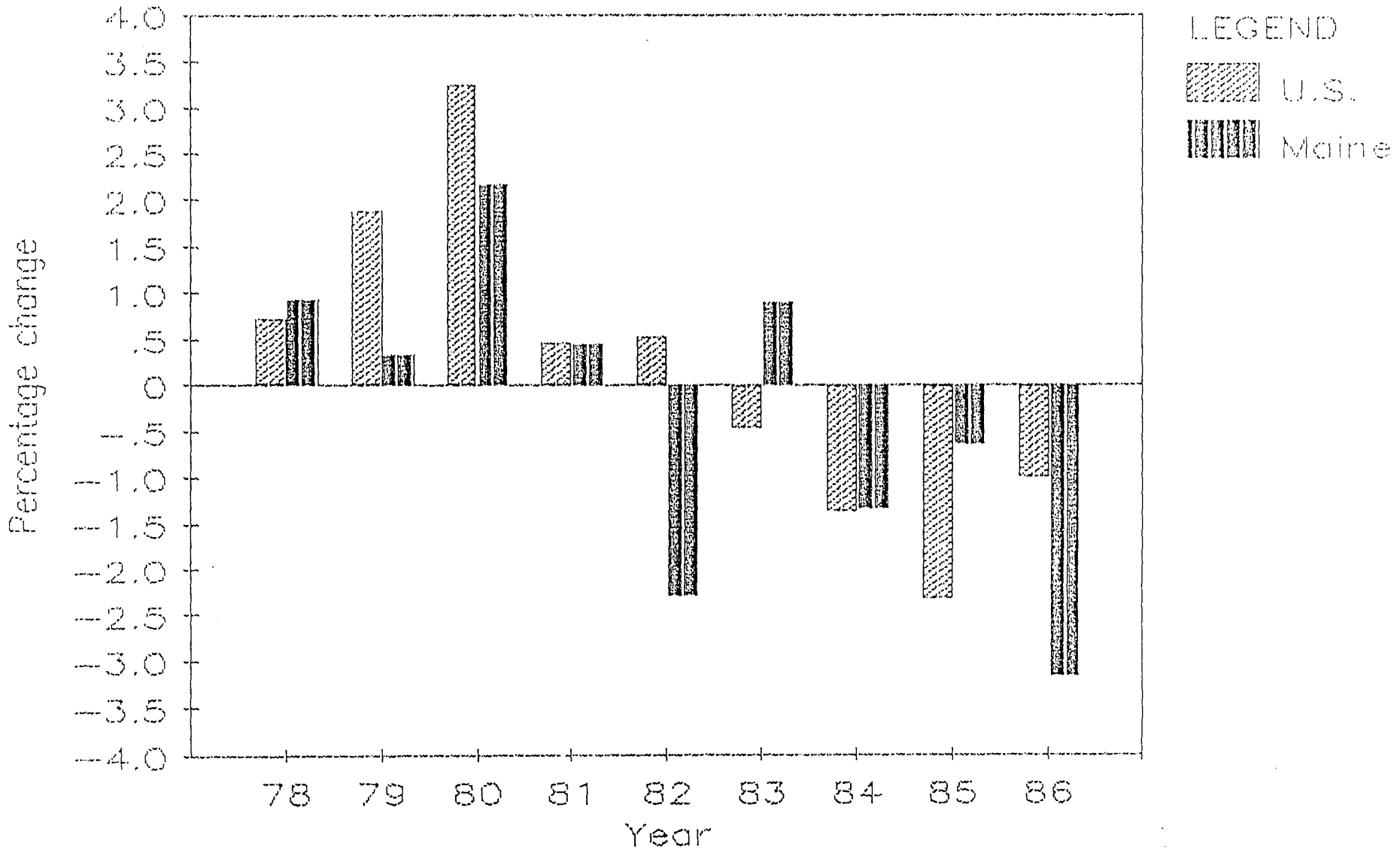
Percentage change in revenue Maine vs. US, 1977 through 1986 Data from "Hospital Statistics"



Percentage change in net revenue Maine vs. US, 1983 through 1986 Data from "Hospital Statistics"



Percentage change in adjusted admissions Maine vs. US, 1977 through 1986 Data from "Hospital Statistics"



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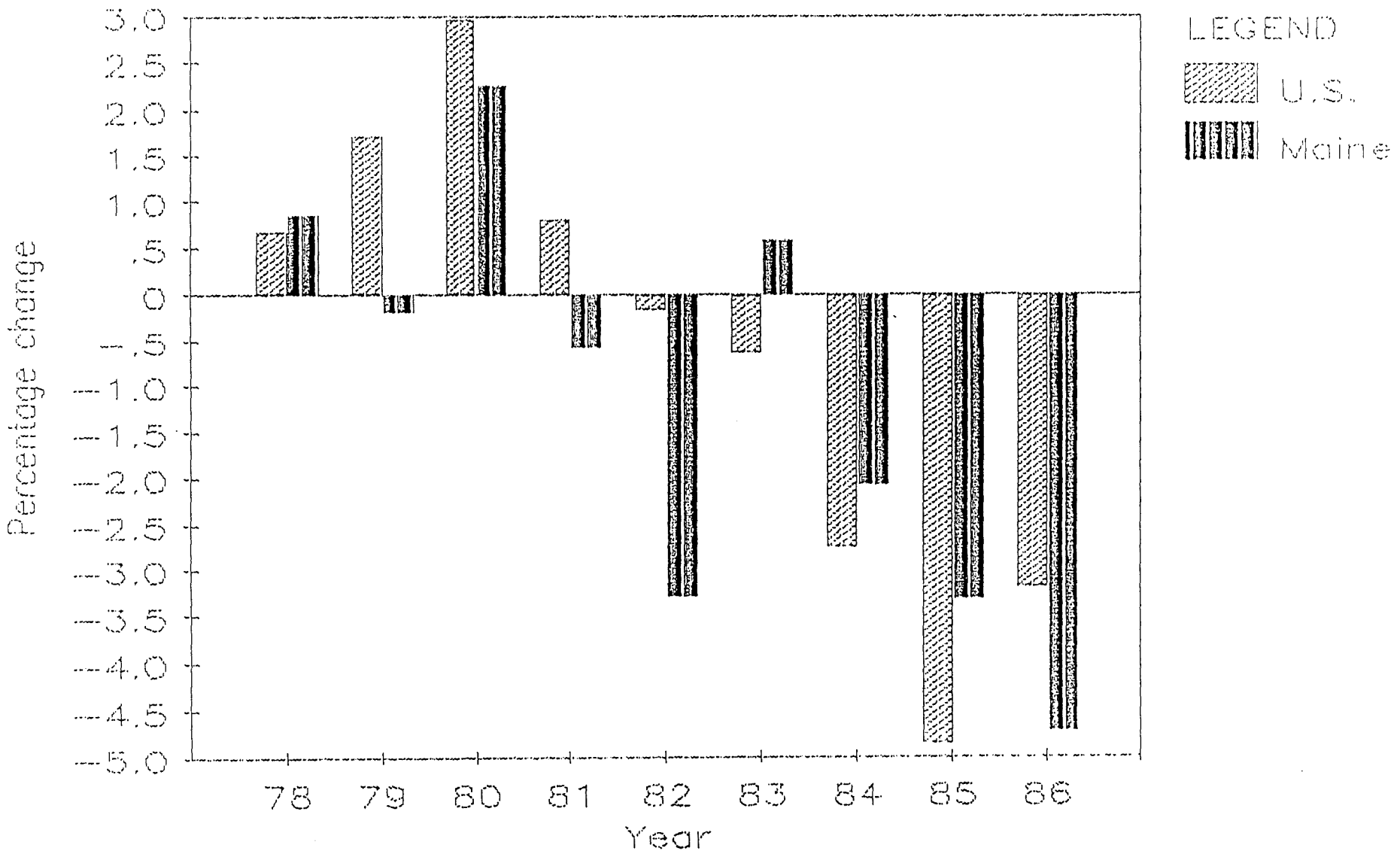
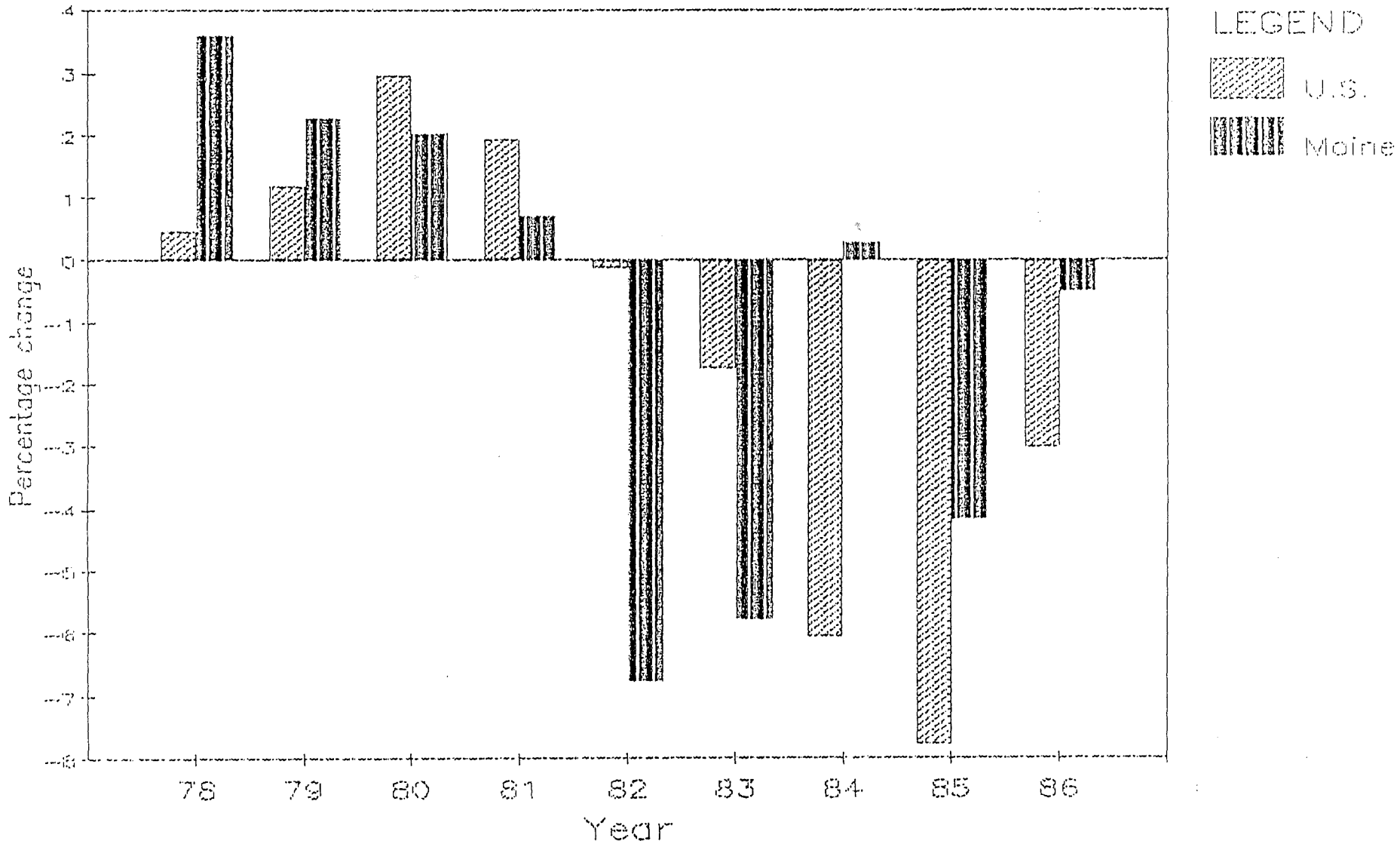
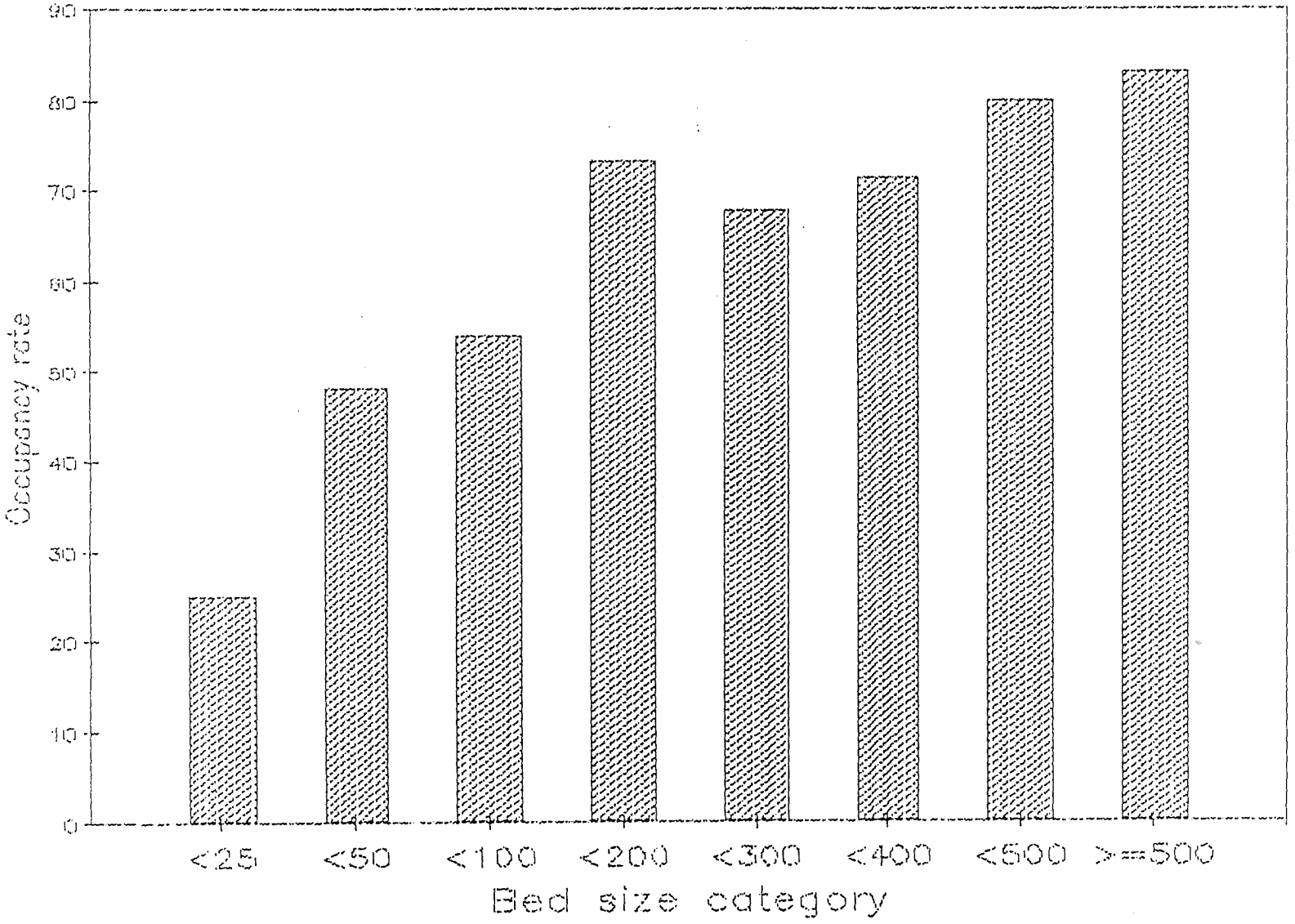
Percentage change in admissions Maine vs. US, 1977 through 1986 Data from "Hospital Statistics"



Percentage change in patient days Maine vs. US, 1977 through 1986 Data from "Hospital Statistics"



Occupancy rate by bed size
Maine 1986
Data from "Hospital Statistics"



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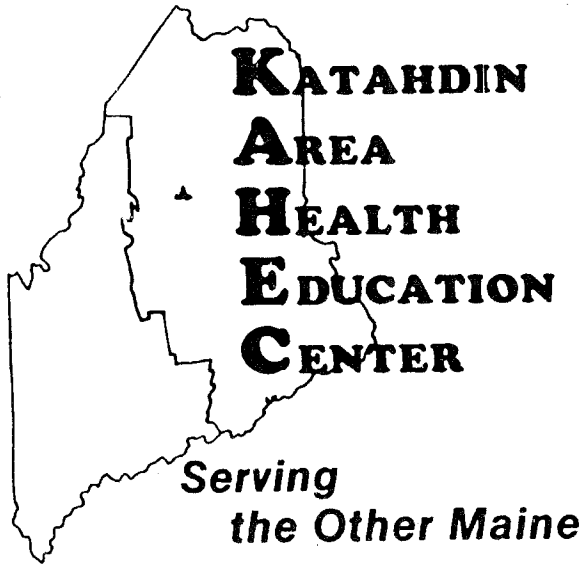

KATAHDIN AREA HEALTH EDUCATION CENTER

Serving the Other Maine

WHAT IS KAHEC?

The Katahdin Area Health Education Center is a locally-controlled, private, non-profit organization working in partnership with post-secondary health professions educational programs, rural health practitioners and community based health organizations in Maine. The principal funding for this effort is a grant from the Office of Health Professions, DHHS, channeled to the KAHEC via a cooperative agreement with the College of Osteopathic Medicine of the University of New England.

The principal objective of this cooperative effort is to address the shortage and maldistribution of health and social service professionals in what is commonly referred to as "*The Other Maine*". It is believed that coordinated health planning and innovative educational programming can have a positive impact on these problems in rural areas.

Realization of these objectives is the raison d'être for the KAHEC. Among our current goals are the following:

- Improving health manpower distribution through the development of rural health training programs in medicine, nursing, social work and allied health.
- encouraging health professions schools to be more responsive to area health needs, and strengthening the community base for planning and supporting programs designed to meet local needs.
- developing continuing education and other support programs for health professionals at the local level which emphasize an approach that is holistic and prevention oriented, and includes access to technical assistance.
- promoting public health education.
- increasing educational opportunities, employment and retention of health professionals, especially Maine natives, in underserved areas.

WHERE IS KAHEC?

KAHEC is the only center planned for the State of Maine. It is specifically designed to serve the needs of rural areas, and programmatically emphasizes the need to identify and address major health issues of concern to under-represented populations including Franco-American, Native-American and other disadvantaged groups.

The KAHEC's current service area includes Aroostook, Washington, Hancock, Penobscot and Piscataquis Counties. The program center is located in Orono, with regional offices in Fort Kent, Calais, and Bangor. In the next year the service area will expand to include Waldo, Franklin, Somerset and Oxford Counties.

Perhaps this is the first you have heard of KAHEC and its activities. Our initial operational year began in October 1987.

KAHEC is committed to community participation in planning and implementing programs. We consider this essential to ensure accurate needs assessment, relevant programming, and communication and cooperation between and among health professionals and institutions - including representatives of the consumer community . Such a cooperative effort has the potential to significantly affect access to quality health services for Maine's underserved citizens.

If you are interested in learning more about the KAHEC and its programs, please contact the Regional Coordinator in your area.

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STATE OF MAINE
ONE HUNDRED AND THIRTEENTH LEGISLATURE
COMMITTEE ON HUMAN RESOURCES

April 8, 1988

TO: Members of the Blue Ribbon Commission on Health Care Expenditures

This session, the Joint Standing Committee on Human Resources considered a bill which proposed substantial structural change to the State's CON program.

The bill (L.D. 2500 AN ACT to revise the Certificate of Need Process Dealing with the Purchasing and Delivery of New Medical Services) proposed establishment of a 7-member committee of experts which would examine medical technologies and treatments not yet offered in Maine and make recommendations regarding their introduction into Maine.

The proposed committee would determine specifically how many locations in the State should offer the technology or treatment and would advise where the technology should be located. The Maine Health Care Finance Commission would be required to increase the hospital's gross patient revenue limit to account for the increased costs attributable to the new technology or treatment where placement is consistent with committee decisions. No certificate of need would be required in such an instance. This is one way of leveling the "playing field" between hospitals and health professionals. However, once the desired number of locations is reached, no automatic adjustments to a hospital's revenue limit would take place.

After much discussion of the pros and cons of the proposed changes, the Committee on Human Resources decided not to act on the bill and to refer the issue to the Blue Ribbon Commission on Health Care Expenditures.

The Commission is reviewing Maine's regulatory system, including the certificate of need process. It therefore seems appropriate to avoid the potential pre-emption of the Commission's work by referring such issues to the Commission for further deliberation.

Sincerely,

Sen. Paul Gauvreau
Senate Chair

Rep. Peter Manning
House Chair

the service or purchase the equipment. Nothing in this chapter prevents a health care facility or hospital from utilizing the certificate of need process. The amount of the adjustment shall be determined by the commission based on the cost of the approved technology or treatment, less the documented acute care hospital savings of that technology or treatment to the health care system.

STATEMENT OF FACT

The purpose of this bill is to establish a proactive, positive approach to the introduction of new medical technology and treatment. Under the State's current regulatory framework, consisting of the certificate of need law and the Maine Health Care Finance Commission, the focus is primarily on cost, rather than on the availability, accessibility and efficacy of health care services. Because the certificate of need program is now subject to an annual cap through the commission's development account, services found to be necessary are routinely denied to the State's citizens because the development account is exhausted.

The bill establishes a 7-member committee of experts which would examine medical technologies and treatments not yet offered in Maine and make recommendations regarding its introduction into Maine. The committee will determine specifically how many locations in the State should offer the technology or treatment and would advise where the technology should be located. The Maine Health Care Finance Commission would be required to increase the hospital's gross patient revenue limit to account for the increased costs attributable to the new technology or treatment where placement is consistent with committee decisions. No certificate of need would be required in such an instance, thus leveling the "playing field" between hospitals and health professionals. However, once the desired number of locations is reached, no automatic adjustments to a hospital's revenue limit would take place.

SECOND REGULAR SESSION

ONE HUNDRED AND THIRTEENTH LEGISLATURE

Legislative Document NO. 2500

H.P. 1825 House of Representatives, March 10, 1988

Approved for introduction by a majority of the Legislative Council pursuant to Joint Rule 26.

Reference to the Committee on Human Resources suggested and ordered printed.

EDWIN H. PERT, Clerk

Presented by Representative BOUTILIER of Lewiston.

Cosponsored by Senators BUSTIN of Kennebec, GILL of Cumberland and Representative KIMBALL of Buxton.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-EIGHT

AN ACT to Revise the Certificate of Need Process Dealing with the Purchasing and Delivery of New Medical Services.

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

Sec. 1. 5 MRSA §12004, sub-§10, ¶A, sub-¶(28-C) is enacted to read:

(28-C) Health Committee on Planning and Placement of New Medical Technology $75/Day 22 MRSA §483

Sec. 2. 22 MRSA c. 152 is enacted to read:

CHAPTER 152

NEW MEDICAL TECHNOLOGY

§481. Findings and declarations of purpose.

1. Findings. The Legislature makes the following findings.

A. The accessibility of new health care technology and treatment to citizens of this State is threatened by the existing certificate of need program and the limits upon it imposed by the law creating the Maine Health Care Finance Commission.

B. The access to new kinds of health care technology and treatment may reduce health care costs by replacing current processes and procedures and reducing the need for expensive inpatient hospitalization.

C. By requiring health care facilities to obtain a certificate of need for new types of technology and treatment and establishing a cap on the amount of funds that may be committed by a facility to a new project, current state law freezes the existing level of medical technology and treatment available to citizens of this State, creating a danger to the public health.

2. Declaration of purpose. The purposes of this chapter are as follows.

A. It is the intent of the Legislature to protect and promote the public health by exempting from the State's certificate of need program and the State's hospital financing program, new health

only after providing at least 120 days' notice to the department. If the cost of the service, technology or treatment is $1,000,000 or less, the committee may choose to review the purchase or not. If the committee chooses not to review or, upon review, recommends against introduction of the technology or treatment, the hospital's gross patient service revenue limit will not be automatically increased by the commission to cover the cost of the purchase. The committee must complete any review undertaken of the technology or treatment within the 120-day notice period. If the committee recommends the introduction of the technology or treatment, the facility shall be entitled to an adjustment in its gross patient service revenue limit, established pursuant to sections 396-H and 398, by an amount required to establish the service, technology or treatment. If the committee recommends against the introduction of the technology, no automatic increase in the revenue limit may be established. There may be no 3rd-party reimbursement for any new medical technology or treatment during the 120-day period unless the committee approves that technology or treatment during that time.

§486. Appeal

In cases where the committee has determined that a technology or treatment should not be introduced or determined a particular number of sites for the technology or treatment, any hospital, health care provider or other person may appeal the decisions to the Superior Court under the Maine Rules of Civil Procedure, Rule 80B.

§487. Certificate of need exemption

When a health care facility or hospital implements new equipment constituting new medical technology or treatment, approved pursuant to this chapter, for the purpose of offering new medical technology or treatment recommended by the committee, the commission shall adjust the hospital's gross patient service revenue limit, established pursuant to sections 396-H and 398, by the amount necessary to establish

allow input and interaction with the major projects cycle in the Certificate of Need Act. Four members of the committee shall constitute a quorum.

3. Compensation. Each member of the committee shall be compensated according to the provisions of Title 5, chapter 379.

§484. Duties and powers of committee

The committee shall review new medical technology and treatment and shall determine its accessibility, efficacy, quality, cost and the extent to which the technology or treatment has the ability to replace current technology, treatment and procedures or to add to the patient's convenience and comfort. The committee shall consult with the Maine Health Policy Advisory Council and advise the council with respect to issues involving medical technology and treatment.

If the committee determines that a new medical technology or treatment should be accessible to citizens of the State and determines that the technology or treatment is affordable to the citizens of the State, the committee shall:

1. Availability of technology or treatment. Determine the number of sites where the technology or treatment shall be available; and

2. Request proposals. Instruct the Department of Human Services to issue requests for proposals to or receive from health care facilities, hospitals and health professionals, asking for proposals to be submitted regarding the establishment of the new technology or treatment in this State. The proposals shall be submitted in forms similar to that used for, and shall meet the same criteria as, a certificate of need. The department shall give all necessary and appropriate assistance to applicants.

§485. Notice

A health care facility or any other provider which desires to introduce new medical technology or treatment which has not been reviewed by the committee may purchase or introduce that technology or treatment

care technology or treatment which replaces existing procedures or which contributes to the health and comfort of citizens of this State.

B. It is further the intent of the Legislature to establish a positive program of promoting and advancing new medical technology and treatment by establishing a committee of experts to advise in determining the health care needs of citizens of this State, and to plan for the orderly implementation of that technology or treatment.

§482. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Commission. "Commission" means the Maine Health Care Finance Commission as set out in chapter 107.

2. Committee. "Committee" means the Committee on Planning and Placement of New Medical Technology established by this chapter.

3. Council. "Council" means the Maine Health Policy Advisory Council as set out in Title 5, chapter 435.

4. Department. "Department" means the Department of Human Services.

5. Health care facility. "Health care facility" means any health care facility required to be licensed under chapter 405 or its successor, with the exception of the Cutler Health Center and the Dudley Coe Infirmary.

6. Hospital. "Hospital" means any acute care institution required to be licensed pursuant to chapter 405 or its successor.

7. New medical technology or treatment. "new medical technology" or "treatment" means any medical

technology or treatment not previously available in the State or any technology or treatment determined by the committee to be necessary to meet the health care needs of citizens of this State.

§483. Committee on Planning and Placement of New Medical Technology

1. Establishment. The Committee on Planning and Placement of New Medical Technology, as established by Title 5, chapter 379, is defined as follows.

A. The committee shall be comprised of 7 members, who shall be appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over human resources and confirmation by the Legislature. In making the appointments, the Governor shall attempt to achieve a broad regional representation. Persons eligible for appointment to, or to serve on the committee, shall be selected as follows.

(1) Three members shall be licensed physicians from various specialties and subspecialties. Each physician shall represent one of the following areas: surgical; medical; and imaging. No more than one physician member may be from any one county.

(2) One member shall be a biomedical engineer.

(3) One member shall be a hospital administrator.

(4) One member shall be a consumer. For purposes of this section, "consumer" means a person who is neither affiliated with nor employed by a 3rd-party payor, any provider of health care, as defined in section 382, subsection 14, or any association representing these providers, provided that neither membership in, nor subscription to, a

service plan maintained by a nonprofit hospital and medical service organization, enrollment in a health maintenance organization, membership as a policy holder in a mutual insurer or coverage under a policy issued by a stock insurer, service on a governmental advisory committee, nor employment by, or affiliation with, a municipality may disqualify a person from serving as a consumer member of the panel.

(5) One member shall represent major 3rd-party payors.

B. The terms of the members shall be staggered. Of the initial appointees, 3 shall be appointed for terms of 3 years, 2 for terms of 2 years and 2 for terms of one year. Thereafter, all appointments shall be for a term of 3 years each, except that a member appointed to fill a vacancy in an unexpired term shall serve only for the remainder of that term. Members shall hold office until the appointment and confirmation of their successors.

C. The Governor may remove any member who would no longer be eligible to serve on the committee by virtue of the requirements of paragraph A, who violates paragraph E or who becomes disqualified for neglect of any duty required by law.

D. The Governor shall appoint a chairman who shall serve in these capacities at the Governor's pleasure.

E. A member shall not participate in any proceeding of the committee if that participation would result in a conflict of interest.

2. Meetings. The committee shall meet as required, but at least twice annually, to fulfill its responsibilities. Meetings shall be called by the chairman or by any 4 members and, except in the event of an emergency meeting, shall be called by written notice. One meeting shall occur at such a time to

SENATE

JOHN E. BALDACCI, DISTRICT 10, CHAIR
JOSEPH C. BRANNIGAN, DISTRICT 29
R. PETER WHITMORE, DISTRICT 22

JOHN KNOX, LEGISLATIVE ANALYST
DOUGLAS HOLMES, COMMITTEE CLERK

HOUSE

CAROL ALLEN, WASHINGTON, CHAIR
JOHN A. ALIBERTI, LEWISTON
NORMAN O. RACINE, BIDDEFORD
CARL F. SHELTRA, BIDDEFORD
CHRISTOPHER SCOTT GURNEY, PORTLAND
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GERALD A. HILLOCK, GORHAM
CATHARINE K. LEBOWITZ, BANGOR
ALBERT G. STEVENS, SABATTUS
GARY W. REED, FALMOUTH

STATE OF MAINE
ONE HUNDRED AND THIRTEENTH LEGISLATURE
COMMITTEE ON BUSINESS LEGISLATION

April 7, 1988

Senator Paul N. Gauvreau
Chair
Blue Ribbon Commission on Health Care Expenditures

Dear Senator Gauvreau:

This session the Joint Standing Committee on Business Regulation considered a bill to require physicians to accept Medicare assignments (LD 2324, An Act Establishing a Medicare Assignment Program). The problems raised by the bill were clearly broader than the proposed solutions offered and the members of the committee felt these concerns were more properly considered in the broader context of access and cost control.

The issues from the patients perspective appear to be a need to know whether they will be able to afford the cost of a visit to a doctor. In order to make this judgment, patients need to know whether the doctor accepts Medicare assignment, whether they charge an additional fee above Medicare or whether they do not participate in Medicare at all. The federal government, on the other hand, is interested in controlling health care costs by holding down fees and directing usage of Medicare patients.

Of particular concern to patients was that physicians post their Medicare policy. The committee has addressed that issue by adding sanctions to the existing law requiring physicians to post whether they accept Medicare assignments. This should help with a patient's desire to know whether there will be any additional charges. It will not solve the patient's total problem, however, if a physician does not accept assignment and the patient is not able to afford the additional costs.

Posting the policy does not solve the problem of affordability. One of the consequences of the federal Medicare policy to hold down health costs by restricting Medicare costs is that physicians either do not accept Medicare payments as full payment or they cost-shift and raise the fees charged non-Medicare patients. In neither case are costs held down. In either case consumers pay more.

The Joint Standing Committee on Business Legislation did not feel that they were the committee with the appropriate expertise to address these health care policy and health insurance issues. The committee is concerned that the issues raised by the large number of individuals testifying before the committee are addressed. Your commission appears be be already engaged in a review of policies in this area and the committee hopes that if you do not already have the issue of Medicare and Medicare assignment on your agenda that you will address this issue during your deliberations.

The Business Legislation Committee recognizes that Medicare is a federal program. If your commission can not add to the pressure on the federal government to change their policies then perhaps your commission can propose an interim state solution to the problem.

During the committee's deliberations on the bill it also became apparent that a similar problem exists with the Medicaid program. Being a state administered program, perhaps the problems associated with providing adequate reimbursement for physicians in order to insure an adequate supply of physicians participating under Medicaid would be amenable to state solutions and hence be an area for you to investigate and recommend solutions.

If you do not feel these issues fall within the purview of your commission, perhaps you could suggest which committee could properly address the problem.

Sincerely,

Rep. Carol M. Allen
House Chair

Sen. John E. Baldacci
Senate Chair

4884m

L.D. 2324

(Filing No. S-393)

STATE OF MAINE
SENATE
113TH LEGISLATURE
SECOND REGULAR SESSION

COMMITTEE AMENDMENT " A " to S.P. 895, L.D. 2324, Bill, "AN ACT Establishing a Medicare Assignment Program."

Amend the bill by striking out everything after the enacting clause and inserting in its place the following:

'**32 MRSA §3297**, as enacted by PL 1983, c. 325, is amended by adding at the end a new paragraph to read:

The Board of Registration in Medicine, the Board of Osteopathic Examination and Registration, the Board of Examiners of Podiatrists and the Board of Chiropractic Examination and Registration shall enforce the provisions of this section and shall inform each licensee of their obligation under this law. Each board shall have the authority to discipline a licensee under its jurisdiction for failing to comply with this section and shall have the authority to impose a monetary penalty of not less than $100 and not more than $1,000 for each violation.'

COMMITTEE AMENDMENT "A " to S.P. 895, L.D. 2324

STATEMENT OF FACT

This amendment deletes the establishment of a mandatory Medicare program and, instead, imposes a financial penalty on Medicare providers who fail to post their policy regarding Medicare assignment.

5345033188

Reported by Senator Whitmore for the Committee on Business Legislation. Reproduced and Distributed Pursuant to Senate Rule 12.
(4/4/88) (Filing No. S-393)

SECOND REGULAR SESSION

ONE HUNDRED AND THIRTEENTH LEGISLATURE

Legislative Document No. 2324

S.P. 895 In Senate, February 22, 1988

Approved for Introduction by a Majority of the Legislative Council pursuant to Joint Rule 26.

Reference to the Committee on Business Legislation suggested and ordered printed.

JOY J. O'BRIEN, Secretary of the Senate

Presented by Senator BUSTIN of Kennebec.

Cosponsored by President PRAY of Penobscot, Representative MATTHEWS of Caribou, Representative HICKEY of Augusta.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-EIGHT

AN ACT Establishing a Medicare Assignment Program.

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

32 MRSA §3297-A is enacted to read:

§3297-A. Acceptance of Medicare assignment

1. Reasonable charges. Each allopathic physician licensed pursuant to chapter 48, each osteopathic physician licensed pursuant to chapter 36, each chiropractor licensed pursuant to chapter 9, and each podiatrist licensed pursuant to chapter 51 who agrees to treat Medicare-eligible individuals shall also agree not to charge to or collect from those beneficiaries any amount in excess of the reasonable charge for the service as determined by the United State Secretary of Health and Human Services.

2. Failure to comply. Failure to comply with this section shall be grounds for revocation of licensure and registration.

3. Compliance; condition of registration. Compliance with this section shall be a condition of granting or renewing a certificate of registration of a physician covered by this section.

4. Annual report. The Office of Vital Statistics shall study the impact of this section on delivery of services and shall make an annual report to the joint standing committee of the Legislature having jurisdiction over human resources and to the Maine Health Policy Advisory Council. The office shall also specifically report on the impact of this section on the availability of medical care in areas designated as medically underserved by the United States Secretary of Health and Human Services.

STATEMENT OF FACT

Currently, a little more than 1/3 of Maine's physicians accept Medicare assignments in all cases. This creates a financial hardship for many of Maine's elderly seeking medical care.

This bill requires doctors who agree to treat Medicare patients to accept Medicare assignments as a condition of licensure and practice. The Office of Vital Statistics shall collect information to provide the basis for a thorough study of the bill's impact on delivery of services and shall annually report to the

Legislature and Maine Health Policy Advisory Council. The study will also focus on the impact on medical services delivery in medically underserved areas.

4245020988

Hospital Competition and Surgical Length of Stay

James C. Robinson, PhD; Harold S. Luft, PhD; Stephen J. McPhee, MD; Sandra S. Hunt, MPA

The hypothesis that competitive pressures encourage hospitals to accommodate patient and physician preferences for longer lengths of stay was tested. Seven hundred forty-seven nonfederal short-term hospitals were divided in terms of the number of neighboring hospitals within a 24-km radius, and this measure of hospital concentration and competition was measured against length of stay for ten surgical procedures, using 1982 data on 498 454 patient discharges. Patient, physician, and hospital characteristics associated with length of stay were controlled for. Competition-related percentage increases in length of stay were identified for all procedures, including total hip replacement (14.8%), transurethral prostatectomy (13.9%), intestinal operations (14.0%), stomach operations (14.7%), hysterectomy (6.9%), cholecystectomy (9.1%), hernia repair (10.5%), appendectomy (8.4%), cardiac catheterization (22.9%), and coronary artery bypass graft surgery (21.2%). It was concluded that there is a strong association between the number of hospital competitors in the local market and the average length of stay in US hospitals.

(*JAMA* 1988;259:696-700)

SUBSTANTIAL differences exist among individual hospitals and among geographic areas in average lengths of hospital stay for patients undergoing similar surgical procedures. While presumably due in part to differences in case-mix severity, these length of stay differences are probably also due to differences in physician practice styles and hospital discharge protocols. A number of major policy initiatives, including Medicare's prospective payment system, have targeted long lengths of stay that are not explainable by case-mix severity as part of a larger effort to reduce the rate of health care cost inflation. Little is known, however, about the factors that influence patient length of stay; it is therefore difficult to predict the long-term effects of financing incentives that penalize those hospitals that keep their patients longer than do other institutions.

We analyzed the effect of competition among hospitals in local geographic areas on the length of stay for ten surgical procedures, controlling for a number of measures of case-mix severity. Hospital and surgeon volumes for each procedure were also controlled for, given the growing literature suggesting that low-volume hospitals and surgeons may have significantly worse outcomes than otherwise comparable hospitals and surgeons performing high volumes of particular surgical procedures.[1-6] Data were obtained on 498 454 surgical discharges from 747 hospitals in 1982, the year immediately before the introduction of Medicare's prospective payment system. We also examined average length of stay for all discharges from our sample of hospitals, controlling for the distribution of patients across 23 broad treatment categories.

The guiding hypothesis in this study was that, at least until 1982, hospitals in areas with other nearby hospitals competed intensely with one another, but on a nonprice rather than price basis. Hospitals in competitive local markets were under especially strong pressure to develop clinical services and administrative procedures designed to attract physician affiliations and patient admissions. Patients generally prefer longer to shorter postoperative lengths of stay to reduce the subsequent burden of nursing on themselves and family members at home. Surgeons are typically paid one fee that covers postoperative care in addition to the actual surgical procedure; hence, they face no direct economic incentives to extend lengths of stay. However, a reduction in preoperative stay may reduce the surgeon's confidence that the patient has been adequately monitored and prepared, while shorter postoperative stays reduce the certainty that the patient is fully recovered before discharge. Much postoperative inpatient care is given by the original referring physician, however, who is typically reimbursed for each visit. Both surgeons and internists are likely to resent pressures to shorten lengths of stay for economic reasons alone.

A number of studies have documented the effects of nonprice competition in hospital markets. Markets with many hospitals have been found to ex-

From the School of Public Health, University of California, Berkeley (Dr Robinson); and the Institute for Health Policy Studies, School of Medicine (Dr Luft and Ms Hunt) and Division of General Internal Medicine, Department of Medicine (Dr McPhee), University of California, San Francisco. Ms Hunt is currently with Coopers & Lybrand, San Francisco.

Reprint requests to School of Public Health, 418 Warren Hall, University of California, Berkeley, Berkeley, CA 94720 (Dr Robinson).

hibit duplication of clinical services[7,8] and high average costs per admission.[9] Using 1972 data on average length of stay for all admissions, two of us (J.C.R. and H.S.L.)[10] found longer stays in competitive markets, that is, ones with many neighboring hospitals, than in noncompetitive local markets. Sloan and Valvona[11] examined year-to-year changes in average lengths of stay for ten medical and surgical procedures. Their finding of no consistent effects attributable to competititon may be due to their measure of competition that was based on the metropolitan area. The present study improves on earlier methodologies by combining procedure-specific lengths of stay, an enlarged set of controls for case-mix severity, and more precise measures of local market competition. The following question was under consideration: Are procedure-specific lengths of stay longer in more competitive than in less competitive local markets, controlling for patient case mix, hospital procedure-specific volume, and other previously identified influences?

PATIENTS AND METHODS

The data used in this study were assembled from four sources. Procedure-specific average lengths of patient stay were obtained from patient record data collected by the Commission on Professional and Hospital Activities. The commission provided case-mix measures, including patient age, sex, and secondary diagnoses and procedures. Procedure-specific rates of patient transfer into and out of each hospital and the distribution of total hospital volume for each procedure across the surgeons performing those procedures were also obtained from the commission. Measures of competition were calculated by the authors using latitude and longitude coordinates for each of the nation's hospitals, as discussed below. Demographic data on the local population were taken from 1982 Area Resource File. Information on hospital role in medical education and ownership status was obtained from the 1982 Annual Survey of Hospitals, conducted by the American Hospital Association (AHA).

Patient Abstract Data

Hospitals were included in the sample if they participated in the Professional Activities Study of the Commission on Professional and Hospital Activities, if they admitted at least one patient during 1982 for any of the ten procedures studied, and if they responded to the 1983 Survey of Specialized Clinical Services, a survey designed by the authors and conducted under the auspices of the AHA. This survey has been described elsewhere.[12] Long-term and federal (Veterans Administration) hospitals were excluded from the analysis. The 747 hospitals in the sample were slightly larger, somewhat more likely to be private nonprofit, and more often affiliated with a medical school than the population of short-term general hospitals in the country. Individual patient records were excluded if data were missing on age, sex, discharge status, or length of stay. To maintain confidentiality, all patient records were aggregated to the hospital level by the commission before we received the data. Risk factor measures for each hospital and procedure were developed using mortality rates and patient characteristics, including age category, sex, type of procedure, and secondary diagnoses and procedures. Each hospital was assigned a risk factor measure for each procedure based on the characteristics of that hospital's procedure-specific population and the association between these characteristics and procedure-specific mortality rates for all hospitals in the sample. The number of classification cells in the matrices ranged from nine for stomach operations, which was categorized by age and admission diagnosis (a 3×3 matrix), to 48 for cholecystectomy, which was a subset by age, sex, type of procedure, and single/multiple diagnoses (a $3 \times 2 \times 4 \times 2$ matrix).

Additional case-mix measures were constructed for nine of the ten procedures based on the proportion of each hospital's patients undergoing the procedure that had a particular secondary diagnosis or procedure. The number of measures that were included ranged from one for appendectomy (proportion of patients with normal tissue at the time of pathologic study) up to eight for stomach operation (proportions of patients with a secondary diagnosis of [1] diabetes, [2] anemias or hemorrhage, and/or secondary procedures of [3] partial gastrectomy, [4] vagotomy, [5] pyloroplasty, [6] suture of ulcer, [7] total gastrectomy, and [8] esophagectomy or gastrectomy). These secondary diagnosis and procedure measures could not be included in the risk factor matrices because dividing the matrices into too many cells reduces the stability of the cell-specific rates. No secondary diagnoses or procedures of relevance could be obtained from the data available on total hip replacement.

To control for the effects of procedure volume on outcome and, hence (potentially), on length of stay, we included in the analysis the annual volume of each procedure performed in each hospital and a measure of the distribution of procedures among surgeons performing the procedure. The surgeon-volume variable was calculated as the proportion of patients undergoing each procedure that was treated by surgeons whose annual volume was less than the median for that procedure among all surgeons in the sample. This measure, which has been described in detail elsewhere,[4] was constructed in such a manner as to capture the influence of having a significant fraction of all procedures performed by especially low-volume surgeons.

The proportion of patients with each procedure who were transferred into a hospital was included to control for the especially severe patient case mix faced by hospitals that attract a disproportionate share of complicated cases from other institutions. The proportion of patients for each procedure who were transferred out of the hospital was also controlled for, since hospitals with high transfer-out rates should report shorter average lengths of stay.

Measurement of Market Competition

The number of competing hospitals in each local market was measured according to the latitude and longitude coordinates for each of the nation's approximately 6000 nonfederal, short-term general hospitals. For each of the 747 hospitals providing patient discharge data, we used a computer algorithm to search for all the neighboring institutions within a 24-km radius (1800 km^2). Straight-line distances between hospitals were calculated from latitude and longitude coordinates using the Pythagorean theorem adjusted for the curvature of the earth. Markets were defined according to whether they included 0, 1 through 4, 5 through 10, or more than 10 neighboring hospitals within a 24-km radius. While procedure-specific patient abstract data were only available for 747 hospitals, as discussed above, the market measures were calculated using the full set of almost 6000 nonfederal, short-term hospitals in the continental United States, as obtained from the 1982 AHA survey. This method of measuring hospital market competition has been discussed at length elsewhere.[13]

This measure of competition assumes that the size of the relevant market does not vary by type of surgical procedure. The 24-km radius was chosen with the hypothesis that this was the maximum distance a physician would be willing to travel among hospitals regularly to conduct rounds. For some procedures, however, surgeons in some areas are willing to travel considerable distances, work-

Table 1.—Hospital and Patient Statistics for Ten Surgical Procedures and for All Discharges

	No. of Hospitals	No. of Patients	Average Length of Stay, d	ICD9-CM Code*
Total hip replacement	500	13656	18.5	81.5
Transurethral prostatectomy	629	41211	10.1	60.2
Intestinal operations	706	28162	19.7	45.71-45.79, 45.8, 45.92-45.94, 46.10-46.14, and 46.20-46.24
Stomach operations	654	9231	18.7	43.6, 43.7, 43.9, 44.0-44.03, 44.2, and 44.41-44.42
Hysterectomy	734	104999	7.9	68.3-68.7
Cholecystectomy	740	79782	10.6	51.21-51.22
Hernia repair	740	77633	4.5	53.00-53.05 and 53.10-53.17
Appendectomy	739	39029	5.5	47.0
Cardiac catheterization	297	75740	6.1	37.2-37.23 and 85.50-88.58
Coronary artery bypass graft	120	29011	15.3	36.10-36.19
All discharges	747	6143237	7.7	...

*ICD9-CM indicates *International Classification of Diseases, Ninth Revision–Clinical Modification.*

Table 2.—Adjusted Average Length of Stay in Days, by Number of Neighboring Hospitals Within 24-km Radius*

	Length of Stay, d			
	No Neighbors	1-4 Neighbors	5-10 Neighbors	≥11 Neighbors
Total hip replacement	17.11	17.59	18.39†	19.64‡
Transurethral prostatectomy	9.43	9.63	10.28§	10.74‡
Intestinal operations	18.47	18.73	19.92§	21.05‡
Stomach operations	17.08	18.27†	18.95§	19.59‡
Hysterectomy	7.64	7.73	7.93†	8.17‡
Cholecystectomy	10.17	10.32	10.71§	11.10‡
Hernia repair	4.19	4.34§	4.50‡	4.63‡
Appendectomy	5.36	5.37	5.55	5.81‡
Cardiac catheterization	4.98	5.95	6.13	6.12
Coronary artery bypass graft	13.13	14.13	14.93	15.91
All discharges	7.04	7.37	7.79‡	8.23‡

*P values given in footnotes below relate to the test of the null hypothesis that average length of stay in hospitals with 1 through 4, 5 through 10, or 11 or more neighbors is identical to average length of stay in hospitals with no neighbors.
†$P<.10$.
‡$P<.01$.
§$P<.05$.

ing in geographically quite distant institutions on different days of the week. Long-distance travel of this type occurs most frequently in less densely populated areas. As a partial adjustment for these differences in the market area, we included as explanatory variables in the regressions both the total population residing in the county where the hospital was located and the population per square mile in the county. These data were based on US Bureau of the Census records and compiled by the Bureau of Health Professions, US Department of Health and Human Services, in the 1982 Area Resource File. Nevertheless, it was to be expected that our measure of market structure provided a more precise index of the true degree of competition for routine surgical procedures, such as appendectomy and hysterectomy, than for more specialized procedures, such as coronary artery bypass graft surgery.

Hospital Characteristics

The 1982 AHA Annual Survey of Hospitals provided information on hospital ownership status (public, private nonprofit, or private for profit) and role in medical education (whether or not the institution was a member of the Council of Teaching Hospitals). The region of the nation (Northeast, Midwest, Southeast, or West) was also used to control for the well-known, though poorly understood, geographic differences in average length of patient stay. Average length of stay for all patients, admitted over the course of 1982, was also derived from the AHA survey. To control for broad differences in patient mix when using this measure, we used the AHA data to calculate the percentage of all inpatient days over the course of 1982 that were accounted for by each of 23 broad diagnostic categories. These 23 categories included five forms of acute care (adult medical and surgical, pediatric, obstetric, psychiatric, and other acute), eight forms of intensive care (general medical and surgical intensive, cardiac intensive, neonatal intensive, neonatal intermediate, pediatric intensive, burn, psychiatric intensive, and other special), five forms of subacute care (nursery long term, psychiatric long term, other long term, self-care, and other subacute), and five miscellaneous forms of care (rehabilitation, respiratory disease, hospice, alcoholism, and other). These 23 categories assumed the role in the analysis of the overall length of stay played by the procedure-specific case mix and secondary diagnosis and procedure measures in the analysis of the ten procedure-specific average lengths of stay.

Analytic Techniques

We used linear multiple regression analysis (weighted least squares) to explain the cross-hospital variation in average length of stay for each of the ten surgical procedures and for all discharges.

To prevent hospitals with small procedure volumes from dominating the statistical results, we weighted each hospital observation by the square root of its volume of patients. For the ten surgical procedures, procedure-specific volumes were used as the basis for the weights. For length of stay for all discharges, the total number of discharges was used.

Each regression used a common set of independent variables plus a unique set of variables tailored to that particular procedure. Variables used in all regressions included the market competition measures, county population, county population density, region of the nation, ownership type, and whether or not the institution was a member of the Council of Teaching Hospitals. Procedure-specific variables for each of the ten forms of surgery included hospital volume for that procedure, our measure of surgeon volume for that procedure, the case-mix measures, the secondary diagnosis and procedure measures, the proportion of cases transferred into the hospital, and

the proportion of cases transferred out of the hospital. The overall length of stay regression used annual discharges as its measure of volume and the 23 diagnostic categories as its measure of patient case mix, in addition to the common set of explanatory variables.

Adjusted lengths of stay for each surgical procedure and for all discharges were calculated based on these regressions. An adjusted mean was an estimate based on the hypothetical situation that all hospital groups had the same (sample mean) values on each of the independent variables that were entered into the regression equation. The adjusted mean lengths of stay were calculated for hospitals in each type of local market, ie, those with no neighboring institution within 24 km, those with one through four neighbors, those with five through ten neighbors, and those with more than ten neighbors.

RESULTS

Table 1 presents descriptive statistics on each of the ten surgical procedures and for all discharges. Sample sizes for the procedures varied according to their degree of complexity and, hence, the proportion of hospitals within which each was performed. Of the 747 hospitals in the sample, only 120 had patients undergoing coronary artery bypass graft surgery in 1982, and only 297 had patients undergoing cardiac catheterization. Over two thirds of the hospitals reported total hip replacement, transurethral prostatectomy, and stomach operations. Almost all reported intestinal operations, hysterectomy, cholecystectomy, hernia repair, and appendectomy. Relatively long average lengths of stay were reported for coronary bypass surgery, total hip replacement, stomach operations, and intestinal operations.

Table 2 presents adjusted average lengths of stay for each of the ten surgical procedures and for all discharges, according to the number of neighboring hospitals within a 24-km radius. These data control for the following: differences among markets in terms of population and population density; differences among major regions of the country; differences among hospitals in ownership status, teaching role, hospital and surgeon volumes, and percentage of patients transferred in and out; and differences in patient case mix in terms of expected inhospital mortality rate and presence of secondary diagnoses and procedures.

The differences in length of stay associated with increasing numbers of neighboring hospitals in the local market were striking. For each of the ten surgical procedures and for all hospital discharges, average length of stay increased with the number of competitors. The size of the market-related differences varied considerably among the procedures, but these differences were consistently associated with differences in average length of stay for each procedure among all hospitals in the sample. In percentage terms, market-related length of stay differences were fairly similar among procedures.

Compared with hospitals with no neighbors within 24 km, hospitals in the most competitive markets reported average lengths of stay that were 14.8% higher for total hip replacement ($P<.01$), 13.9% higher for transurethral prostatectomy ($P<.0001$), 14.0% higher for intestinal operations ($P<.0001$), 14.7% higher for stomach operations ($P<.001$), 6.9% higher for hysterectomy ($P<.01$), 9.1% higher for cholecystectomy ($P<.0001$), 10.5% higher for hernia repair ($P<.001$), 8.4% higher for appendectomy ($P<.01$), 22.9% higher for cardiac catheterization ($P>.05$), and 21.2% higher for coronary artery bypass graft surgery ($P>.05$). The market-related differences for cardiac catheterization and bypass surgery, while large in size, were not statistically significant due to the relatively small sample sizes available for these complex procedures. The explanatory power of the linear regressions underlying these market-related differences was high, with adjusted multiple correlation coefficients ranging from a low of .31 for stomach operations to a high of .48 for cardiac catheterization.

The last row of Table 2 presents adjusted length of stay data for all hospital discharges according to the number of neighboring hospitals in the local market. Hospitals in the most competitive markets reported average lengths of patient stay 16.9% higher ($P<.0001$) than comparable hospitals that had no nearby neighbors. The adjusted multiple correlation coefficient on this regression was .58.

COMMENT

This study documented the strong association between the number of hospital competitors in the local market and average length of stay in US hospitals in 1982. For each of the ten surgical procedures examined, and for the sum of all discharges, hospitals in markets with more neighbors reported substantially longer lengths of stay than otherwise similar hospitals without nearby neighbors. These market-related differences were especially remarkable since they were based on statistical analyses that controlled for total population and population density in the market. As these population measures were both positively associated with average length of stay in their own right and with the number of competing hospitals in the market, the hospital-based measures of market competition understated the full association between average length of stay and the number of neighboring hospitals.

These findings are consistent with the hypothesis that patients and physicians tend to prefer longer over shorter lengths of stay for surgical procedures and that hospitals under competitive pressure are more likely to accommodate those desires than hospitals not under such pressures. These findings are particularly striking since they concern surgical procedures. Given their global-fee method of reimbursement, surgeons do not face economic incentives to lengthen patient stays. The fee covers follow-up visits and, thus, provides some incentives to reduce stays, but this appears to be weak relative to the increased uncertainties associated with shorter stays. Attending physicians for patients undergoing medical treatments tend to be reimbursed for each visit. Competition-related length of stay differences may be greater for some medical admissions than for the surgical procedures reported here.

An additional and complementary explanation for these findings can be derived from economic theories of hospital decisions concerning bed capacity utilization. Harris[14] and Joskow[15] have argued that physicians prefer hospitals to maintain excess bed capacity so as to be able to accommodate unscheduled admissions without delays. This desire for excess capacity is particularly acute where hospital beds are assigned to particular services, such as orthopedic surgery, and cannot be easily switched to another service when an unexpected increase in admissions is experienced. Hospitals facing competitive pressures are more susceptible to physician demands for the maintenance of this excess capacity.[15] Once the excess bed capacity is in place, hospital administrators can be more generous in allowing long lengths of stay during periods when admission rates are not exceptionally high. Pressure can be placed on staff physicians to shorten lengths of stay, thereby freeing up bed capacity, during the rare periods of peak admission rates.

To test the Harris-Joskow hypothesis[14,15] concerning competitive influences on hospital bed utilization, we initially analyzed the influence of local market competition on bed occupancy

rates and on the two components of those rates: the ratio of annual admissions to beds and average length of stay. Using the 1982 AHA survey, we found admissions per bed to be significantly lower in competitive than in noncompetitive markets, while average length of stay for all admissions was significantly longer in competitive than in noncompetitive markets.

These findings reinforced our view that, while occupancy rates may have a substantial influence on a physician's day-to-day ability to admit patients or postpone a discharge, the average occupancy rate over a year reflects overall admissions and length of stay patterns. Therefore, it is inappropriate to include occupancy rates as an explanatory variable in studies such as ours.

Although our analyses controlled for the 23 diagnostic categories available in the AHA data, we were concerned lest these findings be due to unobserved case-mix differences. If hospitals in more competitive local markets had sicker patients than hospitals elsewhere, and, hence, longer average lengths of stay, they would necessarily report fewer annual admissions per bed. The study reported in this communication was designed to evaluate this possibility by measuring the effects of market competition on procedure-specific lengths of stay. The Commission on Professional and Hospital Activities data used in this study also permitted us to control directly for patient age, sex, and presence of specific secondary diagnoses and procedures. While it is possible, in principle, that the statistical associations reported herein were due to continuing unobserved differences in case mix within procedure-specific categories, we feel this is highly unlikely. It is interesting to note that the measured effect of competition on length of stay for all admissions (17%) falls within the range of effects for the ten specific procedures (7% to 23%).

These findings on the association between hospital competition and length of stay for patients undergoing surgery contribute to a growing literature on the effects of market forces on hospital behavior. Given the pervasive consumer uncertainty about quality of care differences among geographically proximate institutions, hospitals have found it necessary to compete with one another through the acquisition of specialized technologies and support staffs that physicians and patients interpret as indicative of high quality. This "medical arms race" has had unfortunate consequences via its tendency to create unnecessary duplication of similar services in nearby hospitals.[7] Average costs per patient admission in 1982 were 26% higher in the most competitive hospital markets than in the least competitive markets, controlling for wage rates, patient case mix, and other relevant factors.[9] Clinically, competition-related duplication of open heart surgery facilities has been found to produce low annual volumes of coronary artery bypass graft surgeries in competitive markets.[8] This has direct potential implications for quality of care, given the association consistently documented between low volumes and high mortality rates for coronary bypass surgery.[6]

Since 1982, the replacement of retrospective by prospective reimbursement methods by Medicare and a variety of Medicaid and private insurance programs has exerted a dramatic effect on the hospital care marketplace. Hospitals now face severe economic pressures that limit their ability to pursue the costly nonprice competitive strategies of earlier years. Long lengths of patient stay are particularly penalized by programs, such as Medicare, that pay a fixed rate per admission within particular diagnostic categories. Hospitals in which procedure- and diagnosis-specific lengths of stay were especially long before prospective payment was introduced are being especially affected. These hospitals will be forced to make the greatest adjustments in discharge protocols and to convince their affiliated physicians to make the greatest adjustments in practice styles. Patients utilizing these hospitals will need to make substantial adjustments in financial and time commitment, given the increasing proportion of total postoperative recovery time that will occur in the home rather than the hospital. The data reported in this study suggest that the adjustment process will be particularly difficult for hospitals, physicians, and patients in competitive local markets, precisely because of the preexisting effects of competition on practice styles.

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When this study was undertaken, Ms Hunt was a research associate at the Institute for Health Policy Studies, University of California, San Francisco.

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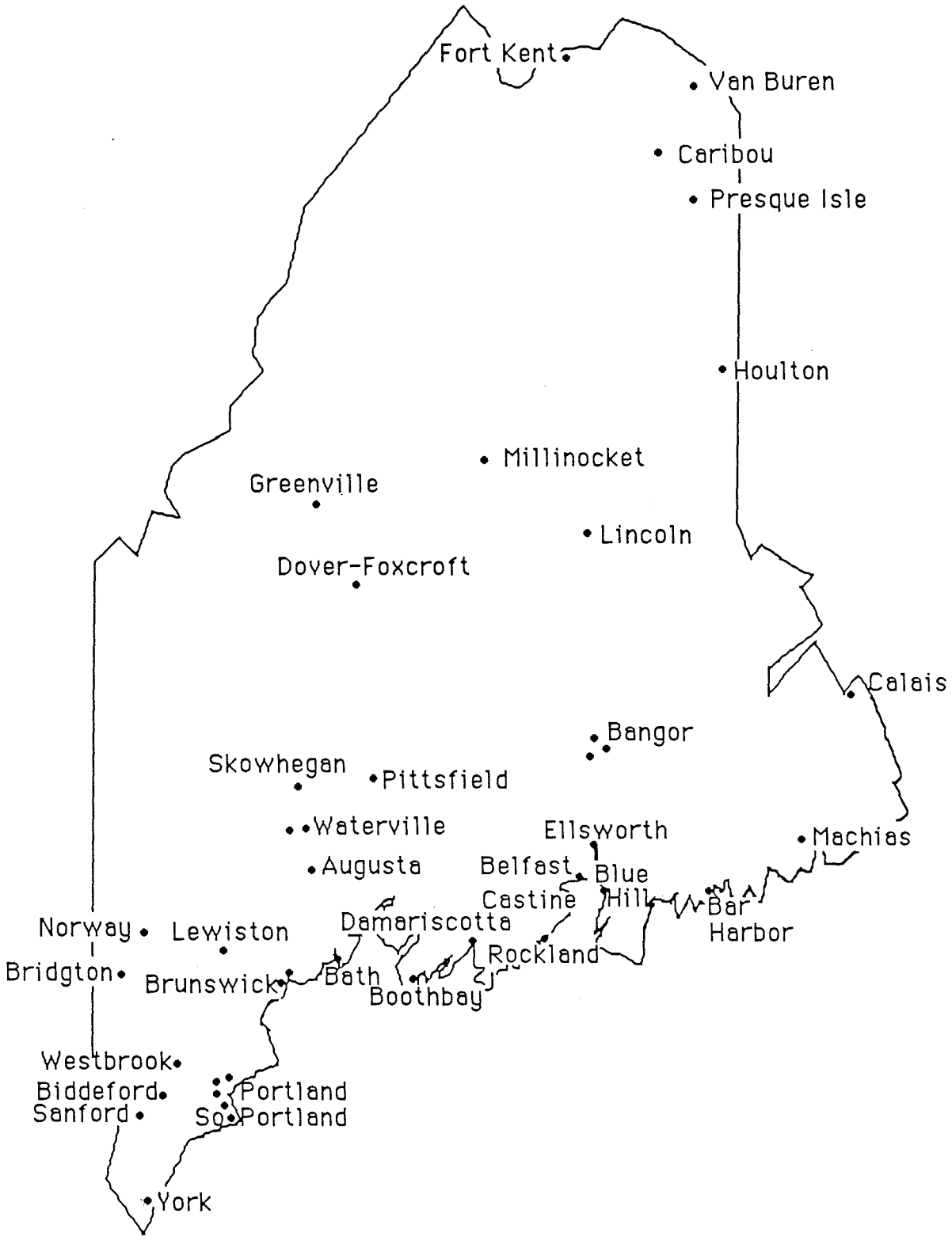
LOCATIONS OF MAINE HOSPITALS



MAINE'S COMMUNITY HOSPITALS

Sole Community Providers

Definition:

Any hospital that:

a) is located in a rural area as defined by 42 CFR 412.62.f. -- which translated to Maine means any county other than Androscoggin, Cumberland, Penobscot, Sagadahoc, and York County **and**

b) meets one of the following criteria:

1. the hospital is more than 50 miles away from a like hospital **or**
2. the hospital is more than 25 miles but less than 50 miles away from a like hospital, and either:
   - A. less than 25% of the residents in the service area are admitted to other like hospitals for care **or**
   - B. the hospital has less than 50 beds and the fiscal intermediary certifies that the hospital would have met the critera in 2.A. above except that residents were forced to recieve care outside the area due to the unavailability of services at the local community hospital **or**
   - C. local topography or weather conditions make services at other like hospitals inaccessible to residents for at least one month a year; **or**
3. the hospital is more than 15 miles but less than 25 miles away from a like hospital but local topography or weather conditions make services at other like hospitals inaccessible to residents for at least one month a year

NO.	HOSPITAL	TOWN	COUNTY	BEDS	SIZE	FY END
3	Mid-Maine Medical Center	Waterville	Kennebec	308	Large	3/31
12	Pen Bay Medical Center	Rockland	Knox	106	Medium	3/31
13	Rumford Community Hospital	Rumford	Oxford	97	Medium	6/30
18	Calais Regional Hospital	Calais	Washington	77	Medium	12/31
20	Franklin Memorial Hospital	Farmington	Franklin	70	Medium	6/30
21	No. Maine Medical Center	Fort Kent	Aroostook	70	Medium	9/30
23	Houlton Regional Hospital	Houlton	Aroostook	65	Medium	9/30
33	Waldo County General Hospital	Belfast	Waldo	49	Small	6/30
36	Down East Community Hospital	Machias	Washington	38	Small	12/31
All				586		

Note: C.A.Dean Hospital is the only part of Mid-Maine Medical Center considered a sole community provider. C.A.Dean Hospital, located in Greenville, has 14 acute care beds. The total of 586 beds has included just those 14 beds.

MAINE'S COMMUNITY HOSPITALS

Medicare Urban Hospitals

Definition:

Any hospital located in an urban area as defined by:

a) a Metropolitan Statistical Area (MSA) or New England County Statistical Area (NECMA), as defined by the Executive Office of Management and Budget **or**

b) certain New England counties (including both York and Sagadahoc Counties), deemed to be urban areas under section 601(g) of the Social Security Admendments of 1983 (Public Law 98-21, 42 USC 1395ww(note)).

NO.	HOSPITAL	TOWN	COUNTY	BEDS	SIZE	FY END
1	Maine Medical Center	Portland	Cumberland	598	Large	9/30
2	Eastern Maine Medical Center	Bangor	Penobscot	416	Large	9/30
4	Central Maine Medical Center	Lewiston	Androscoggin	250	Large	6/30
5	St. Mary's General Hospital	Lewiston	Androscoggin	233	Large	12/31
7	Mercy Hospital	Portland	Cumberland	200	Large	6/30
8	Osteo. Hospital of Maine	Portland	Cumberland	160	Large	8/31
9	So. Maine Medical Center	Biddeford	York	150	Large	4/30
11	St. Joseph Hospital	Bangor	Penobscot	130	Large	12/31
14	Jackson Brook Institute	S. Portland	Cumberland	96	Medium	6/30
16	Regional Memorial Hospital	Brunswick	Cumberland	90	Medium	9/30
19	H.D. Goodall Hospital	Sanford	York	73	Medium	5/31
25	York Hospital	York	York	61	Medium	6/30
26	Taylor Hospital	Bangor	Penobscot	60	Medium	8/31
27	Bath Memorial Hospital	Bath	Sagadahoc	59	Medium	9/30
28	Parkview Memorial Hospital	Brunswick	Cumberland	55	Small	6/30
30	Millinocket Regional Hospital	Millinocket	Penobscot	50	Small	6/30
34	Penobscot Valley Hospital	Lincoln	Penobscot	44	Small	12/31
35	No. Cumberland Hospital	Bridgton	Cumberland	40	Small	10/31
39	Westbrook Community Hosp.	Westbrook	Cumberland	30	Small	12/31
43	New England Rehab. Hospital	Portland	Cumberland	25	Small	8/31
All				2820		

MAINE'S COMMUNITY HOSPITALS

NO.	HOSPITAL	TOWN	COUNTY	BEDS	SIZE	FY END
1	Maine Medical Center	Portland	Cumberland	598	Large	9/30
2	Eastern Maine Medical Center	Bangor	Penobscot	416	Large	9/30
3	Mid-Maine Medical Center	Waterville	Kennebec	308	Large	3/31
4	Central Maine Medical Center	Lewiston	Androscoggin	250	Large	6/30
5	St. Mary's General Hospital	Lewiston	Androscoggin	233	Large	12/31
6	Kennebec Valley Medical Center	Augusta	Kennebec	201	Large	6/30
7	Mercy Hospital	Portland	Cumberland	200	Large	6/30
8	Osteo. Hospital of Maine	Portland	Cumberland	160	Large	8/31
9	So. Maine Medical Center	Biddeford	York	150	Large	4/30
10	The Aroostook Medical Center	Presque Isle	Aroostook	133	Large	12/31
11	St. Joseph Hospital	Bangor	Penobscot	130	Large	12/31
12	Pen Bay Medical Center	Rockland	Knox	106	Medium	3/31
13	Rumford Community Hospital	Rumford	Oxford	97	Medium	6/30
14	Jackson Brook Institute	S. Portland	Cumberland	96	Medium	6/30
15	Redington-Fairview Hospital	Skowhegan	Somerset	92	Medium	6/30
16	Regional Memorial Hospital	Brunswick	Cumberland	90	Medium	9/30
17	Waterville Osteopathic Hospital	Waterville	Kennebec	78	Medium	12/31
18	Calais Regional Hospital	Calais	Washington	77	Medium	12/31
19	H.D. Goodall Hospital	Sanford	York	73	Medium	5/31
20	Franklin Memorial Hospital	Farmington	Franklin	70	Medium	6/30
21	No. Maine Medical Center	Fort Kent	Aroostook	70	Medium	9/30
22	Cary Medical Center	Caribou	Aroostook	65	Medium	12/31
23	Houlton Regional Hospital	Houlton	Aroostook	65	Medium	9/30
24	Maine Coast Memorial	Ellsworth	Hancock	64	Medium	6/30
25	York Hospital	York	York	61	Medium	6/30
26	Taylor Hospital	Bangor	Penobscot	60	Medium	8/31
27	Bath Memorial Hospital	Bath	Sagadahoc	59	Medium	9/30
28	Parkview Memorial Hospital	Brunswick	Cumberland	55	Small	6/30
29	Mayo Regional Hospital	Dover-Foxcroft	Piscataquis	52	Small	9/30
30	Millinocket Regional Hospital	Millinocket	Penobscot	50	Small	6/30
31	Stephens Memorial Hospital	Norway	Oxford	50	Small	12/31
32	Mt. Desert Island Hospital	Bar Harbor	Hancock	49	Small	4/30
33	Waldo County General Hospital	Belfast	Waldo	49	Small	6/30
34	Penobscot Valley Hospital	Lincoln	Penobscot	44	Small	12/31
35	No. Cumberland Hospital	Bridgton	Cumberland	40	Small	10/31
36	Down East Community Hospital	Machias	Washington	38	Small	12/31
37	Sebasticook Valley Hospital	Pittsfield	Somerset	36	Small	11/30
38	St. Andrews Hospital	Boothbay Harbor	Lincoln	32	Small	9/30
39	Westbrook Community Hosp.	Westbrook	Cumberland	30	Small	12/31
40	Van Buren Community Hosp.	Van Buren	Aroostook	29	Small	12/31
41	Miles Health Care Center	Damariscotta	Lincoln	27	Small	4/30
42	Blue Hill Memorial Hospital	Blue Hill	Hancock	26	Small	6/30
43	New England Rehab. Hospital	Portland	Cumberland	25	Small	8/31
44	Castine Community Hospital	Castine	Hancock	12	Small	1/31
All				4646		

Note: Mid-Maine Medical Center includes C.A.Dean Hospital in Greenville (14 acute beds)

After tort reform: What's next?

When medical malpractice insurance rates began their startling upward climb in the mid-1970s, the health care community looked to the court system for relief. Injured plaintiffs were being overcompensated by sympathetic juries, it argued. The system made it all too easy to file unmeritorious lawsuits, which nevertheless were expensive to defend. Sharklike trial lawyers were all too eager to reach into the deep pockets of physicians and hospitals in hopes of coming away with a contingency fee from a huge damage award.

In short, the argument went, the civil justice system was skewed in favor of the plaintiff, and good hospitals and physicians were being stung by sharp increases in insurance premiums—the result of concurrent increases in the number and size of malpractice awards. Although controversial, this argument eventually found a sympathetic audience in most state legislatures. Today, nearly every state has passed legislation known as "tort reform"—changes in the civil justice system meant to control what had become a crisis in the cost of liability insurance.

But studies and interviews with those involved in the tort reform effort find that such legislation has not resulted in a significant check on insurance premiums or on the number and size of damage awards. Reforms are often challenged in court, dampening their effect. Insurance companies, understandably cautious in their underwriting practices, demand to see several years of experience under the new laws before they change their rates.

Many states are still debating and passing tort reform legislation, but some experts say it is time to look beyond the usual tinkering with the system and experiment with new—sometimes radical—approaches.

Costs still rapidly rising. As Frederick Alley, CEO of Brooklyn (NY) Hospital-Caledonian Hospital, says, "The entire system has to be discarded." Otherwise, he says, "The whole system will be bankrupt." Alley is chairman of a seven-hospital insurance consortium that was formed in 1982 as a result of skyrocketing malpractice insurance premiums. The situation is still dangerous, he says, because physicians can't afford malpractice insurance anymore. "It threatens every single member of the medical staff. We face a shortage of practitioners, especially in obststrics."

Dissatisfaction with traditional reforms is reflected in a 1986 General Accounting Office study of six states that had passed reforms in the mid-1970s. The study found that, despite the changes, "insurance costs for many physicians and hospitals increased dramatically, as did the number of malpractice claims filed and the average amounts paid."

In only one of the states—New York—did the average paid claim against hospitals decrease. However, the report points out, the average paid claim in New York was still far higher than were the average paid claims in the other states.

Despite the mid-1970s reforms, the report states, the average paid claim against hospitals insured by the St. Paul Co. rose 137 percent from 1980 to 1984. The company is the country's largest medical malpractice insurer.

Patricia Danzon, a professor at the University of Pennsylvania, Philadelphia, often considered the leading researcher on tort reform, has found more optimistic results. Her 1986 study, *New Evidence on the Frequency and Severity of Medical Malpractice Claims*, found that the number and size of claims against physicians continued to increase steadily, but not as fast as they would have increased without tort reforms.

"Claim frequency per physician has grown at roughly 10 percent a year and severity has increased at twice the rate of inflation of consumer prices" in the decade since 1975, Danzon writes. "Nevertheless, this does not mean that the tort changes have had no effect."

Danzon cites several reforms that have moderated the frequency and severity of claims. Specifically, she found that cutting one year off the statute of limitations for adults reduced claim frequency by 8 percent. Laws allowing malpractice awards to be reduced if the plaintiff has collateral sources of compensation cut the cost of claims by 11 to 18 percent, she found. And caps on awards reduced the cost of claims by 23 percent. Danzon's study involved a comparison of claims from states with these reforms to claims from states without them.

Insurers respond with caution. Danzon did not at-

Despite reforms, claims and premiums skyrocket

Since the mid-1970s, nearly every state has enacted legislation to reform the civil justice system. The goal was to bring some stability to medical malpractice insurance rates and premiums, which had been experiencing nearly uncontrollable growth. It was thought that tort reform legislation, if given the chance to work, would bring some predictability to malpractice awards and, hence, to malpractice insurance premiums.

But as the figure below shows, both the total claims paid by medical malpractice insurers and the total medical malpractice premiums paid have grown rapidly since 1980. The total amount of claims paid by insurers rose 264 percent from 1980 to 1987. The total amount of medical malpractice premiums paid by physicians and hospitals grew 235 percent in that time.

The continuing high cost of malpractice insurance has caused some in the health care community to look beyond the court system for relief.

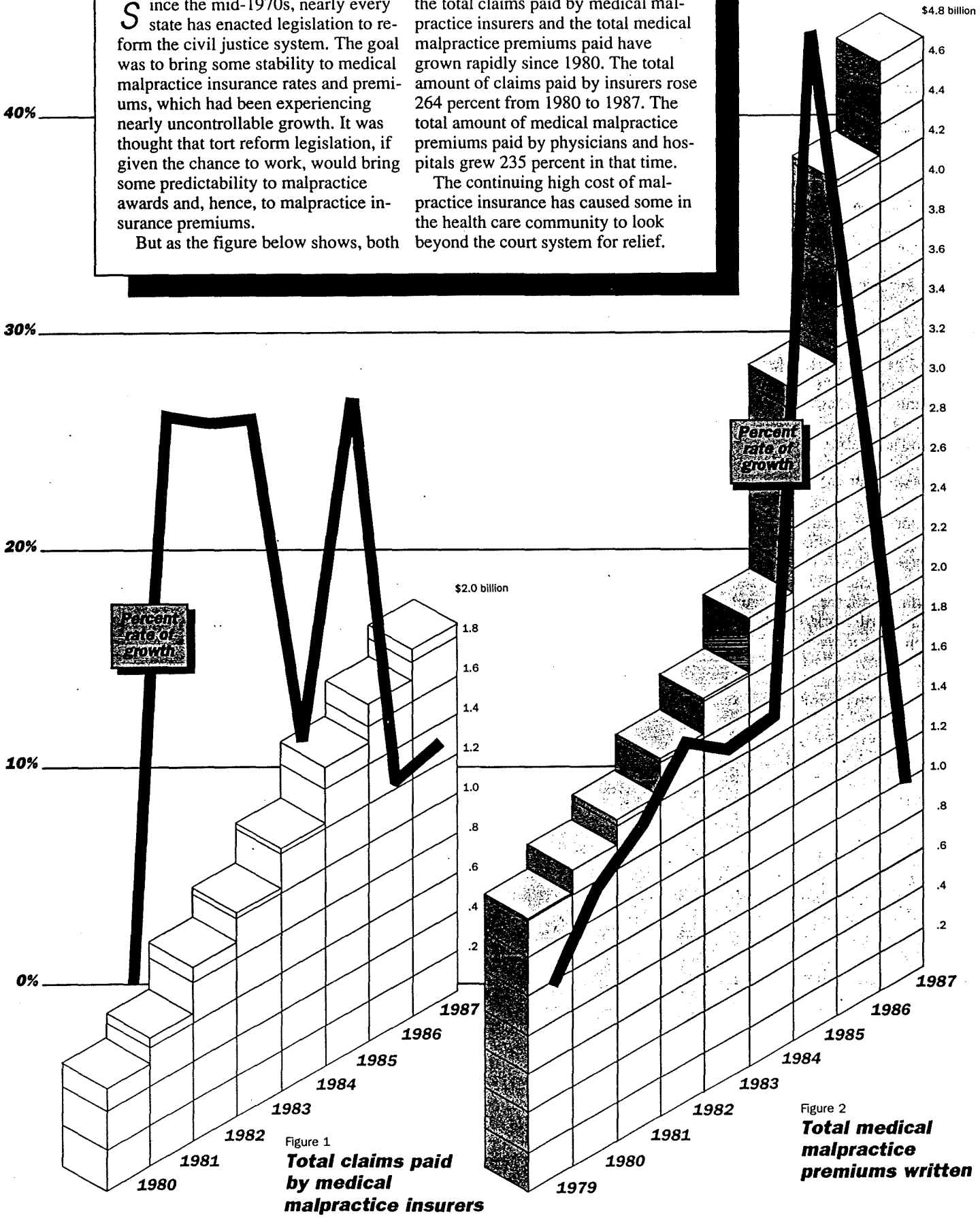


Figure 1
Total claims paid by medical malpractice insurers

Figure 2
Total medical malpractice premiums written

Source A.M. Best Co., 1988 Graphics by **Hospitals**

tempt to measure the effects of reforms on malpractice insurance premiums, but the health care industry has found that medical malpractice insurance companies are slow to respond to tort reforms. "We will not immediately reduce our rates in response to tort reforms," says Robert Trunzo, a government affairs specialist with the St. Paul Co. "Over the course of time, if reform has a significant effect, it will be borne out in loss costs and costs to us—and ultimately in costs to the insured."

But Trunzo is skeptical about the efficacy of reform legislation. "It's difficult to determine if tort reform has had any significant impact," he says. Insurance actuaries typically require three to five years of data before being confident enough of a trend to change rates, he says. Most reforms have not been permitted to work unimpeded that long. Passage of reforms is usually countered with legislative and legal challenges that put their final outcomes in doubt.

Challenges, delays limit impact. Even traditional proponents of tort reform agree that its impact has been limited. A major reason, they say, is that reforms have been hung up in the courts or overturned or reversed by judges and legislators.

"Tort reform has not been, in actuality, as successful as we would have liked to have seen it," says James Todd, M.D., a senior deputy executive vice-president of the American Medical Association. "It's been gutted by constitutional challenges and the further expansion of liability by the courts," he says.

Michael Anthony, senior vice-president for legal affairs with the American Hospital Association, says reforms will work, but they haven't been given the chance. "I think the jury's still out on many of the reforms," he says. Anthony calls for the collection of more information on the impact of tort reform. He also suggests that insurers be open with hospitals on how premiums are determined.

Kenneth Heland, head of the professional liability department of the American College of Obstetricians and Gynecologists, Washington, DC, is in favor of tort reform. Yet he says, "Ultimately, tort reform is just going to be a holding action." And Blair Childs, head of the American Tort Reform Association, Washington, DC, says, "Traditional tort reforms have got to be allowed to play out. You fool yourself if you think you're going to get a quick fix."

Two success stories. The tort reform battle is still being waged in most states, but two states have claimed victory, crediting tort reform legislation with the restoration of stability to the medical malpractice climate. In California, a comprehensive tort reform package is credited with returning normalcy to a state that had been among the worst in the nation for insurance rates. And in Indiana, a patient compensation fund is seen as a key factor in keeping malpractice insurance premiums among the lowest in the country.

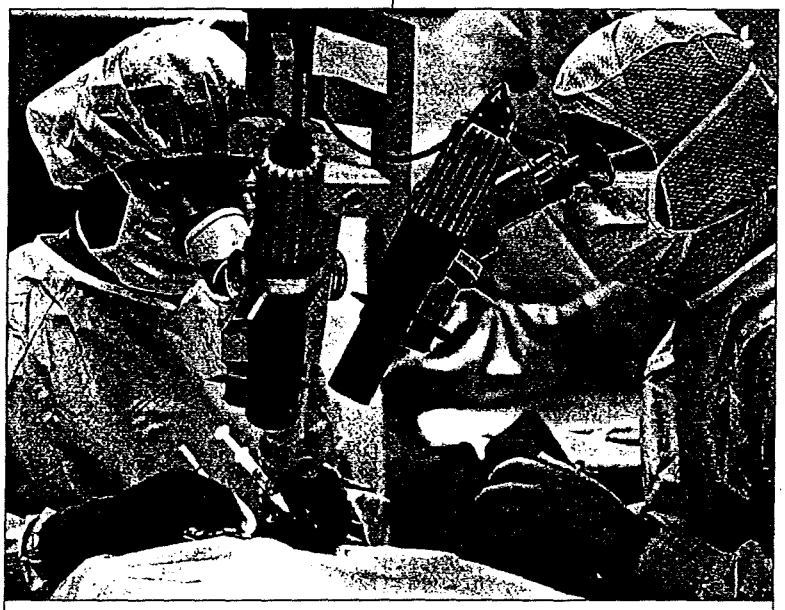
In 1975, California passed the Medical Injury Compensation Reform Act, a comprehensive package that included a cap on noneconomic damages, periodic payment of damage awards, and limits on attorneys' fees. At that time, the state's malpractice rates were among the highest in the nation and commercial insurers were withdrawing from the market.

Today, of the 38 states where physician-owned captive insurance companies operate, 20 have higher average premiums for obstetricians and 22 have higher premiums for neurosurgeons than California does, according to the Physician Insurers Association of America.

Average per-bed rates for hospitals in California are still high, but rates have stabilized. Hospitals insured by the St. Paul Co. pay an average of $3,258 per bed for policies of $1 million per occurrence and $3 million aggregate. But the state's largest insurer of hospitals, the Truck Insurance Exchange, Los Angeles, has filed for only a one-half percent increase for primary insurance and is not seeking an increase in rates for excess insurance.

Also, average indemnity payments for large medical liability verdicts and settlements in California decreased by 31 percent in 1987, according to the Medical Underwriters of California. The average decreased for the second straight year.

Indiana has become the envy of the nation with its relatively low premiums for physicians and hospitals. Its statewide average per-bed rate for hospitals insured by the St. Paul Co. is among the lowest of any state. Its physician-owned captives charge lower premiums, on an average, than those in any other state for internists, general surgeons, and



A New York City hospital CEO says that continuing increases in the cost of medical malpractice insurance "threaten every member of the medical staff." He fears a shortage of physicians.

Steve Loomis/Vim & Vigor Magazine

'Tort deform' unravels malpractice reform legislation

Pro-tort-reform groups have been working for years to modify the civil justice system while others have been working just as hard to keep it from changing.

The anti-tort-reform group has scored some significant victories lately. In the states where they've won, the courts have declared tort reform legislation unconstitutional, leaving the tort reform advocates at a loss. This trend has come to be known as "tort deform."

Unconstitutional. In Kansas, for example, the legislature passed tort reform laws four years running, including a comprehensive package dealing solely with medical malpractice in 1986. That year, the Kansas Supreme Court found a 1985 law changing the collateral source rule for medical malpractice victims unconstitutional because it applied only to plaintiffs injured through medical malpractice and not to everyone.

Seeking to remedy that, the legislature in 1988 passed "generic" tort reform measures that applied a cap on noneconomic damage awards in all personal injury cases, not just in medical malpractice cases.

Wide-ranging decision. But the state supreme court wasn't finished. Earlier this year, after a challenge by a group called the Kansas Malpractice Victims Coalition, the court ruled the 1986 legislation unconstitutional, saying that it denied injured plaintiffs the right to have a jury decide the full amount of compensation due them.

The court's decision puts the future of tort reform in Kansas in doubt. "The decision was so broad that it even throws into question the generic reforms we had passed in 1988," says Tom Bell, general counsel for the Kansas Hospital Association, Topeka. "There's little, if anything, the legislature can do in the area of substantial tort reform that would withstand the court's current constitutional analysis," he says.

'Rights diluted.' In Wyoming, a crucial element of that state's tort reform laws was struck down by the state supreme court. In a 3-2 decision, the court ruled that the Wyoming Medical Review Panel was unconstitutional. The panel, composed of two health care professionals, two attorneys, and one lay member, reviewed all medical malpractice lawsuits in Wyoming for mediation.

In its decision, the court said: "We cannot condone the legislature's use of the law to protect one class of people from financial difficulties while it dilutes the rights under the Constitution of another class of people."[2]

Similarly, in Florida and Virginia, the courts have found caps on damage awards to be unconstitutional, arguing that the caps restricted the plaintiff's right of recourse to the courts.

In May, the Texas Supreme Court found two 1975 reforms limiting damage awards in medical malpractice cases to be unconstitutional. The court said it was the duty of the judiciary, not the legislature, to ensure that damage awards were appropriate.

And in July, the Oklahoma Supreme Court declared unconstitutional a law limiting damages in medical malpractice lawsuits filed more than three years after the injury occurred.

According to Sarah Karzel, a former American Hospital Association attorney who is now with United Health America, Los Angeles, most challenges are brought under the equal protection or due process clauses of the U.S. Constitution. However, she says, if the government can show that its action was related to a legitimate state goal, such as improving the availability and affordability of insurance, the reform measures are usually evaluated under a less stringent standard.

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obstetricians, and the state has the second-lowest premiums for neurosurgeons.

The reason: In 1975, the Indiana legislature passed a law setting a $500,000 limit on the amount a plaintiff can recover. Providers are responsible only for the first $100,000. The rest of the award is paid from a patient compensation pool that is funded through surcharges on premiums. The law "is almost the sole reason our premiums are among the lowest in the country," says John Render, general counsel for the Indiana Hospital Association, Indianapolis.

New alternatives explored. Traditional tort reform is thought to have some stabilizing effect and has had some isolated successes, but it's not considered by most to be the ultimate solution to the problem of high damage awards and malpractice premiums. Increasingly, providers are becoming interested in exploring other, nontraditional, means of bringing predictability back into the system.

As an AHA task force on medical malpractice reported in 1987: "Tort reform alone cannot make the resolution of tort claims efficient, cost-effective, and predictable as applied to medical malpractice cases." That feeling is shared by providers in New York, who pay among the highest malpractice insurance premiums in the country. In 1985 and 1986, New York passed extensive tort reform packages that included allowing for periodic payment of awards, mandatory reduction of awards by collateral sources, penalties for frivolous suits, mandatory certificates of merit, and limits on joint and several liability. The legislature passed nearly every tort reform measure that other states have enacted except for a cap on damage awards.

Nevertheless, the average cost per paid claim jumped

Interest grows in out-of-court alternatives

Malpractice insurance premiums continue to rise even after most states have passed tort reform laws. Consequently, there is a growing interest in ways to resolve malpractice claims outside of the courts.

As Michael Anthony, the American Hospital Association's senior vice-president for legal affairs, says, "It's time to experiment with different options."

Anthony: 'It's time to experiment with options.'

The AHA's Office of Legal and Regulatory Affairs recently published a report called "Nontraditional Approaches to the Medical Malpractice Crisis." The following is a summary of the approaches it discusses.

Contracts

Contracts between providers and patients can be arranged before care is provided to define the duties and modify the rights of the parties. Or they can be entered into after an alleged act of wrongdoing.

Advantages: Contracts can reduce legal expenses and cut down on the practice of defensive medicine. Savings could be passed on to consumers through reduced medical care costs.

Disadvantages: Contracts are viewed with suspicion by patients because of the provider's better education and training.

Arbitration

An impartial panel investigates, makes a decision, and makes awards. Can be binding or nonbinding, but Anthony suggests that voluntary binding arbitration is best because otherwise the process would merely add another layer of bureaucracy before liability cases reach the courts.

Advantages: Legal expenses can be reduced because some cases are removed from the judicial system. Claims are handled quicker and the number of appeals are reduced. It is a private, rather than a public, airing of a dispute.

Disadvantages: Results can be unsatisfactory unless all potentially liable parties submit to binding arbitration. Could be challenged as violation of plaintiff's constitutional rights.

Patient compensation funds

A form of mandatory insurance administered by the state and funded through premiums charged to health care providers. The fund pays malpractice claims over a certain limit. Indiana's is generally considered to be a model, having survived constitutional and financial threats.

Advantages: Providers are protected against huge premium increases because insurers are protected against extremely large awards. Introduces predictability into insurers' rate-setting process.

Disadvantages: No economic incentive is provided to avoid negligent conduct, and the most negligent providers are the most protected. Neither the number of malpractice claims nor the number of judgments is reduced.

Medical offer and recovery

Providers are given the option of paying a claimant out-of-pocket expenses as a result of an unsatisfactory outcome. The patient would waive the right to go to court.

Advantages: Losses are more predictable and payment is prompt and comprehensive. The "lottery" aspect of the tort system would be eliminated. Legal costs could be reduced through elimination of time spent in pretrial preparation and in the trial itself.

Disadvantages: A greater number of outcomes could be compensated. Arbitration and the negotiation of payments and share of liability would be difficult. No compensation for pain and suffering would be provided.

Scheduled benefits

Similar to workers' compensation for injured employees, but [illegible] as the basis for compensation. [illegible] whether a compensable injury [illegible] and [illegible] determines compensation based on a schedule.

Advantages: Awards would be more predictable. Claims would be handled faster.

Disadvantages: System would be vulnerable to constitutional challenges from limiting compensation and eliminating right to trial by jury. Disputes over degree and lengths of disabilities are likely to occur. —[illegible]

31 percent from 1984 to 1986, according to the Medical Society of the State of New York, Lake Success, and the total cost of all claims paid rose 53 percent during that time. Those facts led the state's medical community to rethink its strategy on changing the civil justice system.

"Tort reform hasn't had the impact everyone thought it would," says Donald Foy, executive vice-president of the medical society. "The ultimate answer is to change the system—fundamentally."

The medical society is trying to do that through a bill

introduced in the 1988 session of the state legislature. The bill, which is similar to a proposal put forth by the AMA in January, would essentially remove medical malpractice cases from the courts and into an administrative system. Like the AMA's proposal, it seeks to replace the adversarial courtroom system of settling malpractice claims with one that resolves them through an administrative hearing.

The New York hospital community is ready to consider the idea of a new way to settle malpractice cases. The steady increases in malpractice premiums "mean we'll have to do some new and different things and this may be one of them," says Kenneth Raske, president of the Greater New York Hospital Association.

Jerry Hoffman, vice-president for government affairs for the Hospital Association of New York State, Albany, says, "It's got a lot of potential for removing the excesses from the system." But Hoffman says the proposed administrative system needs more thorough analysis to see if it will be cost-effective. He also suggests extending the system to the entire medical community, not just to the physicians.

If the bill becomes law, it could provide the setting for the pilot project the AMA is seeking for its proposal. Under that plan, malpractice claims would be investigated first by claims reviewers, then, if not resolved, by a hearing examiner whose decision would be subject to review by a medical board. Only if the claimant was still not satisfied would the case be heard in a courtroom. But the decision would be made by a panel of judges, not by a jury.

The AMA is convinced that its proposal is the only way to reverse the trend in malpractice premiums and their effect on the practice of medicine. "I can't think of any alternative, other than what we've put out, that will work," Todd says.

But the proposal is vilified by its opponents. "It's outrageous," says Eugene Pavalon, immediate past president of the American Trial Lawyers Association, Washington, DC. "It totally eliminates the right of trial in a courtroom."

Reform's opponents seek other solutions. Pavalon and others who oppose tort reform do acknowledge that the cost of medical malpractice insurance is a problem. But they also look for solutions elsewhere. In fact, they say that the health care community is searching for answers in the wrong place.

Pavalon says that the solutions lie in stepping up regulation of the insurance industry and in stricter policing of physicians. "Get rid of the inept doctors," he says, "and get rid of the recidivist malefactor"—the small percentage of physicians that accounts for a high percentage of lawsuits. Pavalon also recommends that insurance companies rate individual physicians according to their malpractice experience so that the burden of insurance costs can be shifted to those physicians with a high number of claims against them.

But insurers say that doing this presents problems. "If a doctor has a couple of claims against him, that doesn't necessarily make him a bad doctor," says St. Paul's Trunzo. The AMA's Todd agrees. "It's not the bad doctors who are causing the problem," he says. "The people getting sued are at the height of their careers, treating terribly sick people at the frontier of medicine."

Trunzo says it would be difficult, and possibly arbitrary, to devise a fair formula for rating an individual physician's malpractice experience.

Strengthening physician discipline and licensing is also the answer proposed by Sidney Wolfe, M.D., director of the Public Citizen Health Research Group, Washington, DC. "Tort reform is after the fact," he says. "The people are already injured. The whole tort system is a kind of a mop-up operation." Wolfe does favor some aspects of traditional tort reform. Like Pavalon, he says that merit reviews of malpractice claims before they are filed in court would reduce the number of frivolous lawsuits.

Tort reform is usually considered a state issue, but federal legislators, frustrated by the continuing malpractice problem, have proposed numerous measures that would give the federal government a role. Several proposals have been introduced in recent years that would either mandate certain reforms, fund state-created arbitration panels, or provide incentives to states to pass tort reform laws.

One federal proposal is aimed at removing malpractice claims from the tort system. The Medical Offer and Recovery Act would give health care providers the option of paying an injured claimant's net economic loss in return for the patient's waiver of the right to go to court. Reaction from the health care community to federal involvement in the medical malpractice issue is mixed, with many preferring to let the states handle it.

Reform just the beginning. Even in California, where traditional tort reform measures have withstood numerous legal challenges, passage of the laws is seen as only the first step. "It isn't enough to pass tort reform: It's how you implement it, make it work, and monitor it," says James Ludlam, senior counsel for the California Association of Hospitals and Health Care Systems, Sacramento.

Ludlam was instrumental in organizing a coordinated effort by California's health care community to tackle the malpractice problem. They formed a legal committee that was prepared to intervene in medical malpractice cases and assist defense attorneys. They funded a defense manual, which is updated quarterly, that contains legal briefs on malpractice cases and provides a guide to recent case law.

They worked for four years on an interdisciplinary approach to the prevention of neurological injuries to newborns and found that many cases were being lost because the defense counsel didn't have enough information. As a result, they established a data base of all such cases, which can be converted into material for trial briefs.

Ludlam says the system reduces the cost of legal defense. "We used tort reform as a basis for cooperation," he says. "It's not just one hospital with its risk manager—it's all hospitals."

In California's experience, getting reform legislation passed was merely the beginning. The hard part came later—coordination, cooperation, and prevention. After 10 years, it appears to be paying off.—*David Holthaus* H

H 5210

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE DEPARTMENT
STATE HOUSE • BOSTON 02133

MICHAEL S. DUKAKIS
GOVERNOR

April 21, 1988

The Honorable Michael Joseph Connolly
Secretary of the Commonwealth
State House, Room 340
Boston, MA 02133

Dear Secretary Connolly:

I, Michael S. Dukakis, pursuant to the provisions of Article XLVIII of the Amendments to the Constitution of the Commonwealth of Massachusetts, the Referendum II, Emergency Measures, hereby declare that, in my opinion, the immediate preservation of the public peace, health, safety or convenience requires that the attached Act, Chapter 23 of the Acts of 1988, entitled "An Act To Make Health Security Available To All Citizens Of The Commonwealth And To Improve Hospital Financing", the enactment of which received my approval on April 21, 1988, should take effect forthwith.

I further declare that, in my opinion, it is in the public interest that this Act take effect immediately in order to implement without delay an urgently needed comprehensive health care plan for the citizens of the Commonwealth.

Sincerely,

Michael S. Dukakis
Governor

OFFICE OF THE SECRETARY, Boston, April 21, 1988

I, Michael Joseph Connolly, Secretary of State, hereby certify that the accompanying statement was filed in this Office by His Excellency the Governor of the Commonwealth of Massachusetts at one o'clock and fifty-nine minutes, P.M., on the above date, and in accordance with Article Forty-eight of the Amendments to the Constitution said Chapter takes effect forthwith, being chapter twenty-three of the Acts of nineteen hundred and eighty-eight.

Michael Joseph Connolly
Secretary of State.

H 5210

Chapter 23.

THE COMMONWEALTH OF MASSACHUSETTS

In the Year One Thousand Nine Hundred and Eighty-eight

AN ACT TO MAKE HEALTH SECURITY AVAILABLE TO ALL CITIZENS OF THE COMMONWEALTH AND TO IMPROVE HOSPITAL FINANCING.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. The first paragraph of section 16 of chapter 6A of the General Laws, as appearing in the 1986 Official Edition, is hereby amended by striking out, in line 35, the word "the" and inserting in place thereof the words:- the department of medical security, the acute hospital conversion board; the.

SECTION 2. Said chapter 6A is hereby further amended by striking out section 31, as so appearing, and inserting in place thereof the following section:-

Section 31. As used in sections thirty-two to one hundred and two, inclusive, the following words shall, unless the context clearly requires otherwise, have the following meanings:-

"Acute hospital", any hospital licensed under section fifty-one of chapter one hundred and eleven, and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the department of public health.

"Approved gross inpatient service revenues", for any fiscal year shall be the total approved gross patient service revenues as defined in this chapter less actual gross outpatient service revenues for that year.

"Case mix", the description and categorization of a hospital's patient population according to relevant criteria approved by the commission such as: primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

"Case mix adjusted discharges", the sum of the cost weights of each discharge as stipulated in the current hospital agreement, and as adjusted for coding and grouper changes in order to insure comparability between years.

"Charge", the amount to be billed or charged by a hospital for each specific service within a revenue center.

"Commission", the rate setting commission established under section thirty-two.

"Community health centers", health centers operating in conformance with the requirements of section 330 of United States Public Law 95-626, as most recently amended by Public Law 97-35, and shall include all community health centers which file cost reports as requested by the commission.

"Comprehensive cancer center", the hospital of any institution so designated by the national cancer institute under the authority of Public Law 92-218, section 408(a)(b) and 42 United States Code, organized solely for the treatment of cancer, and offered exemption from the medicare diagnosis related group payment system under 42 Code of Federal Regulations, section 405.475(f).

"Disproportionate share hospital", any acute hospital that exhibits a payor mix where a minimum of sixty-eight per cent of the acute hospital's gross patient service revenue was attributable to Title XVIII and Title XIX of the federal Social Security Act and local and state government subsidy and free care and bad debt.

"Department of mental health approved special project", an approved determination of need project providing psychiatric services for voluntary and involuntary inpatients in need of intensive, twenty-four hours per day psychiatric and nursing care and supervision in a secure setting, which will primarily serve recipients of benefits under Title XIX and other public assistance programs and which is subject to an agreement between the provider of services and the department of mental health; provided, such agreement shall include but shall not be limited to provisions whereby such department will fully control admission to and discharge from such services; provided, further, any project approved by the department of mental health pursuant to section six of chapter one hundred and sixty-seven of the acts of nineteen hundred and eighty-seven shall be considered an approved determination of need project for purposes of this definition.

"Eligible person", a person who qualifies for financial assistance from a governmental unit in meeting all or part of the cost of general health supplies, care, social, rehabilitative or educational services and accommodations.

"Fiscal year", the twelve month period with reference to which a hospital keeps its accounts and which ends in the calendar year by which it is identified; provided, however, that acute hospitals with fiscal years ending on June thirtieth shall be governed in each fiscal year by the provisions of this chapter applicable to the immediately preceding fiscal year, and any reference to a particular fiscal year in this chapter shall be adjusted accordingly where appropriate for such hospitals.

"General health supplies, care, social, rehabilitative or educational services and accommodations", all supplies, care and services of medical, optometric, dental, surgical, podiatric, psychiatric, therapeutic, diagnostic, rehabilitative, educational, supportive or geriatric nature, including inpatient and outpatient hospital care and services, and accommodations in hospitals, sanatoria, infirmaries, convalescent and nursing homes, rest homes, facilities established, licensed, or approved pursuant to the provisions of chapter one hundred and eleven B, and similar institutions including those providing treatment, training, instruction and care of children and adults.

"Governmental unit", the commonwealth, any department, agency, board or commission of the commonwealth, and any political subdivision of the commonwealth.

"Gross patient service revenue", the total dollar amount of a hospital's charges for services rendered in a fiscal year.

"Hospital", any hospital licensed under section fifty-one of chapter one hundred and eleven, the teaching hospital of the University of Massachusetts Medical School and any psychiatric facility licensed under section twenty-nine of chapter nineteen.

"Hospital agreement", an agreement between a nonprofit hospital service corporation and the hospital signatory thereto approved by the commission under section five of chapter one hundred and seventy-six A.

"Medicaid costs", reimbursable costs included in the basis of payment as calculated pursuant to the hospital agreement then in effect, exclusive of any costs attributable to: free care and bad debt expense or, in any hospital fiscal year beginning on or after October first, nineteen hundred and eighty-five, the uniform allowance for the statewide uncompensated care pool as calculated pursuant to section eighty-seven, price level depreciation in excess of historical cost depreciation, and costs of revaluation of assets associated with a transfer of ownership occurring on or after July eighteenth, nineteen

hundred and eighty-four, which exceed those permitted by section 2314 of Public Law 98-369.

"Nonacute hospital", any hospital which is not an acute hospital.

"Nonmedicare gross inpatient service revenues", gross inpatient service revenues less gross inpatient service revenues associated with Title XVIII patients.

"Patient", any natural person receiving health care services from a hospital.

"Provider of health care services", any person, corporation, partnership, governmental unit, state institution or other entity which furnishes general health supplies, care, social, rehabilitative or educational services and accommodations to an eligible person.

"Purchaser", a natural person responsible for payment for health care services rendered by a hospital.

"Purchasers and third party payors who pay on the basis of charges", purchasers and third party payors excluding: Title XVIII and Title XIX, other government payors, and nonprofit hospital service corporations to the extent that payments by such corporation are reduced by the uniform differential.

"Revenue center", a functioning unit of a hospital which provides distinctive services to a patient for a charge.

"Sole community provider", any acute hospital which qualifies as a sole community provider under medicare regulations or under hospital agreement thirty.

"Specialty hospital", any acute hospital qualifying as exempt from the medicare prospective payment system regulations or any acute hospital which limits its admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat, or to children or patients under obstetrical care.

"State institution", any hospital, sanatorium, infirmary, clinic and other such facility owned, operated or administered by the commonwealth, which furnishes general health supplies, care, social, rehabilitative or educational services and accommodations.

"Third-party payor", any entity, including, but not limited to, Title XVIII and Title XIX programs, insurance companies, health maintenance organizations and nonprofit hospital service corporations but not including a purchaser, responsible for payment, either to the purchaser or the hospital, for health care services rendered by a hospital.

"Uniform differential", seventy-five one-thousandths.

SECTION 3. Said chapter 6A is hereby further amended by inserting after section 32A the following two sections:-

Section 32B. (a) Payment for Title XIX services provided by acute hospitals shall be established by the commission for each acute hospital at a percentage of approved charges determined in accordance with the provisions of paragraphs (b) and (c) except where such services are rendered pursuant to a selective product contract.

(b) For each acute hospital for each fiscal year beginning with fiscal year nineteen hundred and eighty-eight, the commission shall establish the percentage of charges to be paid to each hospital for Title XIX services to be equal to medicaid payments for fiscal year nineteen hundred and eighty-seven as determined in the final settlement for such hospital, divided by medicaid approved charges for such hospital for fiscal year nineteen hundred and eighty-seven. Medicaid approved charges for Title XIX inpatient services shall be calculated by dividing medicaid actual inpatient charges for fiscal year nineteen hundred and eighty-seven by the same fiscal year's ratio of actual nonmedicare gross inpatient service revenue divided by approved nonmedicare gross inpatient service revenue unadjusted for compliance. Medicaid approved charges for Title XIX outpatient services shall be considered equal to medicaid actual charges for Title XIX outpatient services for fiscal year nineteen hundred and eighty-seven. Until such time as final data for fiscal year nineteen hundred and eighty-seven is received by the commission, the medicaid payment percentage shall be based upon the most recent data available. Any such percentage computed pursuant to this paragraph shall be adjusted pursuant to paragraph (c). Notwithstanding the foregoing, in establishing rates of payment for Title XIX services provided by hospitals, the commission shall take into account the special circumstances of disproportionate share hospitals by adjusting such rates of payment in a manner to relieve the disproportionate burden of free care given by such hospitals.

(c) Notwithstanding any other provision of law to the contrary, Title XIX payments to acute hospitals shall, in the aggregate, not exceed an amount which conforms to any upper limit requirement imposed by Title XIX of the Social Security Act and defined by relevant provisions of the regulations promulgated by the health care financing administration, hereinafter referred to as HCFA. Prior to the commencement of each fiscal year, the commission

shall determine any applicable upper limit requirement imposed by Title XVIII and Title XIX and the regulations promulgated thereunder by the HCFA. In the event that such limit is exceeded, the commission shall promulgate regulations pursuant to chapter thirty A which specify the manner by which hospitals' percentage rates of payment shall be adjusted so that Title XIX payments to acute hospitals do not exceed said upper limit.

(d) For hospitals which earned deficit revenue in fiscal year nineteen hundred and eighty-seven and whose approved fiscal year nineteen hundred and eighty-eight revenue was adjusted upward as a result of said deficit, a settlement shall occur at the end of fiscal year nineteen hundred and eighty-eight such that the hospital shall pay the department of public welfare an amount equal to Title XIX's percentage share of the upward adjustment, multiplied by the Title XIX percentage of charge calculated pursuant to paragraph (b).

(e) If the Title XIX payment methodology set forth in this section is not approvable by the health care financing administration, the commission is hereby authorized and directed to modify such methodology as may be required to secure health care financing administration approval; provided, however, that any such modified methodology shall have results as comparable as possible to those of the methodology prescribed herein.

Section 32C. There shall be established a separate fund to be known as the "medicare shortfall assistance fund". The purpose of this fund shall be to provide compensation to acute hospitals for shortfalls in medicare payments resulting from annual changes in medicare rates which are less than the rate of inflation as measured by the health care financing administration market basket projection. For purposes of calculating shortfalls, each year's prospective payment system rate shall be compared to the prospective payment system rate which was effective for said hospital in the hospital's fiscal year immediately preceding the effective date of this section. In calculating prospective payment system rates, all adjustment factors shall be included. The Massachusetts hospital association shall annually submit to the rate setting commission a plan for the calculation of said shortfall and the distribution of monies from said fund. The amount available for distribution from said fund shall not exceed fifty million dollars for each year.

The state treasurer shall receive and be the custodian of funds appropriated for the medicare shortfall assistance fund. Such funds shall be distrib-

uted in accordance with methods and procedures adopted by the rate-setting commission giving weight to the plan submitted by the Massachusetts hospital association.

SECTION 4. Section thirty-four A of said chapter six A is hereby repealed.

SECTION 5. Section 43 of said chapter 6A, as appearing in the 1986 Official Edition, is hereby amended by striking out the second sentence.

SECTION 6. Sections fifty to fifty-eight, inclusive, of said chapter six A are hereby repealed.

SECTION 7. Said chapter 6A is hereby further amended by striking out section 59, as appearing in the 1986 Official Edition, and inserting in place thereof the following section:-

Section 59. Any company authorized to sell accident and health insurance under chapter one hundred and seventy-five, or any nonprofit hospital service corporation or health maintenance organization may apply to the commission for a discount from the charges it would otherwise be required to pay under sections seventy-eight to one hundred and two, inclusive, of this chapter. The commission shall grant a discount from charges on a prospective basis if it finds that the applicant has implemented an activity or program resulting in quantifiable savings to acute hospitals.

SECTION 8. Clause (b) of paragraph B of section 60 of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 33 and 34, the words:- , as adjusted for productivity in accordance with sections fifty-one A and fifty-two.

SECTION 9. Section sixty-one of said chapter six A is hereby repealed.

SECTION 10. Said chapter 6A is hereby further amended by striking out section 63, as appearing in the 1986 Official Edition, and inserting in place thereof the following section:-

Section 63. Every acute hospital shall file with the commission within ninety days after the beginning of the fiscal year and at least once during the fiscal year, as deemed appropriate by the commission, a summary of revenues, costs and such statistical information as the commission may require in order to document the relationship of actual nonmedicare gross inpatient service revenue to approved nonmedicare gross inpatient service revenue, so that the commission may determine the extent to which excess revenue or deficit revenue was generated for such fiscal year. For this purpose, excess revenue

for each fiscal year shall equal the amount by which actual nonmedicare gross inpatient service revenues exceed approved nonmedicare gross inpatient service revenues for such fiscal year, and deficit revenue shall equal the amount by which approved nonmedicare gross inpatient service revenues exceed actual approved nonmedicare gross inpatient service revenues for such fiscal year.

SECTION 11. Section sixty-three A of said chapter six A is hereby repealed.

SECTION 12. The first paragraph of section 65 of said chapter 6A, as appearing in the 1986 Official Edition, is hereby amended by striking out the second sentence.

SECTION 13. Said section 65 of said chapter 6A, as so appearing, is hereby further amended by striking out the second paragraph.

SECTION 14. Section 67 of said chapter 6A, as so appearing, is hereby amended by striking out, in line 11, the word "seventy-two" and inserting in place thereof the words:- one hundred and two.

SECTION 15. Sections sixty-eight and sixty-eight A of said chapter six A are hereby repealed.

SECTION 16. The first paragraph of section 70 of said chapter 6A, as appearing in the 1986 Official Edition, is hereby amended by striking out, in line 2, the words "fifty to sixty-nine" and inserting in place thereof the words:- seventy-eight to one hundred and two.

SECTION 17. Section 73 of said chapter 6A, as so appearing, is hereby amended by striking out, in line 3, the words "fifty to seventy-two" and inserting in place thereof the words:- seventy-eight to one hundred and two.

SECTION 18. Sections seventy-four and seventy-five of said chapter six A are hereby repealed.

SECTION 19. The first paragraph of section 76 of said chapter 6A, as appearing in the 1986 Official Edition, is hereby amended by striking out the second and third sentences and inserting in place thereof the following sentence:- The amount of assistance for uninsured individuals for each fiscal year, subject to appropriation, shall be the amount provided in uncompensated care by the community health centers for the preceding fiscal year according to a distribution formula to be developed by the commission, after consultation with the Massachusetts league of community health centers and other interested parties.

SECTION 20. Said chapter 6A is hereby further amended by adding the following twenty-eight sections:-

Section 78. For all acute-care hospitals, excluding any comprehensive cancer center as defined in section thirty-one and any acute-care hospital which predominantly limits its admissions to patients under active diagnosis and treatment of eye, ears, nose and throat, approved gross patient service revenues for fiscal years nineteen hundred and eighty-eight, nineteen hundred and eighty-nine, nineteen hundred and ninety, and nineteen hundred and ninety-one, shall be determined in accordance with the provisions of sections seventy-nine through eighty-eight.

Any comprehensive cancer center may, at its option, elect to be exempt from sections seventy-nine to eighty-eight, inclusive, and establish, prospectively and retrospectively, its approved gross patient service revenues, its Blue Cross rate of payment and compliance with approved gross patient service revenues in accordance with section ninety-nine.

Any hospital which predominantly limits its admissions to patients under active diagnosis and treatment of eye, ears, nose and throat, may, at its option, elect to be exempt from sections seventy-nine to eighty-eight, inclusive, and establish, prospectively and retrospectively, its approved gross patient service revenue, its Blue Cross rate of payment and compliance with approved gross patient service revenues in accordance with section one hundred.

Every acute hospital shall establish its charges in accordance with the provisions of this chapter. The charges established by an acute hospital for health care services rendered shall be uniform for all patients receiving comparable services.

Section 79. In addition to the adjustments prescribed in sections eighty to eighty-two A, inclusive, the patient care costs of certain hospitals shall be adjusted as described in paragraphs (a), (b) and (c) as follows:

(a) For fiscal years nineteen hundred and eighty-eight and nineteen hundred and eighty-nine, the patient care costs of certain hospitals shall be adjusted to incorporate a "low base cost adjustment" pursuant to the distribution methodology set forth in sections eighty-nine to ninety-eight, inclusive. Notwithstanding the provisions of said sections eighty-nine to ninety-eight, inclusive, the commission shall ensure that the sum of all individual hospital adjustments pursuant to this paragraph shall increase the projected payments from purchasers and third-party payors who pay on the basis of charges and a hospital service corporation by fifty-five million dollars for fiscal year nineteen hundred and eighty-eight; and by forty million dollars, multiplied by

one plus the fiscal year nineteen hundred and eighty-eight inflation adjustment pursuant to paragraph (d) of section eighty, for fiscal year nineteen hundred and eighty-nine.

(b) For fiscal years nineteen hundred and eighty-nine, nineteen hundred and ninety, and nineteen hundred and ninety-one, the patient care costs of certain hospitals shall be adjusted to incorporate a "prospective payment system price reduction adjustment" made pursuant to a distribution methodology adopted by the rate setting commission giving weight to the plan submitted by the Massachusetts Hospital Association pursuant to section thirty-two C. The purpose of said adjustment shall be to compensate acute hospitals for those shortfalls in medicare payments for which such hospitals are not compensated pursuant to section thirty-two C. Said distribution plan shall identify every hospital which is to receive this adjustment and shall specify, for each hospital, an amount of projected net patient service revenue which is to be received from a hospital service corporation and purchasers and third party payors who pay on the basis of charges. Said distribution plan shall be submitted to the commission by September first of each year and the commission shall ensure that the sum of all individual hospital adjustments shall increase the projected payments from purchasers and third-party payors who pay on the basis of charges and a hospital service corporation by an amount not to exceed twenty million dollars each year.

(c) Notwithstanding the provisions of paragraph (a) or of sections ninety and ninety-one, for fiscal years nineteen hundred and eighty-eight and nineteen hundred and eighty-nine, the patient care costs of Whidden Hospital shall be adjusted to incorporate a "low cost case mix adjustment" calculated pursuant to a distribution methodology set forth in section ninety-eight A. The commission shall ensure that the adjustment pursuant to this paragraph shall increase the projected payments from purchasers and third party payors who pay on the basis of charges and a hospital service corporation by one-half the amount of the adjustment provided by said section ninety-eight A for fiscal year nineteen hundred and eighty-eight, and by one-half the amount of the adjustment provided by said section ninety-eight A, multiplied by one plus the fiscal year nineteen hundred and eighty-eight inflation adjustment, for fiscal year nineteen hundred and eighty-nine.

Section 80. For fiscal year nineteen hundred and eighty-eight, patient care costs for each acute hospital shall be determined in accordance with the following provisions and calculations:

(a) The fiscal year nineteen hundred and eighty-seven total patient care costs shall include the following provisions:

(i) all hospital agreement twenty-nine base year adjustments and exceptions shall be included at the amount approved or audited by the commission as of December eleventh, nineteen hundred and eighty-seven, except that where a formal settlement agreement was executed between Blue Cross and the hospital prior to December eleventh, nineteen hundred and eighty-seven, the amounts included in said settlement shall be the amounts included in this adjustment;

(ii) absent a commission approved amount as of December eleventh, nineteen hundred and eighty-seven, the amount to be included shall be that amount formally recommended for approval by Blue Cross and included as an adjustment to the appropriate year's hospital agreement twenty-nine year end maximum allowable cost report or as formally agreed to in writing by Blue Cross and the hospital as of April first, nineteen hundred and eighty-eight. No other adjustment shall be made;

(iii) the hospital agreement twenty-nine disputes of Baystate Medical Center, Marlborough Hospital and Goddard Memorial Hospital formally filed prior to December eleventh, nineteen hundred and eighty-seven, when they are resolved, and the hospital agreement twenty-nine dispute of Lawrence Memorial Hospital of Medford when it is resolved. No other adjustment shall be made;

(iv) all hospital agreement thirty recurring base year adjustments and exceptions approved by the commission. The commission shall within one hundred and eighty days after final passage of this act resolve all outstanding hospital agreement thirty base year adjustments and exceptions. Hospitals shall retain the right to appeal any commission disallowances of hospital agreement thirty exceptions and base year adjustments to the division of administrative law appeals;

(v) the commission shall complete all outstanding audits as of September first, nineteen hundred and eighty-eight. The nineteen hundred and eighty-seven maximum allowable cost shall be adjusted to reflect the effects of all resolved audits. Hospitals shall retain the right to appeal audit adjustments to the division of administrative law appeals;

(vi) fiscal year nineteen hundred and eighty-seven total patient care costs as calculated pursuant to hospital agreement thirty schedule A.O, line twelve of year-end per-review filing and as adjusted by the provisions stipulated in subparagraphs (i) through (v) of this paragraph shall be further ad-

justed by subtracting lines nine, ten and eleven of said schedule A.O, as adjusted. This result multiplied by ninety-four and twelve hundredths per cent shall constitute fiscal year nineteen hundred and eighty-seven maximum allowable costs.

(b) Said maximum allowable costs shall be further adjusted in such a manner as to ensure that the projected payments of a hospital service corporation and purchasers and third party payors who pay on the basis of charges will include the amount of net revenue adjustment, if any, provided pursuant to paragraphs (a) and (c) of section seventy-nine.

(c) Said fiscal year nineteen hundred and eighty-seven maximum allowable costs shall be further adjusted by adding or subtracting, as appropriate, one-half of the difference between the inpatient services volume allowance provided in line eight of schedule A.O of the nineteen hundred and eighty-seven year-end filing per-review appendix D maximum allowable cost report and a revised inpatient services volume allowance calculated on the basis of formulas contained in hospital agreement thirty, but utilizing a marginal cost allowance of one hundred per cent. Both the original fiscal year nineteen hundred and eighty-seven inpatient services volume allowance and the revised fiscal year nineteen hundred and eighty-seven inpatient services volume allowance shall be calculated using a conversion program which corrects for inconsistencies resulting from coding and grouper changes between fiscal year nineteen hundred and eighty-four and fiscal year nineteen hundred and eighty-seven.

The following hospitals: Cape Cod, Martha's Vineyard, Nantucket Cottage, North Adams Regional, North Shore Children's and Saint Margaret's shall be exempted from said volume adjustment if an election is made upon execution of the successor agreement to hospital agreement thirty to continue to use the hospital agreement thirty inpatient volume adjustment allowances pursuant to paragraph (f).

(d) Fiscal year nineteen hundred and eighty-seven maximum allowable costs as adjusted pursuant to paragraphs (a) through (c) shall then be multiplied by the fiscal year nineteen hundred and eighty-eight inflation adjustment. Said inflation adjustment shall be equal to the sum of: (i) the composite inflation factor calculated in accordance with the methodology described in hospital agreement thirty utilizing May inflation projections, or February inflation projections in the case of hospitals with fiscal years ending on June thirtieth, and (ii) two one-hundredths. Revenue attributable to said two one-

hundredths shall provide for certain wage increases for technicians, nurses, nursing aides, orderlies and attendants. No carry forward of underprojections or overprojections from the preceding year shall be included.

(e) Said fiscal year nineteen hundred and eighty-seven maximum allowable costs, as adjusted pursuant to paragraphs (b) through (d), shall be further adjusted, if necessary, to increase them to an amount equal to fiscal nineteen hundred and eighty-seven maximum allowable costs determined pursuant to paragraph (a) multiplied by a factor of one and forty-six thousandths.

(f) Fiscal year nineteen hundred and eighty-seven maximum allowable costs determined pursuant to paragraph (d) or (e), as applicable, shall be further adjusted by incorporating a nineteen hundred and eighty-eight volume adjustment which shall be calculated in accordance with the following conditions:

(i) all inpatient and outpatient volume adjustments shall utilize the same statistics as were utilized in hospital agreement thirty to measure volume changes and shall be computed on a cost base which has been adjusted for the level of productivity included in the last year of hospital agreement thirty;

(ii) the inpatient, routine outpatient, surgical day care, and emergency service volume adjustments shall be calculated on the basis of a marginal cost allowance of one hundred per cent and there shall be no corridors applied;

(iii) the outpatient ancillary service volume adjustments shall be calculated on the basis of a marginal cost allowance of sixty per cent and there shall be no corridors applied;

(iv) in determining the inpatient volume allowance for fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one, the statistical base shall be case-mix adjusted discharges, including all transfers of inpatients from an acute hospital to another facility.

The commission shall ensure that the changes in volume are calculated in such a way as to accurately adjust for any coding and grouper changes which have been implemented; and to accurately account for discharges assigned a zero weight under the New Jersey weighting system. Such adjustments may take one or more than one of the following forms but shall not be limited to the options outlined: (a) restatement of all fiscal years into a form consistent with the coding principles and grouper utilized in fiscal year nineteen hundred and eighty-four or nineteen hundred and eighty-seven; (b) restatement of the rate year into a form consistent with the coding principles and grouper

utilized in the year preceding the rate year; (c) restatement of the rate year and year preceding the rate year to account for any updates made by the state of New Jersey in its weighting system which more appropriately reflect the coding principles and grouper being utilized; and (d) development by Blue Cross and the Massachusetts hospital association of weights for discharges assigned a zero weighting under the New Jersey system.

In carrying out its rights and responsibilities granted under this paragraph, the commission must inform hospitals by no later than April thirtieth of the rate year, how the change in case mix adjusted discharges is to be measured for that year. Said determination shall be made only after a series of public hearings has taken place and the commission shall consider the comments of all interested parties in making its final determination.

If Blue Cross and the Massachusetts hospital association have failed to agree on a methodology for deriving weights for discharges assigned a zero weighting by June thirtieth of the rate year, hospitals may submit individual methodologies to the commission for approval and subsequent incorporation.

(v) the following hospitals: Cape Cod, Martha's Vineyard, Nantucket Cottage and North Adams Regional, may elect to participate under the terms and conditions as described in volume option one of hospital agreement thirty. The downside corridors under this volume options shall be twenty-eight per cent, thirty-five per cent, forty-two per cent and forty-nine per cent in fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one respectively;

(vi) the following hospitals: North Shore Children's and St. Margaret's, may elect to continue under the volume adjustment as defined as volume option two in hospital agreement thirty. The downside corridors under this volume options shall be ten per cent, twelve per cent, fourteen per cent and sixteen per cent in fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one respectively.

The amount of fiscal year nineteen hundred and eighty-seven maximum allowable costs, as adjusted pursuant to paragraphs (a) through (f), shall be termed the "fiscal year nineteen hundred and eighty-eight adjusted prior year costs".

(g) Fiscal year nineteen hundred and eighty-seven maximum allowable costs as adjusted pursuant to paragraph (f) shall be further adjusted by adding fiscal year nineteen hundred and eighty-eight depreciation, amortization, inter-

est, determination of need capital cost and other capital costs defined pursuant to hospital agreement thirty. The fiscal year nineteen hundred and eighty-eight dollar amount of said depreciation, amortization, interest, determination of need capital costs and other capital costs that was subject to productivity adjustment in the last year of hospital agreement thirty shall be multiplied by ninety-four and twelve one-hundredths per cent. The remaining fiscal year nineteen hundred and eighty-eight dollar amount shall be allowed in full. The sum of the productivity adjusted portion and the amount allowed in full shall be the adjustment.

(h) Said fiscal year maximum allowable costs shall be further adjusted by adding any incremental costs incurred subsequent to October first, nineteen hundred and eighty-seven associated with government-mandated requirements mandated subsequent to October first, nineteen hundred and eighty-six and approved by the commission. For purposes of this paragraph, government-mandated requirements shall mean the incremental costs for each acute-care hospital resulting from its compliance with any governmental requirement whether established by statute, regulation or governmental ordinance and shall be allowed on the basis of incurred costs.

(i) Said fiscal year nineteen hundred and eighty-seven adjusted maximum allowable costs shall be further adjusted by adding any incremental operating costs associated with approved determination of need projects. Said costs shall be subject to commission approval pursuant to criteria utilized during the term of hospital agreement thirty. In addition, in the case of the department of mental health's approved special projects, the maximum allowable costs shall be further adjusted by an amount, to be determined by the commission, which will provide an incentive for hospitals to undertake said projects, provided that said incentive adjustment shall in no case exceed ten per cent of incremental operating costs.

(j) Said fiscal year nineteen hundred and eighty-seven maximum allowable costs shall be further adjusted to incorporate actual malpractice costs, and sick, vacation and earned time accruals, which are applicable in accordance with provisions contained in hospital agreement thirty. The fiscal year nineteen hundred and eighty-eight dollar amount of actual malpractice costs and sick, vacation and earned time accruals that was subject to productivity adjustment in the last year of hospital agreement thirty shall be multiplied by ninety-four and twelve one-hundredths per cent. The remaining fiscal year

nineteen hundred and eighty-eight dollar amount shall be allowed in full. The sum of the productivity adjusted portion and the amount allowed in full shall be the adjustment.

(k)(i) Fiscal year nineteen hundred and eighty-seven maximum allowable costs, as adjusted pursuant to paragraphs (a) to (j), inclusive, shall constitute fiscal year nineteen hundred and eighty-eight patient care costs for purposes of determining fiscal year nineteen hundred and eighty-eight approved gross patient service revenue pursuant to section eighty-three.

(ii) Each acute hospital which receives an adjustment pursuant to paragraph (b) or (c) shall expend a sufficient portion of its fiscal year nineteen hundred and eighty-eight approved gross patient service revenues upon expenditures in the six nonmanagement labor categories so designated under schedule C.1.0 of appendix D of hospital agreement thirty to ensure that the hospital will not be subject to a labor cost recovery pursuant to section eighty-two.

Section 80A. Except as otherwise provided for in section one hundred and one, a hospital which had an inpatient volume decline of twenty per cent or more from fiscal year nineteen hundred and eighty-four through fiscal year nineteen hundred and eighty-seven and which operated at an occupancy rate of fifty per cent or less in fiscal year nineteen hundred and eighty-seven, shall not be entitled to the adjustment described in paragraph (a) or (c) of section seventy-nine or to the adjustment described in paragraph (e) of section eighty. For the purposes of this section, volume decline shall be measured using case-mix adjusted discharges calculated in the same manner as in paragraph (e) of section eighty, and occupancy rate shall be measured using total fiscal year nineteen hundred and eighty-seven patient days for all services divided by the number of licensed end beds multiplied by three hundred and sixty-five. Licensed beds shall be calculated by taking the number of end beds as reported in rate setting commission form 403, schedule III, column 4, line 14 and subtracting any beds reduced or converted by any determination of need approved or on file as of January first, nineteen hundred and eighty-eight, and further subtracting any beds temporarily removed from service if such removal has been granted by the department of public health pursuant to licensure rules and regulations for hospitals, Code of Massachusetts Regulations, section 130.121(C)(D), and if such removal was effective prior to October first, nineteen hundred and eighty-seven. Occupancy rate shall be calculated by taking the total patient days as reported on rate setting commission

form 403, schedule III, column 6, line 14 and dividing by the product of end beds, as hereinbefore described, times three hundred and sixty-five expressed as a percentage.

Except as otherwise provided for in section one hundred and one, an institution which experienced an occupancy rate of forty per cent or less in fiscal year nineteen hundred and eighty-seven shall not be entitled to the adjustment described in paragraph (a) or (c) of section seventy-nine or to the adjustment described in paragraph (e) of section eighty. Occupancy rate shall be measured as described in the preceding paragraph.

Notwithstanding the foregoing, the following types of hospitals shall be entitled to the adjustments described in paragraphs (a) and (c) of section seventy-nine and paragraph (e) of section eighty regardless of their rates of volume decline or occupancy: (1) a sole community provider; (2) a specialty hospital; or (3) a comprehensive cancer center.

Section 81. For fiscal year nineteen hundred and eighty-nine, patient care costs for each acute hospital shall be determined in accordance with the following provisions:

(a) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs for each acute hospital shall be adjusted to reflect the incremental costs of prior year recurring determination of need exceptions which represent full year costs.

(b) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted in such a manner as to ensure that the projected payments of a hospital service corporation and third party payors who pay on the basis of charges will include the amount of net revenue adjustment, for fiscal year nineteen hundred and eighty-nine, if any, provided pursuant to paragraphs (a) and (c) of section seventy-nine.

(c) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted by adding or subtracting, as appropriate, one-half of the difference between the inpatient services volume allowance and the revised inpatient services volume allowance calculated pursuant to paragraph (c) of section eighty, multiplied by the fiscal year nineteen hundred and eighty-eight inflation adjustment as determined pursuant to paragraph (d) of said section eighty.

The following hospitals: Cape Cod, Martha's Vineyard, Nantucket Cottage, North Adams Regional, North Shore Children's and St. Margaret's shall be ex-

empted from said volume adjustment if an election was made in fiscal year nineteen hundred and eighty-eight to continue under the hospital agreement thirty inpatient volume adjustment allowances as described in paragraph (f) of said section eighty.

(d) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs, as adjusted pursuant to paragraphs (a) to (c), inclusive, shall then be multiplied by the fiscal year nineteen hundred and eighty-nine inflation adjustment. Said inflation adjustment shall be equal to the sum of: (i) the composite inflation factor calculated in accordance with the methodology described in hospital agreement thirty utilizing May inflation projections, or February inflation projections in the case of hospitals with fiscal years ending on June thirtieth, and (ii) one one-hundredth. Revenue attributable to said one one-hundredth shall provide for certain wage increases for technicians, nurses, nursing aides, orderlies and attendants. No carry forward of underprojections or overprojections from the preceding year shall be included.

(e) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted in such a manner as to ensure that the projected payments of a hospital service corporation and purchasers and third party payors who pay on the basis of charges will include the amount of net revenue adjustment, if any, provided pursuant to paragraph (b) of section seventy-nine.

(f) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs as adjusted pursuant to paragraphs (a) to (e), inclusive, shall be further adjusted by incorporating a nineteen hundred and eighty-nine volume adjustment which shall measure volume changes between fiscal year nineteen hundred and eighty-eight and fiscal year nineteen hundred and eighty-nine and which shall be calculated in accordance with the conditions prescribed in paragraph (f) of section eighty.

The resultant amount shall be termed the "fiscal year nineteen hundred and eighty-nine adjusted prior year costs".

(g) Said fiscal year nineteen hundred and eighty-nine adjusted prior year costs shall be further adjusted by adding fiscal year nineteen hundred and eighty-nine depreciation, amortization, interest, determination of need capital costs and other capital costs defined pursuant to hospital agreement thirty. The fiscal year nineteen hundred and eighty-nine dollar amount of said depreciation, amortization, interest, determination of need capital costs and

other capital costs that was subject to productivity adjustment in the last year of hospital agreement thirty shall be multiplied by ninety-four and twelve one-hundredths per cent. The remaining fiscal year nineteen hundred and eighty-nine dollar amount shall be allowed in full. The sum of the productivity adjusted portion and the amount allowed in full shall be the adjustment.

(h) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted by adding any incremental costs associated with government mandated requirements as defined in paragraph (h) of section eighty.

(i) Fiscal nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted by adding any incremental operating costs associated with approved determination of need projects implemented in fiscal year nineteen hundred and eighty-nine. Said costs shall be subject to commission approval pursuant to criteria utilized during the term of hospital agreement thirty. In addition, in the case of the department of mental health's approved special projects, the maximum allowable costs shall be further adjusted by an amount, to be determined by the commission, which will provide an incentive for hospitals to undertake said projects, provided that said incentive adjustment shall in no case exceed ten per cent of incremental operating costs.

(j) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs shall be further adjusted to incorporate actual fiscal year nineteen hundred and eighty-nine malpractice costs, and sick, vacation, and earned time accruals which are applicable in accordance with provisions contained in hospital agreement thirty. The fiscal year nineteen hundred and eighty-nine dollar amount of actual malpractice costs and sick, vacation and earned time accruals that was subject to productivity adjustment in the last year of hospital agreement thirty shall be multiplied by ninety-four and twelve one-hundredths per cent. The remaining fiscal year nineteen hundred and eighty-nine dollar amount shall be allowed in full. The sum of the productivity adjusted portion and the amount allowed in full shall be the adjustment.

(k) Each acute hospital shall report to the commission its actual expenses during fiscal years nineteen hundred and eighty-seven and nineteen hundred and eighty-eight for each of the six nonmanagement labor categories so designated under schedule C.1.0 of appendix D of hospital agreement thirty.

(1)(i) Fiscal year nineteen hundred and eighty-eight adjusted prior year costs, as adjusted pursuant to paragraphs (a) to (j), inclusive, shall constitute fiscal year nineteen hundred and eighty-nine patient care costs for purposes of determining fiscal year nineteen hundred and eighty-nine approved gross patient service revenues pursuant to section eighty-three.

(ii) Each acute hospital which receives an adjustment pursuant to paragraph (b) or (c) shall expend a sufficient portion of its fiscal year nineteen hundred and eighty-nine approved gross patient service revenues upon expenditures in said six nonmanagement labor categories to ensure that the hospital will not be subject to a labor cost recovery pursuant to section eighty-two.

Section 82. For fiscal year nineteen hundred and ninety patient care costs for each acute hospital shall be determined in a manner consistent with section eighty-one exclusive of paragraphs (b) and (c), and substituting "fiscal year nineteen hundred and eighty-nine" and "fiscal year nineteen hundred and ninety", respectively, for "fiscal year nineteen hundred and eighty-eight" and "fiscal year nineteen hundred and eighty-nine" where appearing in section eighty-one.

Fiscal year nineteen hundred and ninety approved revenues of any hospital which received an adjustment pursuant to paragraph (b) or (c) of section eighty or paragraph (b) or (c) of section eighty-one shall be further adjusted by subtracting a labor cost recovery, if any. The labor cost recovery shall be determined as follows:

(a)(i) The fiscal year nineteen hundred and eighty-nine actual expenses for each of the six nonmanagement labor categories so designated under schedule C.1.0 of appendix D of hospital agreement thirty shall be adjusted by subtracting the product of the inflation adjustments associated with said categories which were provided pursuant to paragraph (d) of section eighty and paragraph (d) of section eighty-one, multiplied by the percentage of total gross patient service revenue attributable to purchasers and third party payors who pay on the basis of charges and a hospital service corporation; the results shall then be summed for all six such categories.

(ii) The fiscal year nineteen hundred and eighty-seven actual expenses for the sum of such six nonmanagement labor categories shall be adjusted by adding eighty per cent of the net revenue received from purchasers and third party payors who pay on the basis of charges and a hospital service corporation due to adjustments made pursuant to paragraphs (b) and (c) of section eighty and paragraphs (b) and (c) of section eighty-one.

(iii) Subtract the amount calculated in subparagraph (i) from the amount calculated in subparagraph (ii).

(iv) If the amount calculated in subparagraph (iii) is positive, a labor cost recovery shall be applicable. The labor cost recovery shall be the lesser of the amount in subparagraph (iii) or eighty per cent of the net revenue received from purchasers and third party payors who pay on the basis of charges and a hospital service corporation as a result of adjustments made pursuant to paragraphs (b) and (c) of section eighty and paragraphs (b) and (c) of section eighty-one.

(v) Fiscal year nineteen hundred and ninety approved revenues shall be adjusted in such a manner as to ensure that the projected payments of purchasers and third party payors who pay on the basis of charges and a hospital service corporation are reduced by the amount of the labor cost recovery, if any, calculated pursuant to subparagraph (iv).

(b) The commission may waive any or all of the labor cost recovery pursuant to paragraph (a) upon request for any hospital which demonstrates that such recovery would inappropriately penalize the hospital and its nonmanagement employees, because the hospital's failure to expend sufficient amounts for nonmanagement labor expenses to avoid said recovery is the result of staff reductions necessary to accommodate a volume decline or of inability to hire employees due to a shortage of available personnel.

(c) Each acute hospital shall report its actual expenses during fiscal years nineteen hundred and eighty-seven and nineteen hundred and eighty-nine for each of the six nonmanagement labor categories so designated under schedule C.1.0 of appendix D of hospital agreement thirty.

Section 82A. For fiscal year nineteen hundred and ninety-one, patient care costs for each hospital shall be determined in a manner consistent with section eighty-one, exclusive of paragraphs (b) and (c), and substituting "fiscal year nineteen hundred and ninety," and "fiscal year nineteen hundred and ninety-one," respectively.

Fiscal year nineteen hundred and ninety-one approved revenues of any hospital which received an adjustment pursuant to paragraph (b) or (c) of section eighty or paragraph (b) or (c) of section eighty-one and which was subject to a labor cost recovery pursuant to section eighty-two shall be further adjusted to reflect a labor cost recovery, if any. The labor cost recovery shall be determined as follows:-

(a)(i) The fiscal year nineteen hundred and ninety actual expenses for each of the six nonmanagement labor categories so designated under schedule C.1.0 of Appendix D of hospital agreement thirty shall be adjusted by subtracting the product of: the sum of (i) the inflation adjustments associated with said categories which were provided pursuant to paragraph (d) of section eighty and paragraph (d) of section eighty-one and (ii) the comparable inflation adjustments provided for fiscal year nineteen hundred and ninety; multiplied by the percentage of total gross patient service revenue attributable to purchasers and third party payors who pay on the basis of charges and a hospital service corporation; the results shall then be summed for all six such categories.

(ii) The fiscal year nineteen hundred and eighty-seven actual expenses for the sum of such six nonmanagement labor categories shall be adjusted by adding eighty per cent of the net revenue received from purchasers and third party payors who pay on the basis of charges and a hospital service corporation due to adjustments made pursuant to paragraphs (b) and (c) of section eighty and paragraphs (b) and (c) of section eighty-one.

(iii) Subtract the amount calculated in subparagraph (i) from the amount calculated in subparagraph (ii).

(iv) If the amount calculated in subparagraph (iii) is positive, a labor cost recovery shall be applicable. The labor cost recovery shall be the lesser of the amount in subparagraph (iii) or eighty per cent of the net revenue received from purchasers and third party payors who pay on the basis of charges and a hospital service corporation due to adjustments made pursuant to paragraphs (b) and (c) of section eighty and paragraphs (b) and (c) of section eighty-one.

(v) Fiscal nineteen hundred and ninety-one approved revenues shall be adjusted in such a manner as to ensure that the projected payments of purchasers and third party payors who pay on the basis of charges and a hospital service corporation are reduced by the amount of the labor cost recovery, if any, calculated pursuant to subparagraph (iv).

(b) The commission may waive any or all of the labor cost recovery pursuant to paragraph (a) upon request for any hospital which demonstrates that such recovery would inappropriately penalize the hospital and its nonmanagement employees, because the hospital's failure to expend sufficient amounts for nonmanagement labor expenses to avoid said recovery is the result of staff

reductions necessary to accommodate a volume decline or of inability to hire employees due to a shortage of available personnel.

Section 83. For fiscal years nineteen hundred and eighty-eight to nineteen hundred and ninety-one, approved gross patient service revenue shall be calculated in the following manner:

(a) Each year the malpractice adjustment for medicare shortfall calculated pursuant to the principles governing hospital agreement thirty shall be added to fiscal year patient care costs as calculated pursuant to sections eighty to eighty-two A.

(b) Patient care costs for fiscal years nineteen hundred and eighty-eight to nineteen hundred and ninety-one, as calculated pursuant to section eighty to eighty-two A and as adjusted pursuant to paragraph (a), shall then be multiplied by the proportion of charges attributable to those purchasers and third-party payors who pay on the basis of charges and to a hospital service corporation, excluding those charges associated with free care, bad debt and services rendered to Title XIX recipients. Said product shall be known as private sector patient care costs.

(c) Private sector patient care costs as computed according to paragraph (b) shall then be further adjusted for a working capital allowance as computed in accordance with hospital agreement thirty, and the sum shall be multiplied by one plus the uniform statewide uncompensated care allowance as computed according to section eighty-seven. The resulting product shall be termed the private sector liability.

(d) The private sector liability as computed according to paragraph (c) shall be divided by: (i) the proportion of charges attributable to purchasers and third party payors who pay on the basis of charges, excluding those charges associated with free care and bad debt services, multiplied by one plus the uniform differential; plus (ii) the proportion of charges attributable to a hospital service corporation. The result of this division shall be known as the Blue Cross basis of payment.

(e) The Blue Cross basis of payment as calculated in accordance with paragraph (d) shall be further multiplied by one plus the uniform differential and the resulting product shall be termed approved gross patient service revenue for fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one respectively.

Section 84. For fiscal years nineteen hundred and eighty-eight to nineteen hundred and ninety-one, approved nonmedicare gross inpatient service revenue shall be calculated as follows:

Actual gross outpatient service revenue shall be subtracted from approved gross patient service revenue and the resulting difference shall be known as approved gross inpatient service revenue. Approved gross inpatient service revenue shall then be multiplied by: (i) the ratio of the per cent of actual gross inpatient service revenue attributable to nonmedicare patients to the per cent of case mix adjusted discharges attributable to nonmedicare patients. Said calculation shall utilize gross inpatient service revenues and case mix adjusted discharges for the final six months of the fiscal year beginning on October first, nineteen hundred and eighty-three and the first six months of the fiscal year beginning on October first, nineteen hundred and eighty-four and shall be further adjusted, if applicable, pursuant to changes made in accordance with paragraph (f) of section eighty; and (ii) the per cent of case mix adjusted discharges attributable to nonmedicare patients in the rate year.

The resultant amount shall be termed the approved nonmedicare gross inpatient service revenue without compliance; provided, however, that if an acute hospital appealed to the Division of Administrative Law Appeals the Commission's determination of approved gross inpatient service revenue for such acute hospital for the fiscal years beginning October first, nineteen hundred and eighty-two or October first, nineteen hundred and eighty-three and the Commission affecting the pendency of such appeal ordered such acute hospital to adjust its charges to comply with approved gross patient service revenue which order affected all or part of the final six months of the fiscal year beginning October first, nineteen hundred and eighty-three and the first six months of the fiscal year beginning October first, nineteen hundred and eighty-four, and which order of the Commission was determined by the Division not to have been in accordance with the approved gross patient service revenue determined by the Division for such acute hospital, then the calculation of the ratio of the per cent of actual gross inpatient service revenue attributable to nonmedicare patients to the per cent of casemix adjusted discharges attributable to nonmedicare patients shall utilize gross inpatient service revenues and casemix adjusted discharges for the final six months of the fiscal year beginning on October first, nineteen hundred and eighty-two and the first six months of the fiscal year beginning on October first, nineteen hundred and eighty-three.

Section 85. Beginning with fiscal year nineteen hundred and eighty-eight, and for each fiscal year thereafter, approved nonmedicare gross inpatient service revenue, without compliance, shall be adjusted to reflect any deficit or excess revenue earned in the preceding fiscal year. The dollar amount of the deficit or excess revenue shall be multiplied by one plus the average prime interest rate for such preceding fiscal year plus two per cent and the product shall be the dollar amount added to or subtracted from approved nonmedicare gross inpatient service revenue, without compliance, and the resultant amount shall be termed approved nonmedicare gross inpatient service revenue.

Section 86. Notwithstanding the provisions of sections eighty-four and eighty-five, in computing the amount of each acute hospital's deficit or excess revenue in any fiscal year, the commission shall, subject to regulations to be promulgated by said commission, increase or decrease a hospital's approved nonmedicare gross inpatient service revenue to the extent that it determines that the deficit or excess in the hospital's nonmedicare gross inpatient service revenue is attributable to a change from the base period to said fiscal year in the number and type of services provided to nonmedicare patients, as compared to medicare patients, which change is caused by a change in the relative clinical characteristics and medical needs of nonmedicare and medicare patients not reflected in the measurement of case mix adjusted discharges.

Section 87. (1) For purposes of this section, terms used herein shall have the meanings given them in section one of chapter one hundred and eighteen F. The uniform statewide allowance for uncompensated care for each hospital for each fiscal year beginning in fiscal year nineteen hundred and eighty-eight shall be calculated by the commission by dividing the amount of total private sector liability to the pool for such fiscal year by an amount equal to the sum of: (a) the sum for all acute hospitals of the private sector share of projected patient care costs for such fiscal year, and (b) a working capital allowance specified by the commission for such fiscal year. The amount of total private sector liability to the pool for this purpose shall equal: three hundred twenty-five million dollars for fiscal year nineteen hundred and eighty-eight; three hundred eighteen million, five hundred thousand dollars for fiscal year nineteen hundred and eighty-nine; three hundred twelve million dollars for fiscal year nineteen hundred and ninety; and three hundred twelve million dollars minus the amount appropriated by the com-

monwealth for such fiscal year for coverage of hospitalization expenses of recipients of benefits under chapter one hundred and seventeen for fiscal year nineteen hundred and ninety-one.

(2) Prior to the beginning of each hospital fiscal year, the commission shall, using the most appropriate and accurate data available, estimate the uniform allowance for statewide uncompensated care. These estimates shall be updated, on a timely basis, as significant new information becomes available. The commission shall supply these data and estimates promptly to the department of medical security and shall audit the accounts of hospitals with respect to receipts and liabilities for uncompensated care in accordance with standards adopted by such department pursuant to section fifteen of chapter one hundred and eighteen F.

Section 88. For fiscal years nineteen hundred and eighty-eight, nineteen hundred and eighty-nine, nineteen hundred and ninety, nineteen hundred and ninety-one, the interim rate of payment by a nonprofit hospital service corporation to acute hospitals under the successor agreement to hospital agreement thirty shall be at the level of billed charges multiplied by the ratio of: (a) one; to (b) the sum of one plus the unirorm differential.

Section 89. For the purposes of sections eighty-nine to ninety-eight, inclusive, the following words shall have the following meanings unless the context clearly requires otherwise:

"Gross revenues", the total dollar amount of a hospital's charges for services rendered to patients in a fiscal year.

"RSC-403 form", the cost report as filed with the rate setting commission by each hospital for each of its fiscal years which has been designated by said commission as the "RSC-403 Form".

"Nineteen hundred and eighty-five MAC report", appendix D to an agreement between Blue Cross of Massachusetts, Inc. and a hospital, approved by the rate setting commission pursuant to section five of chapter one hundred and seventy-six A first taking effect on October first, nineteen hundred and eighty-four, as completed and filed by each hospital with the rate setting commission.

"Nineteen hundred and eighty-five total hospital expense", the total expense reported on schedule II, column 7, line 93 of each hospital's nineteen hundred and eighty-five RSC-403 form, less compensation to physicians reported on schedule IX, column 3, line 93 of said nineteen hundred and eighty-five

RSC-403 form, and teaching costs reported on schedule II, column 3, lines 27, 28, and 29.

"Nineteen hundred and eighty-five major movable capital cost", the costs reported on schedule IX, column 7, line 94, of each hospital's nineteen hundred and eighty-five RSC-403 form.

"Noncapital hospital expense", the nineteen hundred and eighty-five total hospital expense less nineteen hundred and eighty-five major movable capital cost.

"Nineteen hundred and eighty-five gross revenues", the amount reported on schedule II, column 8, line 93 of each hospital's nineteen hundred and eighty-five RSC-403 form.

"Nineteen hundred and eighty-five inpatient revenue", the amount reported on schedule II, column 8, line 82 of each hospital's nineteen hundred and eighty-five RSC-403 form.

"Nineteen hundred and eighty-five inpatient admissions", the number of inpatient admissions reported on schedule III, column 9, line 14 of each hospital's nineteen hundred and eighty-five RSC-403 form.

"Nineteen hundred and eighty-five inpatient days", the number of patient days reported on schedule III, column 6, line 14 of each hospital's nineteen hundred and eighty-five RSC-403 form.

"The outpatient adjustment factor", nineteen hundred and eighty-five inpatient revenues divided by nineteen hundred and eighty-five gross revenues.

"Nineteen hundred and eighty-five adjusted admissions", for each hospital, nineteen hundred and eighty-five inpatient admissions divided by the outpatient adjustment factor.

"Nineteen hundred and eighty-five adjusted patient days", for each hospital, nineteen hundred and eighty-five inpatient days divided by the outpatient adjustment factor.

"Net revenues", the actual dollar amount of payments received by a hospital for services provided to patients.

Section 90. Notwithstanding any law to the contrary, the commission shall identify low cost acute hospitals and shall allow each such hospital the low cost hospital adjustment hereinafter provided in sections eighty-nine to ninety-eight, inclusive.

Section 91. Each hospital's qualification for a low cost hospital adjustment shall be determined by:

(a) dividing nineteen hundred and eighty-five adjusted patient days into noncapital expense for each hospital, to derive its nineteen hundred and eighty-five noncapital costs per adjusted patient day;

(b) calculating two standard deviations below the median of all hospitals' nineteen hundred and eighty-five noncapital costs per adjusted patient day;

(c) assigning each hospital an increasing positive or increasing negative arabic number depending on its rank above or below said second standard deviation from the median calculated under clause (b);

(d) dividing nineteen hundred and eighty-five adjusted admissions into noncapital costs for each hospital to derive its nineteen hundred and eighty-five noncapital costs per adjusted admission;

(e) calculating two standard deviations below the median of all hospitals' nineteen hundred and eighty-five noncapital costs per adjusted admissions;

(f) assigning each hospital an increasing positive or increasing negative arabic number depending on its rank above or below said second standard deviation from the median calculated under clause (e);

(g) for each hospital sum the positive and negative arabic numbers assigned by clause (c) and (f) to derive its aggregate ranking.

Every hospital whose aggregate ranking of nineteen hundred and eighty-five noncapital costs per patient day and nineteen hundred and eighty-five noncapital costs per adjusted admission is less than zero, shall be deemed entitled to a low cost hospital adjustment; provided, however, St. Margaret's Hospital shall be entitled to a low cost hospital adjustment regardless of its aggregate ranking.

Section 92. For every hospital entitled to a low cost hospital adjustment whose greater individual negative ranking is for nineteen hundred and eighty-five noncapital costs per adjusted patient day, as assigned pursuant to clause (c) of the first paragraph of section ninety-one, the low cost hospital adjustment shall be the lesser of the noncapital cost per adjusted patient day recovery or the revenue reduction factor provided for by sections ninety-four and ninety-six.

Section 93. For every hospital entitled to a low cost hospital adjustment whose greater individual negative ranking is for nineteen hundred and eighty-five noncapital costs per adjusted admission, as assigned pursuant to

clause (f) of the first paragraph of section ninety-one, the low cost hospital adjustment shall be the lesser of the cost per adjusted admission recovery or the revenue restoration factor provided for by sections ninety-five and ninety-six.

Section 94. The noncapital cost per adjusted patient day recovery shall be calculated separately for each hospital whose low cost hospital adjustment is subject to section ninety-two. For each such hospital the noncapital cost per adjusted patient day recovery shall be equal to the difference between the nineteen hundred and eighty-five noncapital costs per adjusted patient day for all hospitals calculated pursuant to clause (b) of the first paragraph of section ninety-one, less the nineteen hundred and eighty-five noncapital costs per adjusted patient day for the individual hospital, calculated pursuant to clause (a) of the first paragraph of section ninety-one, multiplied by the individual hospital's nineteen hundred and eighty-five adjusted patient days as defined in section eighty-nine. The amount so calculated shall be increased or decreased by the percentage change reported for the Consumer Price Index (ALL URBAN) - Medical Care Services for New England - Data Resources, Inc., Health Care Cost - Regional Forecast between the last amount reported for nineteen hundred and eighty-five and the amount reported and projected through fiscal year nineteen hundred and eighty-eight by Data Resources, Inc.

Section 95. The noncapital cost per adjusted admission recovery shall be calculated separately for each hospital whose low cost hospital adjustment is subject to section ninety-three. For each such hospital the noncapital cost per adjusted admission recovery shall be equal to the difference between the nineteen hundred and eighty-five noncapital cost per adjusted admission calculated pursuant to clause (e) of the first paragraph of section ninety-one, less the nineteen hundred and eighty-five noncapital costs per adjusted admission for the individual hospital, calculated pursuant to clause (d) of the first paragraph of section ninety-one, multiplied by the individual hospital's nineteen hundred and eighty-five adjusted admissions as defined in section eighty-nine. The amount so calculated shall be increased or decreased by the percentage change reported for the Consumer Price Index (ALL URBAN) - Medical Care Services for New England - Data Resources, Inc., Health Care Cost - Regional Forecast between the last amount reported for nineteen hundred and eighty-five and the amount reported and projected through fiscal year nineteen hundred and eighty-eight by Data Resources, Inc.

Section 96. Each hospital's revenue restoration factor shall be calculated by:

(a) dividing revenue charged by the hospital to each of its payors by total hospital patient care related revenue reported on line 23, schedule V of its, as filed, nineteen hundred and eighty-three RSC-403 form to derive separate nineteen hundred and eighty-three fiscal year payor specific revenue to total revenue percentages;

(b) multiplying each payor specific revenue to total revenue percentage by a related fiscal year nineteen hundred and eighty-three payor productivity percentage of two per cent for medicare; zero per cent for Blue Cross; two per cent for medicaid; and one and four-tenths per cent for all other payors;

(c) summing the percentages derived under clause (b) to derive the nineteen hundred and eighty-three hospital specific revenue restoration percentage;

(d) dividing revenue charged by the hospital to each of its payors by total hospital patient care related revenue reported on line 23, schedule V of each hospital's, as filed, nineteen hundred and eighty-four RSC-403 form to derive separate nineteen hundred and eighty-four fiscal year payor specific revenue to total revenue payor percentages;

(e) multiplying each payor specific revenue to total revenue percentage by a related fiscal year nineteen hundred and eighty-four payor productivity percentage of: four per cent for medicare; zero per cent for Blue Cross; four per cent for medicaid; and zero per cent for all other payors;

(f) summing the percentages derived under clause (e) to derive a hospital specific nineteen hundred and eighty-four revenue restoration percentage;

(g) dividing revenue charged by the hospital to each of its payors by total hospital patient care related revenue reported on line 23, schedule V of each hospital's, as filed, nineteen hundred and eighty-five RSC-403 form to derive separate nineteen hundred and eighty-five fiscal year payor percentages;

(h) multiplying each payor specific revenue to total revenue percentage by a related fiscal year nineteen hundred and eighty-five productivity percentage of: four per cent for medicare; two per cent for Blue Cross; six per cent for medicaid; and two per cent for all other payors;

(i) summing the percentages derived under clause (h) to derive a hospital specific nineteen hundred and eighty-five revenue restoration percentage;

(j) dividing revenue charged by the hospital to each of its payors by total hospital patient care related revenue reported on line 23, schedule V of each hospital's, as filed, nineteen hundred and eighty-six RSC-403 form to derive separate nineteen hundred and eighty-six fiscal year payor percentages;

(k) multiplying each payor specific revenue to total revenue percentage by a related fiscal year nineteen hundred and eighty-six productivity percentage of: two per cent for Blue Cross; three per cent for medicaid; and two per cent for all other payors;

(l) summing the percentages derived under clause (k) to derive a hospital specific nineteen hundred and eighty-six revenue restoration percentage;

(m) the nineteen hundred and eighty-seven revenue restoration percentage shall be the same calculation as provided for by clause (k), except that the productivity percentage for medicaid shall be two per cent;

(n) summing the revenue restoration percentages for nineteen hundred and eighty-three, nineteen hundred and eighty-four, nineteen hundred and eighty-five, nineteen hundred and eighty-six and nineteen hundred and eighty-seven calculated pursuant to clauses (c), (f), (i), (l), and (m) to derive an aggregate hospital specific restoration percentage; and

(o) multiplying the aggregate hospital specific restoration percentage by the amount of maximum allowable costs reported by each hospital on line 14, schedule A.O of its as filed nineteen hundred and eighty-five fiscal year MAC report less the amount of capital costs reported on line 9, schedule A.O of said nineteen hundred and eighty-five MAC report as filed by the individual hospital. The amount so calculated shall constitute each hospital's revenue restoration factor and shall be increased or decreased by the percentage change reported for the Consumer Price Index (ALL URBAN) - Medical Care Services for New England - Data Resources, Inc., Health Care Cost - Regional Forecast between the last amount reported for nineteen hundred and eighty-five and the amount reported and projected through fiscal year nineteen hundred and eighty-eight by Data Resources, Inc.

Section 97. The commission shall provide that the low cost hospital adjustment shall be included within any allowance of gross revenues, charges, costs, maximum allowable costs, reasonable financial requirements, rates, prices or the like so that each hospital, in addition to any other allowances as are permitted by law, receives net revenues which reflect its low cost adjustment.

Section 98. The commission shall, after a public hearing, adopt regulations to implement sections eighty-nine to ninety-eight, inclusive. At a minimum said regulations shall set forth the low cost hospital adjustment due to each hospital. All data and computation for such low cost hospital adjustments shall be published no later than twenty-one days prior to the public hearing.

Section 98A. Notwithstanding any provision of law to the contrary, the commission shall identify a case-mix adjusted low cost hospital and allow Whidden hospital the adjustment provided for in paragraph (c) of section seventy-nine. Whidden hospital's qualification for a case-mix adjusted low cost hospital adjustment shall be determined by:

(a) calculating for said hospital's "1985 case mix", which shall be defined as, for said hospital, the average cost weight per discharge calculated by dividing the total case mix adjusted discharges by the total discharges on said hospital's merged billing tapes submitted to said commission for the entire year of nineteen hundred and eighty-five.

(b) assigning to said hospital a "case mix index", which shall be defined as, for said hospital, that hospital's 1985 case mix divided by the mean 1985 case mix of all acute hospitals in the commonwealth as calculated above.

(c) determining the 1985 case mix adjusted cost per patient day, by dividing said hospital's 1985 noncapital cost per adjusted patient day cost calculated pursuant to clause (a) of section ninety-one by its case mix index.

(d) calculating two and one-half standard deviations below the median of all hospitals' 1985 case mix adjusted costs per patient day.

(e) assigning said hospital an increasing positive or increasing negative arabic number depending on its rank above or below said second and one-half standard deviation from the median calculated under clause (d).

(f) determining the 1985 case mix adjusted cost per admission by dividing said hospital's 1985 noncapital cost per adjusted admission calculated pursuant to clause (d) of section ninety-one by its case mix index.

(g) calculating two and one-half standard deviations below the median of all hospitals' 1985 case mix adjusted costs per admission.

(h) assigning said hospital an increasing positive or increasing negative arabic number depending on its rank above or below said second and one-half standard deviation from the median calculated under clause (g).

(i) for said hospital sum the positive and negative arabic numbers assigned by clauses (e) and (h) to derive its aggregate ranking.

(j) Whidden hospital shall be deemed entitled to a case mix adjusted low cost hospital adjustment, provided that such hospital is not otherwise eligible for an adjustment under paragraph (a) of section seventy-nine.

The case mix adjusted low cost hospital adjustment shall be calculated consistent with the methodology employed in sections ninety-two to ninety-eight, inclusive; provided, however that for purposes of this section the following substitution of terms appearing in said sections ninety-two to ninety-eight shall be made:

"case mix adjustment low cost hospital adjustment" for "low cost hospital adjustment",

"1985 case mix adjusted cost per patient day" for "1985 noncapital costs per adjusted patient day",

"case mix adjusted patient day recovery" for "noncapital cost per adjusted patient day recovery",

"1985 case mix adjusted cost per admission" for "1985 noncapital costs per adjusted admission",

"case mix adjusted admission recovery" for "cost per adjusted admission recovery",

clause (c) of this paragraph for clause (a) of section ninety-one,

clause (d) of this paragraph for clause (b) of said section ninety-one,

clause (e) of this paragraph for clause (c) of said section ninety-one,

clause (f) of this paragraph for clause (d) of said section ninety-one,

clause (g) of this paragraph for clause (e) of said section ninety-one,

clause (h) of this paragraph for clause (f) of said section ninety-one.

Section 99. For fiscal years nineteen hundred and eighty-eight through nineteen hundred and ninety-one, a comprehensive cancer center may, at its option, elect to establish prospectively and retrospectively, its approved gross patient service revenues, Blue Cross rate of payment and compliance with approved gross patient service revenues in the following manner:

(a) determining the sum of the comprehensive cancer center's noncapital inpatient and outpatient costs, in accordance with the principles of reimbursement for provider costs under 42 USC s.1395 et seq., and the medicare provider reimbursement manual, as projected prospectively and reported retrospectively by the comprehensive cancer center on the rate setting commission form 403, and as verified by audit. Add depreciation and interest and working capital recognized in hospital agreement thirty. Multiply the resulting amount by one plus the uniform statewide uncompensated care allowance;

(b) multiplying the total amount computed in clause (a) by one hundred and seven per cent to yield the approved gross patient service revenue for the applicable fiscal year.

(c) reflecting any excess or deficit revenues earned in any fiscal year in the approved gross patient service revenue of the subsequent fiscal year.

If a comprehensive cancer center chooses to compute its gross patient service revenue in accordance with clauses (a) to (c), inclusive, a nonprofit hospital service corporation shall pay said comprehensive cancer center the lower of reasonable costs, which shall be defined as the total costs computed pursuant to clause (a) and as referenced in clause (b), or charges.

A comprehensive cancer center must elect to have its payments governed by this section within sixty days of the effective date of this section, or payments to the comprehensive cancer center shall be governed by sections seventy-nine to eighty-eight, inclusive.

Section 100. For purposes of this section, the following words shall have the following meanings, unless the context clearly requires otherwise:

"Eye and Ear Hospital", a hospital licensed under section fifty-one of chapter one hundred and eleven, which derives at least fifty per cent of its total annual revenue from the diagnosis and treatment of eye, ear, nose, throat and head and neck conditions.

Notwithstanding any contrary provision of law, for fiscal years nineteen hundred and eighty-eight, nineteen hundred and eighty-nine, nineteen hundred and ninety and nineteen hundred and ninety-one, an eye and ear hospital may, at its option, elect to establish, prospectively and retrospectively, its approved gross patient service revenue in the following manner:

(a) determining the sum of an eye and ear hospital's inpatient and outpatient noncapital costs, in accordance with the principles of reimbursement for provider costs under 42 USC s.1395 et seq., and the medicare provider reimbursement manual, as projected prospectively and reported retrospectively by the eye and ear hospital on the rate-setting commission form 403, and as verified by audit. Add to the amount of noncapital costs the hospital's patient care related depreciation interest and working capital defined pursuant to hospital agreement thirty. Multiply the sum of noncapital and capital costs by one plus the uniform statewide allowance for uncompensated care;

(b) multiplying the amount computed in clause (a) by one hundred and seven per cent to yield the approved gross patient service revenue.

The rate setting commission shall ensure the gross patient service revenues shall be generated without excess on shortfalls. Any excess or deficit of gross patient service revenue earned in any fiscal year will be reflected in the allowed gross patient service revenue of the subsequent year.

A nonprofit service corporation shall pay an eye and ear hospital based on the lower of: (1) the hospital's charges to the nonprofit hospital service corporation for services rendered, or (2) the nonprofit hospital service corporation's costs determined pursuant to medicare principles of cost apportionment, multiplied by one plus the uniform allowance for uncompensated care.

An eye and ear hospital must elect to have its payments governed by this section within sixty days of the effective date of this section, or payments to the eye and ear hospital shall be governed by section seventy-nine to eighty-eight, inclusive.

Section 101. (a) There shall be within the executive office of human services an acute hospital conversion board, hereinafter referred to as "the board", consisting of the commissioner of public health or his designee, who shall serve as the chairman, the chairman of the rate setting commission or his designee, and the commissioner of the department of medical security or his designee. Said board shall administer the provisions of this section concerning the closing of acute hospitals or their conversion to other health, rehabilitative or public purposes. Said board shall provide assistance to acute hospitals in the identification and development of alternative financial resources and site uses, and in the expedition of state regulatory processes. Said board shall advise the division of employment security, the Massachusetts industrial service program and any other appropriate agencies or institutions regarding the need for reemployment training incentive programs for employees of acute hospitals whose employment is or will be terminated because of the closing or conversion of an acute hospital. Said board shall further have the authority to assist any closing or converting hospital in any other manner necessary and appropriate to ensure an orderly transition, including, but not limited to, ensuring that the hospital's obligations for any bonds issued and for other short and long-term debt are met.

(b) Any acute hospital which applies to the board shall qualify for relief pursuant to this section upon certifying to the board, with any supporting documentation that the board may require:

(1) that it intends to cease operation as an acute hospital by closing, by converting to another health, rehabilitative or other public purpose, or by ceasing to admit or care for patients in its medical-surgical, pediatric, obstetric and maternity beds, no later than twelve months following such certification; or

(2) that there is substantial doubt concerning whether the hospital will be able to continue as a going concern.

Upon receiving certification pursuant to this section of a hospital's intention to close or convert to another purpose, the board shall promptly notify the Massachusetts industrial service program established under chapter twenty-three D.

(c) Within thirty days of the receipt of such certification, the board shall appoint a community need determination committee to study the alternative needs of the community served by the hospital. Such committee shall consist of a trustee of the hospital, the mayor of the city or the head of the board of selectmen of the town in which the hospital is located, a physician with privileges at the hospital, a local representative of the elderly, a local member of the business community, a member of a collective bargaining unit of the hospital, a nurse employed at the hospital and a member of a regional health planning agency serving the community, if any. Such committee shall hold a public hearing within sixty days of its appointment to determine the needs of the community for alternative health, rehabilitative and other public uses of the hospital facility. A report on such hearing shall be filed with the board.

(d) In the case of a hospital certifying its intention to close or convert:

(1) Notwithstanding the provisions of sections seventy-eight to ninety-eight, the board, if satisfied with the documentation provided, shall increase the amount of such hospital's patient care costs as determined pursuant to sections eighty to eighty-two A for its final twelve months of operation as an acute hospital to the extent necessary to allow for an orderly transition for the patients and employees of such hospital. Said board may also, to the extent necessary to make the closure or conversion financially feasible, permanently forgive any outstanding compliance liability pursuant to section eighty-five or its predecessor or successor section.

(2) The board shall further have the authority to exempt such closing or converting hospital or any hospital undertaking to purchase or merge with such closing or converting hospital from the provisions of sections twenty-five B to twenty-five G, inclusive, of chapter one hundred and eleven with regard to any substantial change in services, as defined in said sections and regulations pursuant thereto, proposed as a result of such closing or converting hospital's cessation of operation as an acute hospital; provided, however, that the board approves such proposal pursuant to this section; and provided, further, that the final outcome of any such exempted proposal shall be a net reduction in the number of medical-surgical, pediatric, obstetric and maternity beds equal to the number of such beds contained in such closing or converting hospital. The board shall consider the report of the community need determination committee established pursuant to paragraph (c) in determining whether to approve the hospital's proposal for a change in services.

The board shall approve any such proposal only if it finds that the proposed service will meet an identified health care need in such community; provided, however, that any such proposal which is not approved or disapproved within ninety days of its submission shall be deemed approved for purposes of this section and shall thereupon be exempt from the provisions of said sections twenty-five B to twenty-five G, inclusive, of chapter one hundred and eleven.

(e) In the case of a hospital certifying substantial doubt about its ability to continue as a going concern, notwithstanding the provisions of sections seventy-eight to ninety-eight, the board may increase the amount of the hospital's patient care costs as determined pursuant to sections eighty to eighty-two A, subject to the following conditions and limitations:

(1) The board may approve an increase only if it determines:

(i) that without rates of payment greater than those permitted pursuant to sections seventy-eight to ninety-eight, the hospital will be unable to continue to admit or care for patients in its medical-surgical, pediatric, obstetric and maternity beds; and

(ii) that the unavailability of said beds would necessarily seriously jeopardize the health and well-being of a significant number of persons.

(2) When making the determination required in clause (i) of subparagraph (1), the board shall identify all feasible alternative methods for relieving the hospital's financial distress, including but not limited to

changes in the hospital's management personnel, expense reductions, closure of under-utilized or nonessential services, and merger and consolidation of services with neighboring hospitals.

(3) When making the determination required by clause (ii) of subparagraph (1), the board shall at a minimum, consider the report of the community need determination committee established pursuant to paragraph (c).

(4) Any increase shall be for a period of time to be specified by the board. The duration shall be the minimum necessary to enable the continued availability of essential medical-surgical, pediatric, obstetric and maternity beds, and shall not be indefinite.

(5) The amount of the increase shall be the minimum necessary to enable the continued availability of essential medical-surgical, pediatric, obstetric and maternity beds. In its determination of said amount, the board shall assume implementation of all feasible alternative methods identified pursuant to subparagraph (1), pursuant to the plan of action established pursuant to subparagraph (6).

(6) Any increase made pursuant to this section shall be contingent on the hospital's agreement to and continuing compliance with a plan of action approved by the board. Said plan of action shall specify the steps to be taken to make the hospital financially viable and able to provide essential services to its community. Said steps shall include all necessary changes in the hospital's management personnel and all feasible alternative methods identified pursuant to subparagraph (2).

(7) The board shall make said increase subject to such additional reasonable terms and conditions as it deems necessary and appropriate.

(8) If the plan of action includes steps requiring a determination pursuant to chapter one hundred and eleven, the board shall have the authority specified in subparagraph (2) of paragraph (d).

(f) Any acute hospital which qualifies for and receives relief pursuant to this section shall give its employees at least ninety days' prior written notice of the termination of their employment, such notice to be given in a form and manner prescribed by the board and to include at least the following: notice of their right to continued health benefits pursuant to statute or any applicable collective bargaining agreement; notice of their rights pursuant to sections seventy-one A to seventy-one J, inclusive, of chapter one hundred and fifty-one A; and notice of the availability of the comprehensive job placement

and reemployment training program established pursuant to section four of chapter twenty-three D.

(g) In carrying out its duties pursuant to this section, the board shall seek the advice of an advisory council consisting of the following members: one representative each designated by the Massachusetts hospital association, the Massachusetts nurses' association, the Massachusetts health and educational facilities authority, and Blue Cross of Massachusetts, Inc.; a representative of a collective bargaining unit for hospital workers designated by the Massachusetts federation of labor - congress of industrial organizations; and one representative each, to be appointed by the board, of the following: large teaching hospitals, community hospitals, large businesses, small businesses, commercial insurance companies, and health care consumers.

Section 102. Notwithstanding any provisions of this chapter to the contrary, all costs and charges for patients who are residents of other countries shall, as provided herein, be exempted from the limitations imposed by this chapter. Any hospital shall be allowed to impose a surcharge on the normal charges that would otherwise be allowed under this chapter for such residents of other countries. Such surcharges shall not be included in the calculation of gross patient service revenues. The normal charge and the patient discharge statistics shall otherwise be included under the provisions of this chapter. Blue Cross and the Massachusetts hospital association are hereby directed to submit a supplemental schedule which will become a part of the successor agreement to hospital agreement thirty to the commission for approval by no later than April first, nineteen hundred and eighty-eight.

SECTION 21. The first paragraph of section 4H of chapter 7 of the General Laws, as appearing in the 1986 Official Edition, is hereby amended by inserting after the word "six A", in line 11, the words:- and section five of chapter one hundred and seventy-six A.

SECTION 22. Chapter 15A of the General Laws is hereby amended by inserting after section 7A the following section:-

Section 7B. Effective September first, nineteen hundred and eighty-nine, every full time and part-time student enrolled in a public or independent institution of higher education located in the commonwealth shall participate in a qualifying student health insurance program. For the purposes of this section, "part-time student" shall mean a student participating in at least seventy-five per cent of the full time curriculum. Such an institution may elect

to allow students to waive participation in its student health insurance program or any part thereof; provided, however, that an institution permitting such waivers shall require students waiving participation to certify in writing prior to any academic year in which they will not participate in the institution's plan that they are participating in a health insurance program having comparable coverages.

The department of medical security, with the advice and consent of the board of regents, shall issue regulations to define qualifying student health insurance programs, to establish procedures to monitor compliance, and to implement the provisions of this section.

Each public and independent institution of higher education shall submit an annual report to the department of medical security detailing its procedures for complying with the provisions of this section; provided, however, that prior to the implementation of this section the department of medical security and the board of regents shall submit a report to the house and senate committees on ways and means. Such report shall include, but not be limited, to an analysis of the number of students lacking health insurance, the costs of the requirements of this section to the students and the public and independent institutions of higher education, and a proposed method for meeting such costs.

Any public or independent institution of higher education failing to carry out its responsibilities under this section shall pay a penalty per student for every day during which the failure continues, equal to the penalty per employee per day imposed upon noncomplying employers by subsection (i) of section fourteen G of chapter one hundred and fifty-one A. Any penalties collected pursuant to this section shall be deposited in the public responsibility account of the medical security trust fund established by chapter one hundred and eighteen F. Any institution which, in accordance with the aforesaid regulations, relies in good faith on statements by students relative to their health insurance status shall not be liable for any penalty or for failure to comply with the provisions of this section caused by misstatements of such students.

SECTION 23. Section 4 of chapter 23D of the General Laws, as appearing in the 1986 Official Edition, is hereby amended by striking out, in line 30, the word "purposes." and inserting in place thereof the following:- purposes;

(g) with the advice of the advisory council created in section seventy-eight of chapter six A, establishing and administering a comprehensive job placement and reemployment training program for employees of hospitals and other health care facilities whose employment has been or is likely to be terminated as a result of the closure or conversion of the employing hospital or health care facility.

SECTION 24. Section 8H of chapter 26 of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

The division of insurance is directed to require all health insurers and health maintenance organizations doing business in the commonwealth to identify persons who are recipients of medical assistance under chapter one hundred and eighteen E, or who are responsible for supporting such recipients, and who are also beneficiaries under any policy for health insurance or parties to any health maintenance contract in force and effect in the commonwealth. The department of public welfare shall provide information to the extent sufficient to allow insurers to identify such persons. Such information shall be made available by such insurers and health maintenance organizations and by the department only for the purposes of and to the extent necessary for identifying such persons. No health insurer or health maintenance organization which complies with this section shall be liable in any civil or criminal action or proceedings brought by such beneficiaries or members on account of such compliance. The division shall further direct all health insurers and health maintenance organizations doing business in the commonwealth to participate with the department in any procedure, including but not limited to automated file matches, conducted under the direction of the department for the purpose of identifying those persons who are recipients of medical assistance under chapter one hundred and eighteen E or who are responsible for supporting such recipients, and who are also beneficiaries under any policy for health insurance or parties to any health maintenance contract in force in the commonwealth. Participation in such a procedure by a health insurer or health maintenance organization doing business in the commonwealth shall include but shall not be limited to reasonable financial participation in the cost of any such procedure. The commissioner of insurance is authorized to promulgate regulations necessary to ensure the effectiveness of this section.

SECTION 25. Section 4 of chapter 32A of the General Laws, as so appearing, is hereby amended by adding the following sentence:- The group insurance

commission shall not negotiate, purchase or execute contracts with any health maintenance organization, as defined by section one of chapter one hundred and seventy-six G, unless the health maintenance organization participates in the medical assistance program established under chapter one hundred and eighteen E and enrolls recipients of such program in accordance with a negotiated agreement between the department of public welfare and health maintenance organizations.

SECTION 26. Section 11A of said chapter 32A, as so appearing, is hereby amended by adding the following two paragraphs:-

Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to such divorced or separated spouse at such person's last known address, together with notice of the right to reinstate coverage retroactively to the date of cancellation.

Claims paid on behalf of a divorced or separated spouse or on behalf of a dependent who is not residing with the member shall be paid to the physician, hospital or other provider of covered services or to the person on whose behalf such services were performed, unless the person is a minor child. In the event the person on whose behalf such services were performed is a minor, payment shall be made to the physician, hospital or other provider of such services or to the parent or custodian with whom the child resides.

SECTION 27. Section 9H of chapter 32B of the General Laws, as so appearing, is hereby amended by adding the following two paragraphs:-

(d) Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to such divorced or separated spouse at such person's last known address, together with notice of the right to reinstate coverage retroactively to the date of cancellation.

(e) Claims paid on behalf of a divorced or separated spouse or on behalf of a dependent who is not residing with the member shall be paid to the physician, hospital or other provider of covered services or to the person on whose behalf such services were performed, unless the person is a minor child. In the event the person on whose behalf such services were performed is a minor, payment shall be made to the physician, hospital or other provider of such services or to the parent or custodian with whom the child resides.

SECTION 28. Section 6 of chapter 62 of the General Laws, as amended by section 4 of chapter 773 of the acts of 1987, is hereby further amended by adding the following subsection:-

(f) There is hereby established a credit for businesses offering health insurance to their employees. For the purposes of this section, the term "businesses" shall include professions, sole proprietorships, trades, businesses, or partnerships.

Any business which (a) has one or more full-time equivalent employees unrelated to its owners or partners but no more than fifty of such employees calculated on an average annual basis, (b) has not in any one of the preceding three years made an expenditure for the full or partial payment of premiums for a health insurance plan covering any of its then employees, and (c) makes a health insurance premium expenditure for a health insurance plan which is available to at least all of its full-time employees, shall be allowed a credit against its income tax due under this chapter in each of the first two years it makes such a health insurance premium expenditure.

The amount of such credit in the first year shall be twenty per cent of the entire amount of the health insurance premium expenditure made by such business in the first year and ten per cent of such health insurance premium expenditure made by such business in the second year. To be eligible to receive such credits, the health insurance premium expenditure of such business must equal at least fifty per cent of the total cost of the premiums for the health insurance plan made available to its employees. For the purposes of this section, "unrelated" shall mean not having the familial relationship of spouse, mother, father, or child.

The provisions of this section shall apply to tax years beginning on or after January first, nineteen hundred and ninety and ending on or before December thirty-first, nineteen hundred and ninety-two.

SECTION 29. Chapter 63 of the General Laws is hereby amended by inserting after section 31D, inserted by chapter 736 of the acts of 1987, the following section:-

Section 31E. There is hereby established a credit for corporations offering health insurance to their employees. Any corporation which (a) has one or more full-time equivalent employees unrelated to its shareholders but no more than fifty of such employees calculated on an average annual basis, (b) has not in any one of the preceding three years made an expenditure for the full or partial payment of premiums for a health insurance plan covering any of its then employees, and (c) makes a health insurance premium expenditure for a health insurance plan which is available to at least all of its full-time em-

ployees, shall be allowed a credit against its excise due under this chapter in each of the first two years it makes such a health insurance premium expenditure.

The amount of such credit in the first year shall be twenty per cent of the entire amount of the health insurance premium expenditure made by such corporation in the first year and ten per cent of such health insurance premium expenditure made by such corporation in the second year. To be eligible to receive such credits, the health insurance premium expenditure of such corporation must equal at least fifty per cent of the total cost of the premiums for the health insurance plan made available to its employees. For the purposes of this section, "unrelated" shall mean not having the familial relationship of spouse, mother, father or child.

The provisions of this section shall apply to tax years beginning on or after January first, nineteen hundred and ninety and ending on or before December thirty-first, nineteen hundred and ninety-two.

SECTION 30. Section 4J of chapter 111 of the General Laws, as amended by section 4N of chapter 1229 of the acts of 1973, is hereby further amended by striking out the first two paragraphs and inserting in place thereof the following paragraph:-

No individual from birth to age twenty-two shall be admitted to a nursing home unless, prior to such admission, application has been made by or on behalf of such individual for certification by the Department's Multi-Disciplinary Medical Review Team of eligibility for nursing home care in the nursing home to which the individual seeks admission. A majority of the members of the medical review team shall consist of currently licensed health and allied health professionals who are not employees of the commonwealth and who have been engaged full time in primary care practice in their respective areas of specialization within the two years immediately prior to the commencement of service on the medical review team. Such other individuals as the department may, from time to time, deem appropriate may also serve on the medical review team. No person shall serve on the medical review team for a period exceeding two years. The medical review team shall, in consultation with the individual's referring physician, discharge planners at the individual's referring health care institution, the individual's parents, next-of-kin or guardians, the individual's primary care physician, and, to the extent deemed necessary, the departments of mental health, social services, welfare, education, office

for children and the commission for the blind, assess the medical, nursing, developmental and social needs of such individuals. In the event that the medical review team fails to render a decision on certification within ten business days after submission of any application for certification, the individual may, with the approval of his or her referring physician, be admitted to the nursing home. In reviewing applications for certification of eligibility, the medical review team shall not deny certification on the basis of sex, nationality, religious affiliation, residency or domicile, source of payment or reimbursement, type of illness or injury sustained or suffered by the individual, or, if the nursing home to which the individual seeks admission is able to provide requisite care, the ability of any other health care facility, wherever located, to provide such care. In the event that the medical review team denies certification, it shall recommend an alternative care program appropriate to each individual's needs.

SECTION 31. Said chapter 111 is hereby further amended by inserting after section 24C the following section:-

Section 24D. The department shall establish a program of medical care and assistance for pregnant women and infants who are not otherwise eligible for medical assistance under chapter one hundred and eighteen E and who lack private health insurance coverage or have health insurance coverage which does not cover all medically necessary care covered by the program established by this section. The department shall furnish such medical assistance to each such pregnant woman and infant residing in the commonwealth in accordance with standards of eligibility established by the department; provided, however, that the income eligibility standards shall not be less than two hundred per cent of the non-farm income poverty guidelines defined by the United States Office of Management and Budget.

Assistance furnished pursuant to this section shall be limited to the following care and services; provided, however, that unless otherwise specified to the contrary no payment shall be allowed for inpatient hospitalization:

(i) all medically necessary care to maintain health during the course of the pregnancy and delivery, including newborn hospital care;

(ii) all medically necessary postpartum obstetric and gynecological care;

(iii) newborn care, including one postpartum pediatric ambulatory visit; and

(iv) outreach services designed to identify and encourage the participation of pregnant women and infants in this program.

The department shall ensure that all women who appear to be eligible for medical assistance under said chapter one hundred and eighteen E are assisted in enrolling for such coverage. If a woman receiving services under the program established pursuant to this section is found by the department of public welfare to be eligible for services under said chapter one hundred and eighteen E, the department of public welfare shall pay for all such services and shall reimburse the department of public health for such services; provided that such reimbursements are allowed under Title XIX of the Social Security Act.

The department shall promulgate and, from time to time, amend regulations detailing eligibility criteria, services to be covered in conformity with appropriate standards of care, and reimbursement policies.

SECTION 32. Section 25B of said chapter 111, as appearing in the 1986 Official Edition, is hereby amended by striking out the definitions of "Substantial capital expenditure" and "Substantial change in services" and inserting in place thereof the following twelve paragraphs:-

"Acute-care hospital", any hospital licensed under section fifty-one of chapter one hundred and eleven, and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the department.

"Acute psychiatric service", a service for inpatients in need of intensive, twenty-four hour per day, psychiatric and nursing care and supervision, not including persons hospitalized for alcohol problems, and which includes a staff of mental health specialists who provide psychiatric, psychological and social evaluation, treatment and aftercare planning.

"Ambulatory surgery", health care services restricted to those defined by the department as surgical services, not requiring overnight stay, typically provided to ambulatory patients on an elective, urgent, or emergency basis.

"Innovative service", a service or procedure such as dialysis, transplant services, cardiac catheterization, angioplasty and neonatal intensive care, which for reasons of quality, access, or cost is determined to be innovative by the department.

"Inpatient services", health care services requiring at least one overnight stay, provided to patients on an elective, urgent, or emergency basis.

"Major movable equipment", equipment that is not permanently attached to the building and that has a depreciable life of three or more years.

"New technology", equipment including but not limited to magnetic resonance imagers, lithotrypters, and linear accelerators, as defined by the department, or a service, as defined by the department, primarily intended for use in the provision of medical or surgical services, whether for diagnostic or treatment purposes, which has received approval from the U.S. Food and Drug Administration or which has been placed in "Approvable Status" by the U.S. Food and Drug Administration, or which has been authorized for physician use by appropriate professional societies, but which is not in general use for patient care by physicians qualified to operate the equipment or provide the service.

"Outpatient services", health care services, not requiring overnight stay, typically provided to ambulatory patients on an elective basis.

"Substantial capital expenditures", (1) the expenditure, or obligation of a sum of money for construction of a health care facility (a) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made by lease or comparable arrangement, and (b) which exceeds, or may reasonably be regarded as leading to an expenditure for construction in excess of, the expenditure minimum determined pursuant to this section for an undertaking sufficiently specific to constitute the subject matter of an application for a determination of need under section twenty-five C; or (2) the obtaining by lease or comparable arrangement, by donation, or by transfer for less than fair market value in excess of the expenditure minimum.

"Expenditure minimum with respect to substantial capital expenditures", shall mean, with respect to expenditures and acquisitions made by or for (1) acute-care hospitals and comprehensive cancer centers as defined in section thirty-one of chapter six A, only, seven and one-half million dollars, except that expenditures for or the acquisition of, major movable equipment not otherwise defined by the department as new technology or innovative services shall not require a determination of need, and shall not be included in the calculation of the expenditure minimum; and (2) health care facilities, other than acute-care hospitals, and facilities subject to licensing under chapter one hundred and eleven B, with respect to (a) expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, four hundred thousand dollars, and (b) all other expenditures and acquisitions, eight hundred thousand dollars; provided, further, that expenditures and acquisitions concerned

solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum. Notwithstanding the above limitations, acute-care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

"Substantial change in services", shall mean: (1) (a) with regard to acute-care hospitals only, the addition or expansion of, or conversion to, a new technology or innovate service regardless of whether an expenditure minimum is exceeded; (b) for any acute-care hospital, the addition or expansion of, or conversion to any services which may be provided by facilities which are not acute-care hospitals; except that conversions of acute-care services to skilled nursing, rehabilitation, acute psychiatric, and substance abuse services located in an underbedded areas shall be determined by criteria developed by the department in consultation with the department of elder affairs, department of mental health, the Massachusetts federation of nursing homes, the Massachusetts hospital association and other interested parties, and that no such conversion shall occur until the department has certified in writing the conversions meet the criteria established. The department shall promulgate regulations to implement the provisions of said criteria for underbedded areas including, but not limited to medicaid access, and regulations to define criteria for reconversion; and (2) for any health care facility other than an acute-care hospital (a) the addition of a service which entails annual operating costs in excess of the expenditure minimum determined pursuant to this section; (b) any increase in bed capacity of more than twelve beds; (c) the addition or expansion of, or conversion to, a new technology or innovative service regardless of whether an expenditure minimum is exceeded; (d) provided, however, that no decrease in the level of a service that, pursuant to department regulations, may be offered by a nursing, convalescent, or rest home which does not involve a capital expenditure in excess of eight hundred thousand dollars shall be subject to the provisions of sections twenty-five C to twenty-five G, inclusive; (e) provided, further, that an increase in staff by itself shall not be defined by the department to constitute a substantial change in service unless said increase in staff will result in an addition to annual operating costs which exceeds the expenditure minimum determined pursuant to this section. Notwithstanding any other provisions to the

contrary, a change of service concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as a new technology or innovative services, shall not be defined by the department to constitute a substantial change of service.

"Expenditure minimum with respect to expenditures for a change in service or increase in staff", shall mean three hundred and fifty thousand dollars in annual operating costs.

SECTION 33. Said section 25B of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 5 and 6, the words "which has geographical jurisdiction of the area served by a health care facility" and inserting in place thereof the words:- or its successor agency.

SECTION 34. Said chapter 111 is hereby further amended by inserting after section 25B the following section:-

Section 25B 1/2. Expenditure minimums established pursuant to section twenty-five B shall be adjusted annually by the department after consideration of any inflation index set by the Secretary of the United States Department of Health and Human Services.

SECTION 35. Subsection (a) of section 25C 1/2 of said chapter 111, as appearing in the 1986 Official Edition, is hereby amended by adding the following clause:-

(4) A health care facility if (a) the facility is or is going to be a long-term care facility, an infirmary maintained in a town, a convalescent or nursing home, a rest or charitable home for the aged as defined in section seventy-one, (b) the facility is, or will be located in an underbedded urban area as determined by criteria developed by the department in consultation with the Massachusetts federation of nursing homes and other interested parties, including the department of elder affairs, (c) the facility provides service, or will agree to provide service, to at least seventy per cent of its patients as enrollees in Title XIV of the Federal Social Security Act, (d) the facility presents an adequate quality assurance program plan meeting criteria established by the department subsequent to consultation with the Massachusetts federation of nursing homes and other interested parties, and (e) need for such facility has been established pursuant to an administrative review procedure shall be established by the department within ninety days of the effective date of this act.

SECTION 36. Section 25G of said chapter 111, as so appearing, is hereby amended by striking out the second sentence and inserting in place thereof the following sentence:- A violation of such provisions shall subject the violator to liability for a civil penalty of not more than five hundred dollars for each day of such violation, assessable by the superior court.

SECTION 37. Section 25I of said chapter 111, as so appearing, is hereby amended by inserting after the word "a", in line 6, the words:- schedule I or II.

SECTION 38. Section 51 of said chapter 111, as so appearing, is hereby amended by inserting after the second paragraph the following two paragraphs:-

Each hospital shall give the department an annual written statement containing a licensure adjustment calculated pursuant to this section as of the first day of such hospital's fiscal year, and the department shall adjust the hospital's total licensed bed capacity accordingly. As of such date, each hospital's number of licensed acute-care medical-surgical beds, excluding all critical care beds, shall be adjusted to equal the lesser of: (a) the number of such licensed beds as reported for the prior year on rate setting commission form 403, schedule III, column 4, line 1; or (b) a number equal to the average daily census for such prior year divided by seventy-five hundredths. Such average daily census shall be calculated by dividing the number reported in rate setting commission form 403, schedule III, column 6, line 1, by three hundred and sixty-five. If a hospital experiences eighty-five per cent average occupancy for its adult medical-surgical beds excluding all critical care beds for three consecutive months, it may, by letter application documenting such occupancy, increase its licensed number of such beds to a number equal to the average daily census of adult medical-surgical beds excluding all critical care beds, divided by seventy-five hundredths, or to a number equal to its number of licensed beds for the preceding fiscal year, whichever is less. The department shall approve or disapprove such application within ten days after filing, on the basis of a review limited to the sole issue of whether such hospital is in fact experiencing such occupancy. If such application has not been acted upon by the department within such time limit, the application shall be deemed approved.

Each licensee shall maintain its licensed bed capacity at all times in accordance with the provisions of this chapter and all applicable rules and regulations promulgated by the department.

SECTION 39. Chapter 117 of the General Laws, as appearing in the 1986 Official Edition, is hereby amended by inserting after section 1 the following section:-

Section 1A. As of January first, nineteen hundred and ninety-one, the department shall establish a comprehensive health care program for persons eligible for assistance under this chapter. Such program shall include, at a minimum, coverage for inpatient and outpatient hospital services, physician services, and prescription medicine. In so far as is possible, such program shall be limited to services delivered in a managed care setting.

SECTION 40. Chapter 118E of the General Laws is hereby amended by inserting after section 1 the following two sections:-

Section 1A. The department shall establish a program of medical care and assistance for pregnant women and infants who are not otherwise eligible for medical assistance under this chapter and who lack private health insurance coverage or have a health insurance policy which does not cover all medically necessary care which is covered by the program established by this section. The department shall furnish such medical assistance to each such pregnant woman and infants residing in the commonwealth in accordance with standards of eligibility established by section 1902 of the Social Security Act, as amended by section 4101 of the Omnibus Budget Reconciliation Act of 1987 (P. L. 100-203); provided, however, that the income eligibility standards shall not be less than one hundred and eighty-five per cent of the non-farm income poverty guidelines as defined by the United States Office of Management and Budget.

Section 1B. The benefits of the program of medical care and assistance under this chapter shall be extended for up to twenty-four months for those families and individuals who would otherwise be ineligible for the program due to increased income from employment and whose employer does not offer health care insurance; provided, however, that such person's income during the period of extended eligibility shall not exceed one hundred and eighty-five per cent of the non-farm income poverty guidelines prescribed by the United States office of management and budget. Extended benefits under this section shall not be available after March thirty-first, nineteen hundred and ninety-two.

SECTION 41. Said chapter 118E is hereby further amended by inserting after section 6 the following two sections:-

Section 6A. The department shall establish a program of primary and supplemental medical care and assistance for certain disabled residents of the commonwealth who are not eligible for medical assistance pursuant to Title XIX of the federal Social Security Act. The benefits of such program shall be available to all such persons (1) who are not covered for medical costs relative to their disability by an employer's group health insurance plan, (2) who are not eligible for medical assistance under any work incentive programs with federal participation, and (3) who, if not engaged in substantial gainful activity, would meet all eligibility requirements for supplemental security income under the provisions of Title XVI of said Social Security Act at the time of application for said program of medical care and assistance. Subsequent to their enrollment in said program, such disabled residents may continue in enrollment in said program notwithstanding the fact that they no longer meet the financial requirements of said Title XVI in accordance with income requirements established by the department. The cost of such program shall be funded, in part, by premium contributions, co-payments, and deductibles contributed by enrollees according to a sliding scale schedule designed by the department.

Section 6B. The department shall establish a program of medical care and assistance for certain disabled children of the commonwealth. The benefits of such program shall be available to children who are not eligible for medical assistance programs with federal financial participation and who would meet the disability requirements for supplemental security income under the provisions of Title XVI of the Social Security Act. The cost of such program shall be funded, in part, by premium contributions, co-payments and deductibles according to a sliding scale schedule designed by the department.

SECTION 42. The last paragraph of section 10 of said chapter 118E, as so appearing, is hereby amended by adding the following two sentences:- The income and assets of any applicant for medical assistance under eighteen years of age who lives with his or her parent shall be deemed to include the income and assets of the parent of such applicant unless the applicant is married, divorced, or separated; has served in the armed services; has been emancipated by the courts; or has received or intends to receive care pursuant to section twelve F of chapter one hundred and twelve, and his or her parent does not know that such care has been received or is being sought or has refused to pay for such care; or (1) qualifies as a disabled individual under Title XVI of

the Social Security Act, or if in a medical institution, qualifies for Supplemental Security Income or a state supplemental payment, and (2) would require the level of care provided in a hospital, skilled nursing facility or intermediate care facility, and (3) would incur fewer costs by receiving treatment outside of such facility than inside such facility. Nothing in this section shall either restrict or expand eligibility for medical assistance under any existing procedures or agreements between the department of public welfare and the department of social services.

SECTION 43. Section 18 of said chapter 118E, as so appearing, is hereby amended by striking out, in line 8, the word "and",- and by striking out, in line 10, the word "program." and inserting in place thereof the following:- program;

(5) Participation in the program as a skilled nursing and/or intermediate care facility shall be limited to providers who:

agree to be responsible for all overpayments owed to the department of public welfare, including, in the case of transfer of ownership, the overpayments of any and all previous owners.

SECTION 44. Section 19 of said chapter 118E, as so appearing, is hereby amended by inserting after the word "to", in line 4, the words:- , administrative fines, and.

SECTION 45. The General Laws are hereby further amended by inserting after chapter 118E the following chapter:-

CHAPTER 118F.

DEPARTMENT OF MEDICAL SECURITY.

Section 1. It is hereby found and declared:

That, the access of residents of the commonwealth to basic health care services is a natural, essential, and unalienable right which is protected by Article I of Part the First of the Constitution.

That, there live within the commonwealth many thousands of persons who lack access to basic health care services because they are not able to purchase health care insurance at a reasonable price or because they are restricted from purchasing health insurance by the practices of the insurance industry.

That, such lack of access to health care negatively affects the health status of the uninsured in the commonwealth by the delay or lack of medical treatments, thereby increasing the incidence of disease and illness in the commonwealth.

That, the cost of providing hospital care to the uninsured is a burden on the taxpayers and certain businesses in the commonwealth.

That, most businesses in the commonwealth assist their employees in the purchase of health care insurance and that many other businesses are precluded from providing such assistance because of economic and cost concerns.

That, the inability of certain businesses to offer health insurance benefits to their employees is a hindrance to their ability to compete for capable employees in the labor market and therefore has a negative economic impact on the commonwealth.

Therefore, it is found that it is in the public interest of the commonwealth to promote the accessibility of health care services for all its citizens, a public purpose for which public money may be expended.

Section 2. The following terms as used in this chapter shall have the following meanings, except where the context clearly indicates otherwise:-

"Acute hospital", any hospital, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the department of public health.

"Bad debt", an account receivable based on services furnished to any patient which (i) is regarded as uncollectable, following reasonable collection efforts consistent with the regulations of the department, (ii) is charged as a credit loss, (iii) is not the obligation of any governmental unit or of the federal government or any agency thereof, and (iv) is not free care.

"Child", any person who is under eighteen years of age.

"Chronic hospital", any hospital which is not an acute hospital.

"Community health center", an organization which provides primary health care and other health care services in conformance with the requirements of section 330 of United States Public Law 95-626, as most recently amended by United States Public Law 97-35.

"Consumer", a natural person responsible for payment for health care services rendered by a provider.

"Department", the department of medical security.

"Dependent", the spouse and children of an employee if these persons would qualify for dependent status under the Internal Revenue Code or for whom a support order could be granted under chapters two hundred and eight, two hundred and nine, or two hundred and nine C.

"Employee", a person who performs services primarily in Massachusetts for remuneration for a Massachusetts employer; provided, however, that a person who is self-employed is not considered to be an employee.

"Employer", any employer as defined in section one of chapter one hundred and fifty-one A.

"Enrollee", a person who becomes a member of an insurance program of the department either individually or as a member of a family.

"Free care", a revenue deduction associated with the provision of services to patients who have reasonably been deemed financially unable to pay, in whole or in part, for their care, consistent with the regulations of the department.

"Health care services", supplies, care, and services of medical, surgical, optometric, dental, podiatric, chiropratic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive, or geriatric nature, including but not limited to, inpatient and outpatient acute hospital care and services, and services provided by a community health center, by a sanatorium as included in the definition of "hospital" in title XVIII of the federal Social Security Act and treatment and care compatible with such services, or by a health maintenance organization.

"Health insurance company", any company as defined in section one of chapter one hundred and seventy-five which engages in the business of health insurance.

"Health insurance plan", the medicare program or any individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization.

"Health maintenance organization", a company which provides or arranges for the provision of health care services to enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum as further defined in section one of chapter one hundred and seventy-six G.

"Hospital", any hospital licensed under section fifty-one of chapter one hundred and eleven, and the teaching hospital of the University of Massachusetts Medical School and any psychiatric inpatient facility licensed under section twenty-nine of chapter nineteen.

"Hospital agreement", an agreement between a nonprofit hospital service corporation and signatory hospitals approved by the rate setting commission pursuant to section five of chapter one hundred and seventy-six A.

"Hospital service corporation", any corporation established for the purpose of operating a nonprofit hospital service plan as provided for in chapter one hundred and seventy-six A.

"Managed health care plan", a health insurance plan which provides or arranges for, supervises and coordinates health care services to enrolled participants, including plans administered by health maintenance organizations and preferred provider organizations.

"Maximum reimbursable uncompensated care costs", the sum of (a) one hundred and fourteen per cent multiplied by the projected patient care costs for a hospital service corporation and for purchasers and third party payors who pay on the basis of charges, and (b) the payments the Title XVIII program made for free care to the acute hospital for the fiscal year beginning October first, nineteen hundred and eighty-four or July first, nineteen hundred and eighty-five trended to the then current fiscal year by the most applicable composite Data Resources, Incorporated, inflation index that was utilized under hospital agreement thirty.

"Medicaid program", the medical assistance program administered by the department of public welfare pursuant to chapter one hundred and eighteen E and in accordance with Title XIX of the federal Social Security Act.

"Medical assistance program", the medicaid program, the Veterans Administration health and hospital programs, and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

"Medical service corporation", any corporation established for the purpose of operating a nonprofit medical service plan as provided for in chapter one hundred and seventy-six B.

"Medicare program", the federal medical insurance program established by Title XVIII of the federal Social Security Act.

"Patient care costs", reimbursable costs derived in accordance with sections eighty to eighty-two A, inclusive, of chapter six A.

"Private sector share of projected patient care costs", for any hospital in a fiscal year shall be the sum of the projected patient care costs of a hospital service corporation and the projected patient care costs for purchasers and third party payors who pay on the basis of charges.

"Provider", any person, corporation, partnership, governmental unit, state institution, and other entity qualified under the laws of the commonwealth to perform or provide health care services.

"Purchasers and third party payors who pay on the basis of charges", purchasers and third party payors excluding: Title XVIII and Title XIX, other government payors, and nonprofit hospital service corporations to the extent that payments by such corporation are reduced by the uniform differential.

"Reimbursable bad debt costs", the amount of projected patient care costs which are written off as bad debt, net of amounts recovered as a result of collection efforts by the hospital or its agents.

"Reimbursable free care costs", the projected patient care costs which are written off as free care, net of any payments for free care pursuant to section thirty-two B of chapter six A and net of free care income and grants.

"Reimbursable uncompensated care costs", the sum of reimbursable bad debt costs and reimbursable free care costs.

"Resident", a person living in the commonwealth, as defined by the department by regulation; provided, that the person did not move to Massachusetts for the sole purpose of securing health insurance under this chapter; provided, further, that confinement of a person in any nursing home, hospital, or other medical institution in the commonwealth shall not by itself be sufficient to qualify such person as a resident.

"Self-employed", a person who, under the common law applicable to the employer-employee relationship, is not considered to be an employee and whose primary source of income is derived from the pursuit of a bona fide business.

"Self-insurance health plan", a plan which provides health benefits to the employees of a business, which is not a health insurance plan, and in which the business is liable for the actual costs of the health care services provided by the plan plus administrative costs.

"Small business", any business, including a business consisting only of the self-employed, in which the total of full time equivalent employees when averaged on an annual basis does not exceed fifty.

"Third-party payor", any entity including, but not limited to, the medicaid program, the medicare program, a health insurance company, a health maintenance organization, a hospital service corporation, a medical service corporation, but not including a consumer, responsible for payment to a provider for health care services rendered by such provider.

Section 3. There is hereby established the department of medical security and a commissioner of the department who shall exercise supervision and control of the department. All action of the department shall be taken by the

commissioner, or at the direction of said commissioner, by such agents or subordinate officers as he shall determine.

The purpose of the department shall be to provide, on a basis calculated to reduce or contain the costs of the program, a program of insurance coverage for health care services for persons in the commonwealth who are not otherwise eligible for or covered by a health insurance plan, a self-insurance health plan, a medical assistance program, or any other plan or program which provides for payment by a third-party payor for health care services.

The department shall be a corporation for the purpose of taking, holding, and administering in trust for the department any grant, devise, gift, or bequest and any revenue collected in any trust fund of the department.

Section 4. The secretary of human services shall appoint, with the approval of the governor, a commissioner of the department of medical security who shall serve at the pleasure of the secretary and may be removed by the secretary at any time, subject to the approval of the governor. The commissioner shall have such educational qualifications and such administrative and other experience as the secretary of human services determines to be necessary for the performance of the duties of commissioner. The commissioner shall appoint and may remove such agents and subordinate officers as the commissioner may deem necessary and may establish such divisions and subdivisions within the department as the commissioner deems appropriate from time to time. The position of commissioner shall be classified in accordance with section forty-five of chapter thirty and the salary shall be determined in accordance with section forty-six C of said chapter thirty.

Section 5. The commissioner shall appoint, with the approval of the secretary of human services, a person qualified to serve as deputy commissioner of the department. Said deputy commissioner shall perform such duties as the commissioner may determine and shall, in the case of a vacancy in the office of commissioner and during said commissioner's absence or disability, exercise the powers and perform the duties of the office of the commissioner.

The deputy commissioner shall have such educational qualifications and such administrative and other experience as the commissioner determines to be necessary for the performance of the duties of deputy commissioner. The position of deputy commissioner shall be classified in accordance with section forty-five of chapter thirty and the salary shall be determined in accordance with section forty-six C of said chapter thirty.

Section 6. In addition to all powers conferred on state agencies, the department shall have the following powers:-

(a) to make, amend, and repeal rules and regulations for the management of its affairs;

(b) to make contracts and execute all instruments necessary or convenient for the carrying on of its business;

(c) to acquire, own, hold, dispose of, and encumber personal property and to lease real property in the exercise of its powers and the performance of its duties;

(d) to enter into agreements or transactions with any federal, state, or municipal agency, or other public institution, or with any private individual, partnership, firm, corporation, association, or other entity;

(e) to manage the hospital uncompensated care pool established pursuant to section fifteen, in conjunction with the rate setting commission;

(f) to establish advisory boards to expand the participation in its decisions and to draw on the experience of representatives from all aspects of the health care financing field, including, but not limited to, providers, consumers, third-party payors, businesses, unions, and academicians;

(g) to procure insurance in connection with its duties in such amounts and from such insurers as may be necessary or desirable;

(h) to provide a health insurance program through the purchase of health insurance plans from the private sector, including managed health care plans; provided that the financial assumptions underlying these purchasing arrangements shall be made on an actuarially sound basis; and provided, further, that the department shall not, unless specifically required by the provisions of this chapter, be subject to the provisions of chapters one hundred and seventy-five, one hundred and seventy-six A, one hundred and seventy-six B, or one hundred and seventy-six G;

(i) to design and to revise a basic schedule of health care services which enrollees in the health insurance program shall be entitled to receive, such covered services to include those which typically are included in employer-sponsored health benefit plans in the commonwealth; provided, however, that the department may promulgate schedules of covered health care services which differ from the basic schedule and which apply to specific classes of enrollees;

(j) to establish a schedule of premium contributions, co-payments, co-insurance, and deductibles to be paid by enrollees in its health insurance program, including reduced premiums based on a sliding fee, and other fees and revise them from time to time, subject to the approval of the division of insurance; provided, however, that such schedule shall provide for such enrollees to pay one hundred per cent of such premium contributions if their income substantially exceeds the non-farm poverty guidelines of the United States office of management and budget;

(k) to maintain a prudent level of reserve funds to protect the solvency of the trust funds of the department; and

(l) to conduct studies concerning the status of health care access in the commonwealth, including the impact on consumers and businesses of the various programs established by this chapter.

Section 7. The department shall establish such advisory boards as it deems necessary to advise it in matters relating to the functions, duties and powers set forth in this chapter.

One advisory board shall advise the department relative to small business access to affordable health care. Such board shall consist of nine members appointed by the commissioner, five of whom shall represent small businesses, one of whom shall be an agent or broker of health insurance, one of whom shall represent a hospital service corporation, one of whom shall represent a health insurance company, and one of whom shall represent a health maintenance organization. Said board shall meet from time to time and shall advise the commissioner on all matters concerning small businesses for which the department is authorized to establish programs, and shall review menu or cafeteria plans, so-called, for the purpose of recommending whether such plans ought to be included as an allowable deduction under subsection (c) of section fourteen G of chapter one hundred and fifty-one A.

Another advisory board shall advise the department on matters relative to the uninsured. Such board shall consist of nine members appointed by the commissioner, three of whom shall be consumer representatives, one of whom shall be an organized labor representative, one of whom shall be a hospital representative, one of whom shall be a community health center representative, one of whom shall be a physician representative, one of whom shall be a health insurance representative, and one of whom shall be a business representative. Such board shall advise the department on all matters relative to the programs of the department to provide health insurance to the uninsured.

Section 8. The department shall establish health insurance programs consistent with this chapter to improve the access to health care for all residents of the commonwealth who are not covered by a health insurance plan, a self-insurance plan, or a medical assistance program. The department shall not operate as an insurance company but shall make health insurance plans available to such residents of the commonwealth through the purchase of health insurance plans, including managed health care plans, from private health insurance companies, a hospital service corporation, a medical service corporation, or health maintenance organizations, and through the brokering of health insurance for employers and consumers of health care services. The department shall endeavor to purchase health insurance plans in an economical manner, and shall enroll individuals in managed health care plans wherever practicable.

Section 9. The department shall, subject to appropriation or subject to the availability of unappropriated funds, negotiate with and purchase, on such terms as it deems to be in the best interest of the department and its enrollees, from one or more insurance companies, hospital service corporations, medical service corporations, or health maintenance organizations, a policy or policies of group general or blanket insurance providing hospital, surgical, medical, and other health insurance benefits covering the following persons: (1) residents of the commonwealth, and their dependents, who are receiving benefits under chapter one hundred and fifty-one A and who are not enrolled in health insurance plans, self-insurance health plans, or medical assistance programs, (2) employees and their dependents not eligible for group health insurance partially or fully paid for by employers and who are not enrolled in any other health insurance plans, self-insurance health plans, or medical assistance programs, and (3) all other residents of the commonwealth not enrolled in health insurance plans, self-insurance health plans, or medical assistance programs.

The department shall execute all agreements or contracts pertaining to said policies or any amendments thereto for and on behalf and in the name of the department. Said department may negotiate any contract for such term not exceeding three years as it may in its discretion deem to be the most advantageous to the department and its enrollees; provided, however, that the department shall endeavor to contract with such insurance companies, a hospital service corporation, or medical service corporations only for managed health care plans or for health insurance plans which employ other methods to reduce costs

of health care services; provided, further, that the department shall ensure that every enrollee shall have a choice of a least two plans providing health care insurance benefits; and provided, further, that not more than thirty per cent of the enrollees may be enrolled in a health insurance plan of a single health insurance company, hospital service corporation, or health maintenance organization.

The department shall promulgate regulations regarding eligibility criteria, enrollment, and termination policies. The department shall establish procedures consistent with the provisions of chapter thirty A by which individuals who participate or are seeking to participate in the health insurance program of the department may appeal determinations of noneligibility, enrollment, and termination. The department shall allow, on an annual basis, an opportunity for enrollees to transfer their enrollments among participating health insurance plans.

The department shall establish a schedule of premium contributions, copayments, deductibles, or co-insurance amounts to be paid by individual enrollees for any policy or policies purchased by the department. The schedule shall establish a sliding scale of payments for enrollees based on family income and size and any other factor or factors determined to be relevant or appropriate by the department; provided, however, that such schedule shall provide for enrollees to pay one hundred per cent of such premium contributions if their income substantially exceeds the non-farm poverty guidelines of the United States office of management and budget. The department shall establish procedures by which any enrollee may appeal the determination of his contribution.

The department shall require that any insurance company, hospital service corporation, medical service corporation, or health maintenance organization, that provides health care benefits to enrollees shall establish grievance procedures which are approved by said department and, in the case of actions taken directly by the department, the department shall establish its own grievance procedures. Such procedures shall not be subject to the requirements of chapter thirty A.

Any health insurance plan provided by the department to its enrollees through a contract with a health insurance company, hospital service corporation, medical service corporation, or health maintenance organization, shall provide a reasonable range of health care services to enrollees, shall ensure

access to an adequate range of health care providers, and shall include any mandated benefits otherwise required by law. Any such health insurance plan which constitutes a managed health care plan shall provide, at a minimum, the following benefits: inpatient and outpatient acute hospital services, inpatient and outpatient physician services, diagnostic and screening tests, preventive care, prenatal and well-baby care; medically necessary emergency health services; and all other benefits which health maintenance organizations are required by law to provide. For the purposes of this chapter, the term "physician" shall include a podiatrist acting within the limitations imposed by section thirteen of chapter one hundred and twelve.

Section 10. The department shall, subject to appropriation or subject to the availability of unappropriated funds, establish phase-in initiatives on a regional, statewide, or population basis which shall be designed to test the relative advantages and disadvantages of alternative methods of providing health insurance plans, particularly managed health care plans, to persons lacking health insurance. Such phase-in initiatives shall be established through contracts with appropriate health insurance companies, hospital service corporation, medical service corporation, or health maintenance organizations. The department shall utilize such phase-in initiatives as part of a plan to provide health insurance to the uninsured on an orderly and gradual basis. Such phase-in initiatives shall be funded for a period not to exceed two years; provided, however, that any such initiative found by the department to be an efficient and effective method of providing health care services to the uninsured may be funded by the department on a permanent basis, subject to the conditions of section nine.

The department may include in such a phase-in initiative any of the persons eligible for coverage in a health insurance program authorized by this chapter as well as persons eligible for medicare and medicaid programs. The department shall endeavor to test several alternative methods of providing health care to the uninsured, including the utilization of preferred provider arrangements established by health insurance companies. The department shall also endeavor to establish such phase-in initiatives in different regions of the state and in urban and rural settings. The department shall make a study of the effectiveness of the various phase-in initiatives.

The department shall require that any health insurance plan, including a managed health care plan, with which it contracts under this section must sub-

mit annually to the department a report of the demographics and utilization patterns of the enrollees. The department shall have the authority to conduct a financial and program audit of any such health insurance plan.

Section 11. The department shall establish programs to enable small businesses to purchase health insurance for their employees at rates which are as equivalent as possible to the rates at which large employers can purchase health insurance. Such programs shall include, but not be limited to, the following:

(1) the study of the insurance market and the practices of insurance companies, hospital service corporations, medical service corporations and health maintenance organizations, to determine the causes of the relative unavailability of health insurance plans for small businesses and of disproportionate health insurance premium costs for small businesses and to recommend and develop initiatives and strategies to improve the availability and reduce the relative cost of health insurance for small businesses;

(2) the establishment of phase-in initiatives to broker health insurance transactions between small businesses and health insurance companies, hospital service corporations, medical service corporations, and health maintenance organizations;

(3) the awarding of technical assistance grants to private organizations to assist them to act as brokers on behalf of small businesses seeking to procure health insurance plans;

(4) the establishment of a small business health insurance pool for businesses consisting of six or fewer full time equivalent employees, for the purpose of purchasing health insurance plans for employees and their dependents of businesses in the pool, and the study of the expansion of such pool to cover small businesses of up to ten full time equivalent employees; provided, however, that not more than thirty per cent in the aggregate of the employees may be enrolled in a health insurance plan of a single health insurance company, hospital service corporation, or health maintenance organization;

(5) the evaluation of the effectiveness of the initiatives of the department and tax incentives in reducing the cost of health insurance to small businesses and the impact of such voluntary incentives on the number of small businesses offering health insurance to their employees; and

(6) the management of the health insurance hardship trust fund to protect certain businesses from being overburdened by the contribution required pursuant to section fourteen G of chapter one hundred and fifty-one A.

The small business advisory board shall establish criteria to assess and evaluate the incentives and mechanisms created herein for small businesses concerning voluntary participation in a universal health insurance program. The results of said assessment and evaluation shall be reported to the department no later than March first, nineteen hundred and ninety-one, with recommendations for such changes to assure the effectiveness of such voluntary incentives. The department shall make its recommendations to the general court by July first, nineteen hundred and ninety-one concerning such voluntary incentives and any desirable statutory changes, including repeal or postponement of the contribution required by subsection (b) of section fourteen G of chapter one hundred and fifty-one A, if necessary, to assure the effectiveness of said incentives. The recommendation shall include an assessment of the impact of the hardship trust fund on small businesses, and shall include a recommendation as to whether business profits should be an element of eligibility under the hardship trust fund.

Section 12. The department shall, subject to appropriation or subject to the availability of unappropriated funds, establish a small business health insurance pool program by negotiation with private third-party payors, and purchase, on such terms as it deems to be in the best interest of the department and its enrollees, from one or more insurance companies, hospital service corporations, medical service corporations, or health maintenance organizations, a policy of group general or blanket insurance providing hospital, surgical, medical, and other health insurance benefits covering persons who are the employees and their dependents of small businesses in which the number of full-time equivalent employees does not exceed six.

The department shall execute all agreements or contracts pertaining to said policies or any amendments thereto for and on behalf of and in the name of the department. Said department may negotiate a contract for such term not exceeding three years as it may in its discretion deem to be the most advantageous to the department and the eligible small business employees; provided, however, that the department shall endeavor to purchase health insurance plans in an economical manner and shall enroll individuals in managed health care plans whenever practicable; provided, further, that the department shall ensure that every enrollee shall have a choice of at least two policies providing health care insurance benefits. The department shall promulgate regulations regarding eligibility criteria, enrollment, and termination policies.

The department shall allow, on an annual basis, an opportunity for enrollees to transfer their enrollments among participating health insurance plans.

The department shall establish a schedule of premium contributions, copayments, deductibles, or co-insurance amounts to be paid by eligible small businesses and individual enrollees; provided, however, that such schedule shall provide for enrollees to pay one hundred per cent of such premium contributions if their income substantially exceeds the non-farm poverty guidelines of the United States office of management and budget.

Section 13. The department shall, subject to appropriation or subject to the availability of unappropriated funds, establish a health insurance hardship program to assist employers severely impacted by the medical security contribution established pursuant to subsection (b) of section fourteen G of chapter one hundred and fifty-one A. Said program shall provide assistance to such employers (1) who are small businesses and (2) for whom said medical security contribution exceeds five per cent of the employer's gross revenue. Such assistance shall reduce the employer's medical security contribution to an amount equal to five per cent of the employer's gross revenues.

Such assistance shall be expended from the health insurance hardship trust fund without further appropriation in accordance with rules and regulations of the department.

The commissioner may transfer amounts from the medical security trust fund to the health insurance hardship trust fund only upon a finding by the rate review board established by section fourteen G of chapter one hundred and fifty-one A that there is a surplus in said medical security trust fund and that such transfer would be in the best interest of the employers of the commonwealth.

Section 14. The department shall establish a continuing program of investigation and study of the uninsured and underinsured in the commonwealth.

One such study shall examine the impact of the lack of adequate health insurance on residents in the commonwealth, including the effects of medicare cutbacks and medex premium increases on poor and near-poor elders and the problems of persons, particularly children, with disabilities who have difficulty obtaining adequate health insurance coverage. Such study shall document such impact and shall develop recommendations and proposals to remedy the situation.

Another such study shall examine the overall impact of programs developed by the department and the department of public welfare on the uninsured, the underinsured, and the role of employers in assisting their employees in affording health insurance.

Section 15. (1) The department shall administer an uncompensated care pool consisting of the revenues produced by the uniform statewide allowance for uncompensated care included in gross patient service revenues of acute hospitals pursuant to section eighty-three of chapter six A and of state revenues appropriated for the pool in accordance with this section.

(2) The hospital's liability to the pool shall equal the product of the uniform statewide allowance for uncompensated care times the sum of (a) the hospital's private sector share of projected patient care costs for the fiscal year, and (b) a working capital allowance specified by the commission for such fiscal year.

(3) The liability of the pool to the hospital shall equal the lesser of: (i) the reimbursable uncompensated care costs of such hospital for such fiscal year, or (ii) the maximum reimbursable uncompensated care costs of such hospital for such fiscal year.

(4) The department shall manage the pool in order to provide for prompt payments to and from hospitals, create a consistent and orderly transfer of funds to and from hospitals, and encourage maximum efficiency and appropriateness in the utilization of acute hospital services. Such management shall include the purchase and enrollment of individuals in managed health care plans. For each fiscal year, the department shall calculate the net liability of each acute hospital to the pool by subtracting from the amount of the liability of the hospital to the pool for such fiscal year the amount of the liability of the pool to the hospital for such fiscal year. The result, if positive, shall be the net hospital liability to the pool, and, if negative, shall be the net liability of the pool to the hospital. The department shall establish a system of payments by hospitals and by the pool whereby each fiscal year each hospital pays an amount of revenue equal to its net liability to the pool or receives from the pool an amount of revenue equal to the net liability of the pool to the hospital. Such system may provide for periodic payments of net liabilities to and from the pool, for the collection and expenditure by the pool of revenues equal to the amounts of hospitals' liabilities to and from the pool, or for any other payment mechanism which the department finds appro-

priate to the management of the pool and the financial needs of the hospitals.

(5) The department shall establish an appropriate mechanism for enforcing a hospital's obligation to the pool in the event that any hospital does not make a scheduled payment to the pool. Such enforcement mechanism may include the assessment of a five per cent surcharge on any withheld amount. The department shall not at any time make payments from the pool for any period in excess of amounts that have been paid into or are available in the pool for such period; provided, however, that the department may temporarily prorate payments from the pool for cash flow purposes. The department shall establish a final settlement of the pool for each fiscal year to adjust for audit findings the differences between any interim payments to or from the pool and the actual liability of each acute hospital to the pool or of the pool to the hospital.

(6) No more than one hundred thousand dollars of the amount paid by the hospitals to the pool may be expended in any fiscal year for the reasonable costs of administering the pool.

(7) Subject to the limits contained in this subdivision, the revenues in the pool shall be supplemented by amounts appropriated by the commonwealth in the event that the total liability of the pool to all hospitals for such fiscal year exceeds the total private sector liability of the pool for such fiscal year as prescribed in section eighty-seven of chapter six A. The total amount of such supplement for any fiscal year shall not exceed the sum of (a) one hundred and fifteen per cent of the amount of such total liability of the pool to all hospitals for the prior fiscal year, minus such total private sector liability for the current year and (b) fifty per cent of any amount by which the total of the liability of the pool to all hospitals for the current fiscal year exceeds one hundred and fifteen per cent of the amount of such liability of the pool to all hospitals for the prior fiscal year. The department shall not pay any amount of such liability of the pool to all hospitals which exceeds the sum of the total private sector liability to the pool for the fiscal year and the amount of the commonwealth's supplement for such fiscal year pursuant to this subdivision. The department shall prorate any resulting shortfall among all hospitals. The department and the rate setting commission shall periodically evaluate and shall determine jointly whether a supplement pursuant to this subdivision is necessary for any fiscal year.

(8) Payments by acute hospitals to the pool and state revenues appropriated for the supplement provided in subdivision (7) shall be placed in an uncompensated care trust fund established in section seventeen. Amounts placed in the fund may be expended by the department for the purposes of said pool, including lawful expenditures for the purpose of reducing hospitals' write-offs for bad debt and free care.

(9) The department shall promulgate regulations establishing criteria for hospital credit and collection policies, after consultation with the Massachusetts hospital association and other concerned organizations as identified by the department, to ensure that hospitals make reasonable efforts to collect payment for hospital services prior to attributing those services to bad debt or free care. In developing such criteria, the department shall identify those populations which shall not require collection action. Such policies shall be in conformance with applicable credit laws of the commonwealth and the United States. The department shall also promulgate regulations necessary to manage the uncompensated care pool pursuant to this section, including, but not limited to: regulations providing audit standards for the pool, regulations establishing an enforcement mechanism pursuant to subdivision (5), and regulations containing reasonable controls on utilization which shall include the purchase and enrollment of individuals in managed health care plans and which are consistent with such controls contained in the most current hospital agreement and in regulations pursuant to Title XVIII of the Social Security Act. Regulations regarding utilization control shall be adopted only after a public hearing.

Section 16. There is hereby established a medical security trust fund, which shall be administered and expended by the department without further appropriation. Said fund shall consist of all premiums, fees, contributions, and other monies paid into the state treasury and credited to the trust fund as provided in this chapter; all property and securities acquired by and through the use of monies belonging to the trust fund and all interest thereon; less amounts transferred to the health insurance hardship trust fund pursuant to section thirteen; less payments therefrom for payments to health insurance companies, nonprofit hospital and medical service companies, health maintenance organizations, for refunds or abatements for enrollees or former enrollees. All monies appropriated for the use of the department for the purpose of providing health insurance for the uninsured and all monies earned on

the amounts in said trust fund shall be deposited or retained in said trust fund. In addition, all of the contributions collected pursuant to section fourteen G of chapter one hundred and fifty-one A shall be deposited in the trust fund.

There shall be within the medical security trust fund at least three separate accounts described as follows:

(a) an unemployment health insurance contribution account which shall consist of all employer contributions required pursuant to subsection (a) of section fourteen G of chapter one hundred and fifty-one A and premiums paid by enrollees and which shall be used exclusively for the payments of premiums for health insurance plans provided to persons receiving unemployment compensation;

(b) a medical security contribution account which shall consist of all employer contributions required pursuant to subsection (b) of section fourteen G of chapter one hundred and fifty-one A, premiums paid by enrollees, other voluntary contributions by other persons or entities, and appropriations from the commonwealth and which shall be used exclusively for the payments of premiums for health insurance plans provided to eligible employees and their families; and

(c) a public sector responsibility account which shall consist of all premiums paid by enrollees, voluntary contributions by other persons and entities, and appropriations from the commonwealth and which shall be used for payments of premiums for health insurance plans provided to all other residents of the commonwealth who lack health insurance.

Amounts in said accounts shall be kept separate and not commingled except upon approval of the rate review board established pursuant to paragraph (h) of section fourteen G of chapter one hundred and fifty-one A and a finding by said board that temporary commingling of said accounts is a short-term measure necessary to ensure the solvency of the trust fund. Any amounts so commingled shall be restored to the appropriate account within ninety days.

The commissioner shall from time to time requisition from said trust fund such amounts as he deems necessary to meet the current obligations of the department and estimated obligations for a reasonable future period.

Section 17. There is hereby established an uncompensated care trust fund, which shall be administered and expended by the department without further appropriation. The fund shall consist of all amounts paid by hospitals to the

uncompensated care pool established by section fifteen; all appropriations for the purpose of uncompensated hospital care; all property and securities acquired by and through the use of monies belonging to the trust fund and all interest thereon; less payments therefrom for the purposes of the pool pursuant to section fifteen. All interest earned on the amounts in said trust fund shall be deposited or retained in said trust fund.

The commissioner shall from time to time requisition from said trust fund such amounts as the commissioner deems necessary to meet the current obligations of the department for the purposes of said trust fund and estimated obligations for a reasonable future period.

Section 18. There is hereby established a health insurance hardship trust fund which shall be administered and expended by the department without further appropriation. The fund shall consist of all penalties collected pursuant to section fourteen G of chapter one hundred and fifty-one A; all appropriations for the purpose of section thirteen; all property and securities acquired by and through the use of monies belonging to the trust fund and all interest thereon; all amounts transferred from the medical security fund in accordance with section thirteen; less payments therefrom for the purposes of the health insurance hardship program. All interest earned on the amounts in said trust fund shall be deposited or retained in said trust fund.

The commissioner shall from time to time requisition from said trust fund such amounts as he deems necessary to meet the current obligations of the department for the purposes of said trust fund and estimated obligations for a reasonable future period.

Section 19. The department shall provide that all residents of the commonwealth will have access to basic health insurance or managed care at a reasonable cost by March first, nineteen hundred and ninety-two, subject to appropriation or subject to the availability of unappropriated funds. To achieve the goal of universal access to health care, the following programs shall be established in accordance with the following schedule:

(1) As of April first, nineteen hundred and eighty-eight, or as soon as possible thereafter, the department shall begin the following responsibilities:

(a) initiation of a study of the adequacy of health insurance for certain residents of the commonwealth pursuant to section fourteen;

(b) initiation of a study of the relationship of small businesses to the insurance market pursuant to clause (1) of section eleven; and

(c) the purchase and enrollment of individuals in managed health care plans pursuant to section fifteen.

(2) As of July first, nineteen hundred and eighty-eight, the following programs shall become effective:

(a) the program of supplemental health care coverage to disabled adults as established by section six A of chapter one hundred and eighteen E;

(b) the program of supplemental health coverage to disabled children as established by section six B of chapter one hundred and eighteen E; and

(c) at least two phase-in initiatives to provide health insurance for the uninsured in accordance with section ten.

(3) As of October first, nineteen hundred and eighty-eight, the department shall assume the management of the uncompensated care pool pursuant to section fifteen.

(4) As of July first, nineteen hundred and eighty-nine, the following programs shall become effective:

(a) completion of the study authorized in clause (b) of paragraph (1) of this section;

(b) the small business health insurance pool as established by section eleven and other initiatives authorized by clauses (2), (3), and (4) of section eleven;

(c) the tax credit for businesses providing health insurance to their employees for the first time as authorized in subsection (e) of section six of chapter sixty-two and in section thirty-one D of chapter sixty-three; and

(d) additional phase-in initiatives to provide health insurance for the uninsured in accordance with section ten.

(5) On September first, nineteen hundred and eighty-nine, the requirement that all college and university students have health insurance pursuant to section seven B of chapter fifteen A shall become effective.

(6) On January first, nineteen hundred and ninety, the program to provide health insurance to persons receiving unemployment insurance pursuant to subsection (1) of chapter fourteen G of chapter one hundred and fifty-one A shall become effective. Health insurance benefits shall become available to eligible persons as of April first, nineteen hundred and ninety. In addition, as of said date, the department shall complete the study authorized in clause (a) of paragraph (1) of this section.

(7) As of January first, nineteen hundred and ninety-one, the commonwealth shall reassume the cost of hospital care for general relief recipients as authorized by section one A of chapter one hundred and seventeen.

(8) As of July first, nineteen hundred and ninety-one, the department shall complete the study of the phase-in initiatives as authorized in section ten.

(9) On January first, nineteen hundred and ninety-two, the program to provide health insurance to employed persons pursuant to section fourteen G of chapter one hundred and fifty-one A shall become effective. Health insurance benefits shall become available to eligible persons as of April first, nineteen hundred and ninety-two.

(10) As of January first, nineteen hundred and ninety-three, the department shall complete a study of the impact of the programs authorized or referred to in this chapter on the availability of health care for the uninsured in the commonwealth as authorized in section fourteen.

Section 20. Nothing in this chapter shall be construed to authorize any person not licensed to practice medicine to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.

SECTION 46. Chapter 151A of the General Laws is hereby amended by inserting after section 14F the following section:-

Section 14G. (a) Each employer, except those employers who employ five or fewer employees, subject to the provisions of section fourteen, fourteen A, or fourteen C shall pay, in the same manner and at the same times as the director prescribes for the contribution required by section fourteen, an unemployment health insurance contribution computed by multiplying the wages paid its employees by twelve hundredths of one per cent.

(b) Each employer, except those employers who employ five or fewer employees, subject to the provisions of section fourteen, fourteen A, or fourteen C shall pay, in the same manner and at the same times as the director prescribes for the contribution required by section fourteen, a medical security contribution for each employee computed by multiplying the wages paid each employee by twelve per cent. For the purposes of this section, "employee" shall not include the following employees of any employer: (i) any employee who has been employed by such employer for fewer than ninety days from date of hire, (ii) any employee who normally works for fewer than thirty hours

per week; provided, however, that any head of household who has dependent children living at home and is working at least twenty hours per week or any employee having worked at least five hundred and twenty hours in the prior six months shall be considered to be an employee for the purposes of this section; (iii) any employee who is hired to perform a service for a period of less than five months; (iv) any seasonal agricultural employee, who for the purposes of this section shall be defined as an individual who is employed in agricultural employment of a seasonal or other temporary nature; and (v) any employee who is covered by a group or nongroup health benefit plan which is financed without any participation by the employer, who is enrolled in the medicare program, or who is covered by a government operated medical assistance program; and provided, further, that any employee covered by a health insurance plan established pursuant to section nine of chapter one hundred and eighteen F shall be considered to be an employee for the purposes of this section. Each employee as defined in section one shall be presumed to be an employee as included in this section unless the employer certifies to the director, in such form and manner as the director may require, that such employee should not be included under the provisions of this section. Each employer may require any employee to verify his health insurance status pursuant to such rules and regulations as the director shall promulgate. No employer may require an applicant for employment to disclose his health insurance status or that of his spouse, dependents, or other family members. In no case may an employer discriminate against such applicant on the basis of said applicant's health insurance status. Any person aggrieved by a violation of the preceding two sentences may institute within three years of such violation a civil action for injunctive relief and any damages thereby incurred. Any employer found to be in violation pursuant to the action of the aggrieved person shall reimburse such reasonable attorney fees and court costs incurred in the protection of rights granted as shall be determined by the court.

(c) An employer may deduct from the amount owed for each employee under subsection (b) its average expenses per employee for providing health insurance coverage or other health care benefits for its employees, allowable for the current quarter by the Internal Revenue Service as a deductible business expense; provided, however, that any nonincorporated employer may deduct from the amount owed for each employee under subsection (b) its average expenses per employee for providing health insurance coverage or other health care ben-

efits for its employees as reported and allowed pursuant to rules and regulations promulgated by the director; and provided, further, that such deduction for any employer shall not reduce the contribution for any employee below zero.

(d) Such unemployment health insurance contribution and such medical security contribution shall be paid to the director in accordance with the procedures prescribed by the director. The receipts from such contributions shall not be deposited in the state unemployment compensation fund, but shall be impressed with a trust and dedicated, through the state treasurer as trustee, to the medical security trust fund established in chapter one hundred and eighteen F. Prior to the depositing of the receipts, the director may deduct all administrative costs incurred as a result of this section, including an amount as determined by the United States secretary of labor in accordance with federal cost rules, but in no calendar year may such deduction exceed five per cent of the amounts collected pursuant to this section.

(e)(1) For the purposes of this section, the term "wages" shall not include that part of remuneration which, after remuneration equal to the medical security wage base with respect to employment with such employer has been paid to an individual during the calendar year, is paid to such individual during such year. For the purposes of this paragraph, remuneration shall include remuneration paid to an individual during the calendar year with respect to employment with a transferring employer, as that term is used in subsection (n) of section fourteen.

(2) For the purposes of this section, the term "medical security wage base" shall mean fourteen thousand dollars for the calendar years nineteen hundred and ninety to nineteen hundred and ninety-two, inclusive. For each subsequent calendar year the medical security wage base shall equal the product of (i) the medical security wage base for the then previous calendar year and (ii) the sum of one and the health insurance inflation rate for the then previous calendar year, as reported by the rate review board established pursuant to subsection (h).

(f)(1) The provisions of this section shall not apply to an employer newly subject to this chapter, as defined in paragraph (3) of subsection (i) of section fourteen, until it has been an employer for not less than the twelve consecutive months' period specified in paragraph (1) of subsection (b) of section fourteen.

(2) During the first calendar year in which this section applies to an employer newly subject to this chapter pursuant to paragraph (1): (i) such employer's unemployment health insurance contribution shall be computed by substituting in subsection (a) the words "four hundredths of one per cent" for the words "twelve hundredths of one per cent", and (ii) such employer's medical security contribution shall be computed by substituting in subsection (b) the words "four per cent" for the words "twelve per cent".

(3) During the second calendar year in which this section applies to an employer newly subject to this chapter pursuant to paragraph (1): (i) such employer's unemployment health insurance contribution shall be computed by substituting in subsection (a) the words "eight hundredths of one per cent" for the words "twelve hundredths of one per cent", and (ii) such employer's medical security contribution shall be computed by substituting in subsection (b) the words "eight per cent" for the words "twelve per cent".

(g) Except where inconsistent with the provisions of this section, the terms and conditions of this chapter which are applicable to the payment of and the collection of contributions or payments in lieu of contributions shall apply to the same extent to the payment of and the collection of such unemployment health insurance contribution and such medical security contribution; provided, however, that said contributions shall not be credited to the employer's account or the solvency account established pursuant to section fourteen, fourteen A, or fourteen C of this chapter.

(h) There shall be a rate review board composed of the secretary for administration and finance or his designee, the secretary of human services or his designee, and the secretary of economic affairs or his designee. Said board shall determine the rate of health insurance inflation for the previous year to be applied to the medical security wage base for the subsequent calendar year and shall certify said rate to the director on or before November thirtieth of the year preceding the year to which the medical security wage base is to be applied. This inflation rate shall be the average percentage increase in premiums for accident and sickness insurance policies issued in the commonwealth during the then current calendar year over premiums for accident and sickness insurance policies issued in the commonwealth during the then previous calendar year.

On or before November thirtieth of each year, the commissioner of the department of medical security shall certify to said board the estimated costs

for the subsequent year of health insurance coverage provided by said department of medical security for individuals and their families who (1) are eligible for the health insurance program established by section nine of chapter one hundred and eighteen F for individuals receiving unemployment insurance compensation or (2) are eligible for the health insurance program established by said section nine of said chapter one hundred and eighteen F for employees. Such estimated costs shall be exclusive of amounts to be covered by premiums, co-payments, deductibles and co-insurance to be paid by covered individuals and any anticipated appropriations. The rate review board shall further adjust such estimated costs to reflect prudent levels of reserves sufficient to carry out the responsibilities of the department for said health insurance programs. If in the opinion of the said board the rate of health inflation on the medical security wage base as calculated above would be inadequate to properly fund said health insurance programs, said rate of health insurance inflation shall be appropriately adjusted.

(i) Any employer who fails to comply with the provisions of this section shall pay a penalty of not less than thirty-five dollars or five dollars for each employee, whichever is greater, for every day during which the failure continues, in addition to restitution for any amounts owed to the medical security trust fund as a result of such failure to make a correct contribution.

Any penalties collected pursuant to this section shall be deposited in the heath insurance hardship trust fund established by chapter one hundred and eighteen F.

Any employer, in accordance with rules and regulations promulgated by the director, who relies in good faith on statements by employees relative to their health insurance status shall not be liable for any penalty or restitution for failure to comply with the provisions of this section caused by misstatements of such employees.

Any contribution under this section shall be allowable as a business expense.

(j) Any employer notified of a determination of the director that it is subject to the provisions of subsection (a) or subsection (b), or notified of a determination of the director that an individual is an employee for the purposes of subsection (b) and subsection (c), may request a hearing on such determination. The request for hearing shall be filed within ten days after mailing of the notice of the determination. If a hearing is requested, the

director shall give the employer a reasonable opportunity for a fair hearing before an impartial hearing officer designated by the director. The conduct of such hearing shall be in accordance with the procedures prescribed by subsection (b) of section thirty-nine. Any employer aggrieved by the decision following such hearing may appeal such decision. Such appeal shall be in accordance with the procedures prescribed by sections forty to forty-two, inclusive. Unless action is taken under section forty, the decision of the director shall be final on all questions of fact and law.

SECTION 47. The definition of "facility" in section 71A of said chapter 151A, as appearing in the 1986 Official Edition, is hereby amended by inserting after the word "business", in line 31, the word:- hospital.

SECTION 48. Section 47C of said chapter 175, as so appearing, is hereby amended by adding the following paragraph:-

Any policy of insurance or any employers' health and welfare fund, as described in this section, shall provide in addition to the coverage described in the preceding paragraph benefits for expense of residents of the commonwealth covered under such policy or fund, for the provision of preventive and primary care services for children. For the purposes of this paragraph preventive care services shall mean services rendered to a dependent child of an insured from the date of birth through the attainment of six years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the next year, annually until age six. Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematrocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the physician.

SECTION 49. Section 110 I of said chapter 175, as so appearing, is hereby amended by adding the following two subsections:-

(d) Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to such divorced or separated spouse at such person's last known address, together with notice of the right to reinstate coverage retroactively to the date of cancellation.

(e) Claims paid on behalf of a divorced or separated spouse or on behalf of a dependent who is not residing with the member shall be paid to the physician, hospital or other provider of covered services or to the person on whose

behalf such services were performed, unless the person is a minor child. In the event the person on whose behalf such services were performed is a minor, payment shall be made to the physician, hospital or other provider of such services or to the parent or custodian with whom the child resides.

SECTION 50. Section 5 of chapter 176A of the General Laws, as so appearing, is hereby amended by striking out the sixth to ninth paragraphs, inclusive, and inserting in place thereof the following four paragraphs:-

In negotiating a contract with a nonprofit hospital service corporation, a hospital shall have the right to designate the Massachusetts hospital association, incorporated, or any other state-wide, hospital member organization as its agent for negotiating such contract. Each individual hospital, however, shall retain the right to accept or reject all or part of such negotiated contract.

When any such corporation is informed that such a negotiating agent represents one or more hospitals, such corporation shall have the right to propose to the agent, and thereafter negotiate, a hospital contract that would be applicable to some or all of the hospitals represented by the agent.

Such a negotiating agent that represents more than one hospital shall have the right to propose to said corporations, and thereafter negotiate, a hospital contract which would be applicable to some or all of the hospitals represented by it.

The commission shall not disapprove any contract between a hospital and said corporations on the grounds that a term or terms of the contract are similar or identical to the terms of a proposed or approved contract between any other hospital and such corporations, or that the hospital was represented by a negotiating agent which represented one or more other hospitals.

SECTION 51. Said section 5 of said chapter 176A, as so appearing, is hereby further amended by inserting after the word "record", in line 169, the words:- appeal such an order, filing, decision or other action with the division of administrative law appeals as established by section four H of chapter seven if (1) the appeal is by an acute-care hospital and (2) the total amount subject to appeal is less than one hundred thousand dollars, or.

SECTION 52. Section 8B of said chapter 176A, as so appearing, is hereby amended by adding the following paragraph:-

Any contract, as described in this section, shall provide as benefits to all subscribers and members in addition to the benefits described in the pre-

ceding paragraph the provision of preventive and primary care services for children. For the purposes of this paragraph preventive and primary care services shall mean services rendered to a dependent child or a subscriber or member from the date of birth through the attainment of six years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the year annually until age six. Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood test and urinalysis as recommended by the physician.

SECTION 53. Section 8F of said chapter 176A, as so appearing, is hereby amended by adding the following two paragraphs:-

(d) Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to such divorced or separated spouse at such person's last known address, together with notice of the right to reinstate coverage retroactively to the date of cancellation.

(e) Claims paid on behalf of a divorced or separated spouse or on behalf of a dependent who is not residing with the member shall be paid to the physician, hospital or other provider of covered services or to the person on whose behalf such services were performed, unless the person is a minor child. In the event the person on whose behalf such services were performed is a minor, payment shall be made to the physician, hospital or other provider of such services or to the parent or custodian with whom the child resides.

SECTION 54. Said chapter 176A is hereby further amended by inserting after section 10 the following section:-

Section 10A. Other provisions of this chapter and chapter one hundred and seventy-six G notwithstanding, any nonprofit hospital service corporation, either individually or by contract with a corporation formed under chapter one hundred and seventy-six B, one or more hospitals licensed under chapter one hundred and eleven, one or more health maintenance organizations under chapter one hundred and seventy-six G, physicians registered under chapter one hundred and twelve and other providers of health care licensed or registered pursuant to chapter one hundred and eleven or one hundred and twelve or one or more insurance companies licensed under chapter one hundred and seventy-five, may establish, maintain, operate, own or offer preferred provider arrangements which

have been approved by the commissioner under chapter one hundred and seventy-six I.

Provided that contracts governing payment for services rendered to patients covered, by a selective product may not be tied to contracts governing payment for services rendered to other patients.

The entire arrangement or contract between a medical service corporation and a hospital service corporation which involves the operation by one of those entities of a preferred provider program shall be subject to all of the requirements of chapter one hundred and seventy-six I.

SECTION 55. Section 1 of chapter 176B of the General Laws, as appearing in the 1986 Official Edition, is hereby amended by inserting after the definition of "Medical service corporation" the following definition:-

"Nonparticipating provider", a registered physician under the provisions of chapter one hundred and twelve or other provider of health care services licensed under the laws of the commonwealth who is not party to an agreement in writing with a medical service corporation to perform medical services for subscribers and covered dependents who are covered under a preferred provider arrangement approved by the commissioner under chapter one hundred and seventy-six I.

SECTION 56. Said section 1 of said chapter 176B, as so appearing, is hereby further amended by striking out the definition of "Nonprofit medical service plan" and inserting in place thereof the following definition:-

"Nonprofit medical service plan", a plan operated by a medical service corporation under the provisions of this chapter, whereby the cost of medical and chiropractic services and other health services furnished to subscribers and covered dependents is paid by the corporation, to participating physicians, to participating chiropractors, to nonparticipating providers if the subscriber is covered by a Preferred Provider Organization, and to such other physicians as are provided for herein, and to providers of other health services.

SECTION 57. Section 3 of said chapter 176B, as so appearing, is hereby amended by striking out the first paragraph and inserting in place thereof the following paragraph:-

The by-laws of a medical service corporation may contain any lawful provisions approved by the commissioner, and shall provide that a majority of the incorporators or members of the corporation and a majority of the directors

shall at all times be persons who are not providers of health services licensed under the laws of the commonwealth and that a majority of the directors shall at all times be persons who are or agree to become subscribers to the nonprofit medical service plan. The by-laws of such a corporation may define the qualifications of those persons eligible to become subscribers as provided in section five. Any such corporation may adopt such rules and regulations as may be consistent with the provisions of this chapter. Such rules and regulations and any changes or amendments thereto shall be filed with the commissioner thirty days before their effective dates and shall be subject to subsequent disapproval by the commissioner.

SECTION 58. Said section 3 of said chapter 176B, as so appearing, is hereby further amended by adding the following three paragraphs:-

Other provisions of this chapter and chapter one hundred and seventy-six G notwithstanding, any medical service corporation, either individually or by contract with a corporation formed under chapter one hundred and seventy-six A, one or more hospitals licensed under chapter one hundred and eleven, one or more health maintenance organizations under chapter one hundred and seventy-six G, physicians registered under chapter one hundred and twelve and other providers of health care licensed or registered pursuant to chapter one hundred and eleven and chapter one hundred and twelve or one or more insurance companies licensed under chapter one hundred and seventy-five, may establish, maintain, operate, own or offer plans, programs or arrangements which have been approved by the commissioner under said chapter one hundred and seventy-six I.

A medical service corporation shall not condition its willingness to allow any physician or other provider of health services to participate in a preferred provider arrangement on such physician's or provider's agreeing to enter into other contracts or arrangements with the medical service corporation or any other persons that are not part of or related to such preferred provider arrangement.

The terms and conditions offered by a medical service corporation that must be met or agreed to by physicians and other providers of health services desiring to enter into a preferred provider arrangement or plan shall be fair and reasonable. No physician or other provider of health services willing to meet the reasonable terms and conditions proposed or offered in connection with such preferred arrangements shall be denied the opportunity to enter into

an agreement with such medical service corporation. The terms and conditions offered by a medical service corporation that must be met or agreed to by physicians and other providers of health services desiring to enter into such agreements shall be subject to the disapproval of the commissioner.

SECTION 59. Section 4 of said chapter 176B, as amended by section 4 of chapter 621 of the acts of 1987, is hereby further amended by striking out the first paragraph and inserting in place thereof the following paragraph:-

Any medical service corporation may enter into contracts with its subscribers, and with participating physicians, chiropractors, nurse midwives, optometrists, dentists, podiatrists, psychologists, licensed independent clinical social workers, certified clinical specialist in psychiatric and mental health nursing and other providers of health services licensed under the laws of the commonwealth for such medical, chiropractic, visual, surgical, midwifery, mental health and other health services as may lawfully be rendered by them to subscribers and their dependents and shall make payment for such services either, or directly to participating providers or to nonparticipating providers if the subscriber is covered by a Preferred Provider Organization, as provided for in this chapter. The form of any and all agreements with such participating physicians, chiropractors, nurse midwives, optometrists, dentists, podiatrists, psychologists, licensed independent clinical social workers, certified clinical specialist in psychiatric and mental health nursing and other providers of health services shall at all times be subject to the written approval of the commissioner, but no participating provider shall be denied the right to enter into any agreement with any medical service corporation by reason of any unfair or arbitrary discrimination. The methods of compensating such physicians, chiropractors, nurse midwives, optometrists, dentists, podiatrists, psychologists, licensed independent clinical social workers, certified clinical specialist in psychiatric and mental health nursing and other providers of health services for their services to subscribers, or covered dependents shall at all times be subject to the written approval of the commissioner.

SECTION 60. Section 4C of said chapter 176B, as appearing in the 1986 Official Edition, is hereby amended by adding the following paragraph:-

Any subscriptions certificate, as described in this section, shall provide as benefits to all subscribers and members in addition to those benefits described in the preceding paragraph the provisions of preventive and primary

care services for children. For the purposes of this paragraph preventive and primary care services shall mean services rendered to a dependent child or a subscriber or member from the date of birth through the attainment of six years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the year annually until age six. Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests and urinalysis as recommended by the physician.

SECTION 61. Section 6B of said chapter 176B, as so appearing, is hereby amended by adding the following two paragraphs:-

(d) Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to such divorced or separated spouse at such person's last known address, together with notice of the right to reinstate coverage retroactively to the date of cancellation.

(e) Claims paid on behalf of a divorced or separated spouse or on behalf of a dependent who is not residing with the member shall be paid to the physician, hospital or other provider of covered services or to the person on whose behalf such services were performed, unless the person is a minor child. In the event the person on whose behalf such services were performed is a minor, payment shall be made to the physician, hospital or other provider of such services or to the parent or custodian with whom the child resides.

SECTION 62. Section 7 of said chapter 176B, as so appearing, is hereby amended by inserting after the first paragraph the following four paragraphs:-

No such agreement may be terminated by a medical service corporation unless such corporation shall first have given the participating physician or other provider of health services a written statement of the charges against him or her, an opportunity for hearing, reasonable notice of the time and place of hearing, and a written decision accompanied by a statement of the reasons for the decision. A participating physician or other provider of health services shall also have (a) the right, within sixty days after receipt by a medical service corporation from a provider of a completed claim form for covered services, to receive (i) payment, (ii) notice of the reasons for any nonpayment or (iii) notice of additional information or documentation necessary to establish entitlement to payment; (b) the right, upon request follow-

ing denial of entitlement to payment for covered service because such services were determined by a medical service corporation to be unnecessary for the medical or other health care of a subscriber or covered dependent to a formal peer review process; (c) the right to inspect a listing of his or her usual charges maintained by a medical service corporation; (d) the right to inspect a listing of customary charges maintained by a medical service corporation which are applicable to his or her services; and (e) the right to a copy of the bylaws of a medical service corporation and rules and regulations adopted by the board of directors of such a corporation.

A participating physician or other professional provider of health services may terminate his or her agreement with a medical service corporation at any time upon giving not less than one year notice in writing to the medical service corporation and each of his patients to terminate as of a date specified in such notice; provided however, that any physician or provider giving such notice shall not terminate any physician-patient relationship after the one-year notice period with any subscriber or covered dependent unless and until arrangements have been made for appropriate referrals, continuation, and follow-up care. Until such time as a patient or subscriber has been referred to and has established a physician-patient relationship with another participating physician, the medical services corporation shall continue to provide compensation to the terminating physician or provider at the rate allowed for such services prior to termination and said terminating physician or provider shall not be allowed to charge the patient any additional amount for such services.

Nothing in this section shall limit or derogate from the rights of beneficiaries of health insurance under Title XVIII of the federal Social Security Act to the benefits of chapter four hundred and seventy-five of the acts of nineteen hundred and eighty-five.

Every participating provider shall receive from a medical service corporation not less than annually a handbook, written in plain English and subject to the commissioner's approval, that explains said corporation's methods of payment, including but not limited to, all requirements for the submission of charges, all restrictions on payments, an explanation of the usual and customary charge system and methods of updating a provider's charge profile. Said handbook shall be made available to participating providers at least six months prior to any annual update of charge profiles.

SECTION 63. The first paragraph of section 12 of said chapter 176B, as so appearing, is hereby amended by adding the following sentence:- If the board fails to resolve a dispute or controversy not involving a medical service corporation's methods of compensating such participating physician or provider within one year, any such participating physician or other participating provider of health services and any such subscriber or person may commence an action against such medical service corporation with respect to such dispute or controversy by filing a complaint in the superior court for the county in which he resides, which action may be maintained as a class action, subject to the provisions of rule twenty-three of the Massachusetts rules of civil procedure and shall be assigned by the court for a speedy completion of the pleadings, pretrial discovery, and hearing on the merits.

SECTION 64. Section 5A of chapter 176G of the General Laws, as so appearing, is hereby amended by adding the following two paragraphs:-

(d) Notice of cancellation of coverage of the divorced or separated spouse of a member shall be mailed to such divorced or separated spouse at such person's last known address, together with notice of the right to reinstate coverage retroactively to the date of cancellation.

(e) Claims paid on behalf of a divorced or separated spouse or on behalf of a dependent who is not residing with the member shall be paid to the physician, hospital or other provider of covered services or to the person on whose behalf such services were performed, unless the person is a minor child. In the event the person on whose behalf such services were performed is a minor, payment shall be made to the physician, hospital or other proivder of such services or to the parent or custodian with whom the child resides.

SECTION 65. The General Laws are hereby further amended by inserting after chapter 176H the following chapter:-

CHAPTER 176I.

PREFERRED PROVIDER ARRANGEMENTS.

Section 1. The following words as used in this chapter shall have the meanings given to them in this section unless the context clearly requires otherwise:

"Commissioner", the commissioner of insurance.

"Covered person", any policy holder or other person on whose behalf the organization is obligated to pay for or provide health care services.

"Covered services", health care services which the organization is obligated to pay for or provide under the health benefit plan.

"Emergency care", covered services delivered to a covered person who has suffered an accidental bodily injury or illness which reasonably requires the beneficiary or insured to seek immediate medical care.

"Health benefit plan", the health insurance policy, subscriber agreement, or contract between the covered person and an organization which defines the covered services and benefit levels available.

"Health care provider", a provider of health care services licensed or registered pursuant to chapter one hundred and eleven or chapter one hundred and twelve.

"Health care services", services rendered or products sold by a health care provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

"Organization", an insurer authorized to write accident and health insurance under chapter one hundred and seventy-five, a nonprofit hospital service corporation authorized under chapter one hundred and seventy-six A, a nonprofit medical service corporation authorized under chapter one hundred and seventy-six B, a dental service corporation authorized under chapter one hundred and seventy-six E, an optometric service corporation authorized under chapter one hundred and seventy-six F, a health maintenance organization authorized under chapter one hundred and seventy-six G, or any other entity approved by the commissioner under this chapter.

"Preferred provider", a health care provider or group of health care providers who have contracted to provide specified covered services.

"Preferred provider arrangement", a contract between or on behalf of an organization and a preferred provider which complies with all the requirements of this chapter.

Section 2. An organization may enter into a preferred provider arrangement with one or more health care providers upon a determination by the commissioner that the organization and the arrangement comply with the requirements of this chapter and the regulations hereunder. An organization shall not condition its willingness to allow any health care provider to participate in a preferred provider arrangement on such health care provider's agreeing to enter into other contracts or arrangements with the organization that are not part of or related to such preferred provider arrangements.

An organization shall submit information concerning any proposed preferred provider arrangements to the commissioner for approval in accordance with regulations promulgated by the commissioner. Said regulations shall comply with the applicable provisions of chapter thirty A of the General Laws. Said information shall include at least the following: (a) a description of the health services and any other benefits to which the covered person is entitled; (b) a description of the locations where and the manner in which health services and other benefits may be obtained; (c) a copy of the evidence of coverage; (d) copies of any contracts with preferred providers; (e) a description of the rating methodology and rates. The arrangement shall meet the following standards:

(a) Standards for maintaining quality health care, including satisfying any quality assurance regulations promulgated by any state agency;

(b) Standards for controlling health care costs;

(c) Standards for assuring reasonable levels of access of health care services and an adequate number and geographical distribution of preferred providers to render those services;

(d) Standards for assuring appropriate utilization of health care service; and

(e) Other standards deemed appropriate by the commissioner.

Section 3. Organizations may offer health benefit plans which provide for incentives for covered persons to use the health care services of preferred providers. Such health benefit policies or plans shall meet at least the following minimum requirements:

(a) Benefit levels for health care services rendered by nonpreferred providers shall be at least eighty per cent of the benefit levels for services rendered by preferred providers.

(b) If a covered person receives emergency care and cannot reasonably reach a preferred provider, payment for care related to the emergency shall be made at the same level and in the same manner as if the covered person had been treated by a preferred provider;

(c) A procedure shall be specified for resolving consumer complaints and grievances; and

(d) A procedure shall be specified for the disclosure to covered persons of the names of current preferred providers by specialty and geographic area.

Section 4. An organization shall not refuse to enter into a preferred provider arrangement with a health care provider on the basis of religion, race, color, national origin, age, sex, marital status, sexual orientation, or such provider's relationships with any other organization. The selection of preferred providers shall be based primarily on cost, availability and quality of covered services. The terms and conditions offered by an organization that must be met or agreed to by physicians and other professional providers of health care services desiring to enter into a preferred provider arrangement shall be subject to the disapproval of the commissioner if said terms and conditions are not consistent with the purposes, policies and provisions of this chapter.

Section 5. An organization shall maintain financial and utilization records for its preferred provider arrangements and activities in a form separate or separable from the financial and utilization records of other operations and activities carried on by the organization.

Section 6. An organization shall furnish to the commissioner evidence of a surety bond, reinsurance or other financial resources in an amount satisfactory to the commissioner as a guarantee that obligations to covered persons will be performed.

Section 7. An organization which enters into a preferred provider arrangement shall file annually with the commissioner, within one hundred and twenty days of the close of its fiscal year, a report covering its prior fiscal year. The report shall include:

(a) the number of covered persons under health benefit plans which include preferred provider arrangements;

(b) financial and utilization date of health benefit plans which include preferred provider arrangements;

(c) a list of preferred providers; and

(d) such other information as the commissioner may reasonably require.

Section 8. In addition to other powers specified in this chapter, the commissioner may, after due hearing:

(a) promulgate appropriate rules and regulations necessary to the administration and enforcement of this chapter;

(b) issue an order requiring any person or organization to cease and desist from violating any provision of this chapter or any rules, regulations, or order hereunder;

(c) require any person or organization found to have violated any provision of this chapter or any rule, regulation or order hereunder to forfeit an amount not to exceed ten thousand dollars for any single violation; and

(d) institute a rehabilitation or liquidation proceeding in accordance with the provisions of section one hundred and eighty A through one hundred and eighty L of chapter one hundred and seventy-five.

Section 9. An organization which offers or administers a health benefit plan under a preferred provider arrangement shall be subject to all of the provisions of its enabling or licensing statute and of any other provisions of the general laws applicable thereto, including but not limited to any benefits required to be provided by law. In connection with any preferred provider arrangement and activities, an organization shall be considered to be an insurance company for the purposes of sections one hundred and ninety-three C, one hundred and ninety-three D, one hundred and ninety-three L, one hundred and ninety-three M and one hundred and ninety-three N of chapter one hundred and seventy-five.

Section 10. Any organization which has entered into preferred provider arrangements prior to the effective date of this chapter shall file an application within ninety days of the effective date of this chapter, and may continue to operate until such time as its application may be denied.

Section 11. (a) Every organization operating a preferred provider arrangement shall annually pay an assessment equal to two and twenty-eight hundredths per cent of the gross premiums received during the preceding calendar year for coverage of covered persons residing in this commonwealth; provided, however, that no assessment shall be imposed on premiums for medicare supplemental coverage. In calculating said gross premiums, there shall be deducted any amounts eligible for deduction pursuant to section twenty-four of chapter sixty-three and any amounts that are subject to the assessment imposed by section one hundred and ten L of chapter one hundred and seventy-five or by section ten A of chapter one hundred and seventy-six G. All said assessments, including interest thereon or penalties, shall be deposited in the general fund.

(b) The assessment imposed by this section shall be collected and administered by the commissioner of revenue. Every organization operating a preferred provider arrangement shall annually, on or before March fifteenth, make a return to said commissioner giving such information as said commissioner may

deem necessary for the determination of the assessment for the preceding calendar year. The payment and collection of the assessments imposed by this section shall, to the extent consistent with this section, be governed by the provisions of chapters sixty-two C and sixty-three B. This provision shall take effect for premiums received after December thirty-first, nineteen hundred and eighty-eight.

SECTION 66. Section 28 of chapter 208 of the General Laws, as appearing in the 1986 Official Edition, is hereby amended by striking out the fourth and fifth sentences and inserting in place thereof the following two sentences:- When the court makes an order for maintenance or support of a child, said court shall determine whether the obligor under such order has health insurance or other health coverage on a group plan available to him through an employer or organization or has health insurance or other health coverage available to him at a reasonable cost that may be extended to cover the child for whom support is ordered. When said court has determined that the obligor has such insurance or coverage available to him, said court shall include in the support order a requirement that the obligor exercise the option of additional coverage in favor of the child or obtain coverage for the child.

SECTION 67. Section 34 of said chapter 208, as so appearing, is hereby amended by striking out the fourth and fifth sentences and inserting in place thereof the following three sentences:- When the court makes an order for alimony on behalf of a spouse, said court shall determine whether the obligor under such order has health insurance or other health coverage available to him through an employer or organization or has health insurance or other health coverage available to him at reasonable cost that may be extended to cover the spouse for whom support is ordered. When said court has determined that the obligor has such insurance or coverage available to him, said court shall include in the support order a requirement that the obligor do one of the following: exercise the option of additional coverage in favor of the spouse, obtain coverage for the spouse, or reimburse the spouse for the cost of health insurance. In no event shall the order for alimony be reduced as a result of the obligor's cost for health insurance coverage for the spouse.

SECTION 68. The third paragraph of section 32 of chapter 209 of the General Laws, as so appearing, is hereby amended by striking out the second and third sentences and inserting in place thereof the following two sentences:- When the court makes an order for maintenance or support on behalf

of a spouse or child, said court shall determine whether the obligor under such order has health insurance or other health coverage available to him through an employer or organization or has health insurance or other health coverage available to him at reasonable cost that may be extended to cover the spouse or child for whom support is ordered. When said court has determined that the obligor has such insurance or coverage available to him, said court shall include in the support order a requirement that the obligor exercise the option of additional coverage in favor of the spouse and child or obtain coverage for the spouse and child.

SECTION 69. Subsection (a) of section 9 of chapter 209C of the General Laws, as so appearing, is hereby amended by striking out the second and third sentences and inserting in place thereof the following two sentences:- When the court makes an order or judgment for maintenance or support of a child, said court shall determine whether the obligor under such order or judgment has health insurance or other health coverage available to him through an employer or organization or has health insurance or other health coverage available to him at reasonable cost that may be extended to cover the child for whom support is ordered. When said court has determined that the obligor has such insurance or coverage available to him, said court shall include in the support judgment or order a requirement that the obligor exercise the option of additional coverage in favor of the child or obtain coverage for the child.

SECTION 70. Section 18A of chapter 273 of the General Laws, as so appearing, is hereby amended by striking out paragraph (b) and inserting in place thereof the following paragraph:-

(b) When the court reviews or modifies an order for support on behalf of a spouse or child, said court shall determine whether the obligor under such order has health insurance or other health coverage available to him through an employer or organization or has health insurance or other health coverage available to him at reasonable cost that may be extended to cover the spouse or child for whom support is ordered. When said court has determined that the obligor has such insurance or coverage available to him, said court shall include in the support order a requirement that the obligor exercise the option of additional coverage in favor of the spouse and child or obtain coverage for the spouse and child.

SECTION 71. Section 10 of chapter 273A of the General Laws, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

When the court makes an order for support on behalf of a spouse or child, said court shall determine whether the obligor under such order has health insurance or other health coverage available to him through an employer or organization or has health insurance or other health coverage available to him at reasonable cost that may be extended to cover the spouse or child for whom support is ordered. When said court has determined that the obligor has such insurance or coverage available to him, said court shall include in the support order a requirement that the obligor exercise the option of additional coverage in favor of the spouse and child or obtain coverage for the spouse and child.

SECTION 72. All acute hospitals shall be offered a successor agreement to hospital agreement thirty by a nonprofit hospital service corporation which shall implement and serve to administer the reimbursement elements included in sections seventy-nine to one hundred and two of chapter six A of the General Laws, inserted by this act. This agreement shall have a term of four years. If such nonprofit hospital service corporation cancels the reimbursement sections of this agreement, such corporation shall pay the hospital charges for covered services as such charges are calculated pursuant to sections seventy-nine to ninety-eight, inclusive, of said chapter six A but without application of section eighty-eight of said chapter six A. In the event that an acute hospital chooses not to enter into the reimbursement section of the hospital agreement then the approved gross patient service revenues for such hospital shall be the amount of such revenues in effect for the last fiscal year of hospital agreement thirty. The reimbursement section of the agreement may be supplemented by amendments consistent with said sections of said chapter six A where such amendments are the result of negotiations between a hospital service corporation and individual hospitals or the Massachusetts Hospital Association as provided for in section five of chapter one hundred and seventy-six A. For each acute hospital, the rate-setting commission shall not approve a successor hospital agreement to hospital agreement thirty unless it includes the reimbursement elements in said sections seventy-nine to one hundred and two, inclusive, of said chapter six A, plus the contents of this section. The successor agreement shall be presented by a nonprofit hospital service corporation to the commission for approval within sixty days after the effective date of this section, and for hospitals with a fiscal year beginning on or about October first, nineteen hundred and eighty-seven, shall be retroactive to October first, nineteen hundred and eighty-seven.

Upon final passage of this legislation, the rate setting commission shall promulgate emergency regulations which shall allow hospitals to effect charge levels on an estimated interim level for the lesser of ninety days or until the successor agreement to hospital agreement thirty is approved by the commission.

The successor agreement to hospital agreement thirty shall include a yearly settlement provision for the difference between the effective and actual differential of a nonprofit hospital service corporation pursuant to the methodology for said settlement contained in hospital agreement thirty.

SECTION 73. The joint committee on administration established under hospital agreement twenty-seven, and continued in hospital agreements twenty-nine and thirty, shall be continued.

Said committee shall report to the rate-setting commission by July first, nineteen hundred and eighty-eight, recommendations for the following matters:

(a) development of diagnosis related group cost weights for diagnosis related groups without weights;

(b) development of a new volume statistic for surgical day care recognizing surgical day care intensity levels; and

(c) establishing criteria for ensuring that each year's data is consistent with the agreed upon version of the diagnosis related groups.

SECTION 74. The auditor of the commonwealth shall conduct a study and examination of nongroup and medicare supplementary health care programs offered by nonprofit hospital and medical service corporations organized under chapters one hundred and seventy-six A and one hundred and seventy-six B of the General Laws, by health maintenance organizations operating under chapter one hundred and seventy-six G of the General Laws, by health insurance companies operating under chapter one hundred and seventy-five of the General Laws, by preferred provider organizations, so-called, by self-insured employee welfare benefit plans, by third-party administrators, and by health claims administration programs.

Said auditor shall study the need for, the availability of, the financing for, and supportive governmental incentives available for nongroup and medicare supplementary health care programs in the commonwealth.

Said auditor shall conduct an audit of nongroup and medicare supplementary health care programs offered by nonprofit hospital and medical service corporations. Such audit shall determine and examine the losses from nineteen hun-

dred and seventy-seven through nineteen hundred and eighty-seven attributable to such programs and the financial impact of the statutory responsibilities and benefits conferred on such nonprofit hospital and medical corporations.

Said auditor may be assisted by the secretary of consumer affairs and business regulation and the commissioner of insurance in the performance of his duties under this section. All nonprofit hospital and medical service corporations, health maintenance organizations, health insurance companies, preferred provider organizations, so-called, self-insured employee welfare benefit plans, third-party administrators, and health claims administration programs referred to in the first paragraph shall cooperate with and make all information available to said auditor or his designee in the performance of his study and examination. Any organization voluntarily providing trade secret or commercial or financial information to said auditor may request that such information be maintained as confidential information by said auditor. Information so provided which is accepted by the state auditor as confidential shall not be public records for purposes of clause twenty-sixth of section seven of chapter four and chapter six of the General Laws.

Said auditor may consult, as necessary, with state agencies and elected officials, health care providers, consumer representatives, and other parties in the course of his study and examination.

Said auditor shall make an interim report on the results of his study and examination and audit to the governor, the house and senate committees on ways and means, the joint committee on insurance, the joint health care committee, and the special commission on health insurance reform created pursuant to section thirty-six of this act on or before July first, nineteen hundred and eighty-eight and shall submit his final audit report not later than October first, nineteen hundred and eighty-eight. All nonprofit hospital and medical service corporations, health maintenance organizations, health insurance companies, preferred provider organizations, so-called, self-insured employee welfare benefit plans, third-party administrators, and health claims administration programs shall have an opportunity to review and comment on the interim and final reports thirty days prior to their submission to the governor and said committees of the general court. These comments shall be incorporated in the reports as filed.

For the purposes of funding such study and examination, said auditor is hereby authorized to assess a sum not to exceed one hundred thousand dollars

in the aggregate against all nonprofit hospital and medical service corporations, health maintenance organizations, and health insurance companies in proportion to the gross revenue obtained by each organization in providing health care programs in the commonwealth.

SECTION 75. There is hereby established a special commission on health insurance reform which shall consist of a representative of a nonprofit hospital and medical service corporation, a representative of the Life Insurance Association of Massachusetts, a representative of the office of the attorney general, a representative of health care consumer groups to be appointed by the governor, a representative of health maintenance organizations to be appointed by the governor, and a chairman to be appointed by the governor. Said commission shall be appointed within thirty days of the effective date of this section and shall be charged with examining and determining what alternatives, if any, exist to provide citizens of the commonwealth with an improved health care delivery and health insurance system, by improving the competitive environment in the health insurance system, and the affordability and availability of actuarially sound nongroup and medicare supplementary health insurance coverage. Said commission shall consult with health care consumer groups regarding such study and examination before undertaking it. Said commission shall also study the implications of the provisions of this act relative to preferred provider arrangements and relative to the relationship between nonparticipating providers and hospital and medical service corporations; said study shall be completed prior to the effective date of such provisions. Before making recommendations to the governor, said commission shall consult with health care consumer groups regarding its recommendations and shall give such groups an opportunity to respond at a public hearing and in writing. Any written responses shall be incorporated in the commission's final report.

The commission shall make its recommendations to the governor and the general court on or before October first, nineteen hundred and eighty-eight and shall issue a final report on or before November fifteenth, nineteen hundred and eighty-eight. The report of the commission shall include recommendations concerning maintenance of the current status by nonprofit hospital and medical service corporations, alternative methods to fulfill to the insurer of last resort responsibilities of the nonprofit hospital and medical service corporations, if needed, or reorganization of these corporations as a mutual insurance company under the provisions of chapter one hundred and seventy-five of the General Laws.

SECTION 76. Notwithstanding the provisions of sections twenty-five B to twenty-five H, inclusive, of chapter one hundred and eleven of the General Laws, no determination of need shall be required for any substantial capital expenditure for construction, including renovations, additions, or total replacement, for major movable equipment, or for new technology related to provision of services or for any substantial change in services or increase in staff if the health care facility is any hospital facility of the Shriner's Hospitals for Crippled Children.

SECTION 77. (1) The provisions of this section shall apply to the uncompensated care pool until the department of medical security assumes responsibility for managing the uncompensated care pool on October first, nineteen hundred and eighty-eight. For purposes of this section, the terms defined in section thirty-one of chapter six A of the General Laws, and in sections one and fifteen of chapter one hundred and eighteen A of the General Laws shall have the meanings given them therein. The rate-setting commission shall calculate each acute hospital's net estimated liability to the uncompensated care pool established by said section fifteen of chapter one hundred and eighteen F of the General Laws using the same data and estimates as the rate setting commission uses to calculate the uniform allowance for uncompensated care pursuant to section eighty-seven of chapter six A of the General Laws. The commission shall notify the hospital and said pool's administrative agent of the estimated net liability to said pool, or adjustment thereof, no later than thirty days in advance of the first periodic payment and fifteen days in advance of any subsequent adjustment to said periodic payment.

(2) The commission shall establish an interim payment system to assure periodic payments of estimated liabilities to and from the pool. Acute hospitals that have an estimated annual net liability to the pool shall be required to pay monthly a percentage of their estimated net annual liability to said pool which will ensure that the full annual net liability is paid, and acute hospitals to which said pool owes an estimated net liability shall receive monthly from said pool a percentage of this estimated annual net liability which will ensure that the full annual net liability is received. Each hospital's payments to or from the voluntary uncompensated care pool in operation from October first, nineteen hundred and eighty-seven until the effective date of this section of this act shall be credited against its net liability to or from the pool.

(3) The commission shall contract with a nonprofit hospital service corporation to act as its administrative agent for payments to and from said pool. Said agent shall maintain any cash balance in the pool in a separate interest-bearing account and any interest on this account shall accrue and be applied to the final settlement of said pool. Said agent shall disburse payments determined by the commission subject to paragraph (4). Said agent shall provide the commission with the detail of monthly receipts to and payments from said pool at the end of each monthly period, including the name of any acute hospital which did not make its scheduled periodic payment to said pool. Upon proper notification by said agent and verification by the commission, said commission shall instruct said agent to offset payments on hospital claims from the agent in the amount of the payment owed to the pool, plus a surcharge of five per cent on that amount, and to transfer the withheld funds into said pool.

(4) At no time shall said agent make any periodic pay-outs from said pool in excess of monies that have been paid into the pool for the same period. Each acute hospital having an estimated net liability to said pool shall make payment to said agent on the first day of each month. On the fifteenth day of the same month, the agent shall make payment to each hospital that is to receive a periodic payment for an amount which shall equal said pool's periodic net liability to the hospital multiplied by the lesser of (i) one, or (ii) the ratio of said pool's total receipts to the pool's total expected receipts for that period; except that any late payments to said pool made in one period for prior periods shall be added on a pro rata basis to the next periodic payment to hospitals.

(5) The nonprofit hospital service corporation shall, when acting upon the instructions of the commission and as its administrative agent, be immune from all liability, legal actions, damages or other penalties for administration of said pool, except for its own fraudulent or negligent acts. If said agent offsets claims payments as ordered by the commission, it shall be deemed not to be in breach of contract, and hospitals to which payment is offset under order of the commission must serve all members and subscribers of the nonprofit hospital service corporation in accordance with hospital agreement thirty or other hospital agreements then in effect. For the cost of administering said pool for the fiscal year ending on or about October first, nineteen hundred and eighty-eight, the commission may pay the administrative agent from said pool its reasonable costs up to one hundred thousand dollars.

(6) There shall be rendered, at the conclusion of the year ending on or about October first nineteen hundred and eighty-eight, an audit opinion of said agent's administration of said pool, if said agent is appointed. Such audit opinion shall be made by the outside auditors employed by said agent to audit its other financial operations, and the audit results shall be reported to the commission for review.

SECTION 78. The provisions of this act shall be deemed severable, and if any part of this act shall be adjudged unconstitutional or invalid, such judgment shall not affect the validity of other parts thereof.

SECTION 79. Except as otherwise provided, the provisions of subsection (a) of section fourteen G of chapter one hundred and fifty-one A of the General Laws shall apply to wages paid on or after January first, nineteen hundred and ninety. The provisions of subsections (b) and (c) of said section fourteen G shall apply to wages paid on or after January first, nineteen hundred and ninety-two.

SECTION 80. Notwithstanding the provisions of: section ten of chapter three hundred and seventy-two of the acts of nineteen hundred and eighty-two; section nine of chapter three hundred and forty-seven of the acts of nineteen hundred and eighty-four; or sections twenty-two or twenty-four of said chapter five hundred and seventy-four of the acts of nineteen hundred and eighty-five; the provisions of sections thirty-one, fifty-nine, fifty-nine A, sixty, sixty-two, sixty-three, sixty-four, sixty-five, sixty-five A, sixty-six, sixty-seven, sixty-nine, seventy, seventy-one, seventy-two, seventy-six, and seventy-seven, of chapter six A of the General Laws and of the sixth, seventh, eighth and ninth paragraphs of section five of chapter one hundred and seventy-six A of the General Laws, shall be applicable to services provided after September thirtieth nineteen hundred and eighty-seven by community health centers and by acute hospitals with fiscal years beginning on or about October first and for services provided after June thirtieth, nineteen hundred and eighty-eight for hospitals with fiscal years beginning on July first. Notwithstanding the provisions of section twenty-three of said chapter five hundred and seventy-four of the acts of nineteen hundred and eighty-five, the provisions of sections thirty-seven to forty-seven of chapter six A of the General Laws shall apply only to nonacute hospitals effective October first, nineteen hundred and eighty-seven.

SECTION 81. Effective October first, nineteen hundred and ninety-one for hospitals with fiscal years beginning on or about October first and July first, nineteen hundred and ninety-two for hospitals with fiscal years beginning on July first, acute hospital rates shall be governed by the provisions of sections thirty-seven to forty-seven of chapter six A of the General Laws, notwithstanding the language in said provisions limiting their applicability to nonacute hospitals, and the provisions of section eighty-seven of said chapter six A of the General Laws, of section fifteen of chapter one hundred and eighteen F of the General Laws, and of the sixth, seventh, eighth and ninth paragraphs of section five of chapter one hundred and seventy-six A of the General Laws shall not apply to such acute hospitals.

SECTION 82. The executive office of administration and finance shall, subject to appropriation, contract for a comprehensive, six-year study of the impact of mandatory health care in the commonwealth as proposed herein. Such study shall include, but not be limited to, projected costs to the commonwealth for the following programs: the establishment of voluntary incentives for small business, including technical assistance grants, tax credits, the Health Insurance Hardship Trust Fund, and an experimental project of state brokering health care for small business; the commonwealth's share of the uncompensated care pool; the operation of the department of medical services; all pilot programs established to provide health care coverage to the uninsured; all costs to the commonwealth, beginning in nineteen hundred and ninety-two, for providing health care to those individuals not otherwise provided for herein including demographic information relative to said individuals; and the assumption of all hospital costs of general relief recipients. Said study shall also assess the costs to all colleges and universities, students, and the commonwealth associated with the implementation of mandatory health care coverage for college students as provided herein. Said study shall also assess the economic impact of mandatory health care coverage on the cost of doing business in the commonwealth and the impact, if any, on the competitiveness of Massachusetts firms. Said study shall also include the projected costs to the commonwealth for the Medicaid program, including any changes to the existing program as provided herein. Said study shall provide not less than one periodic report each year to the house and senate committees on ways and means and the joint committee on health care.

SECTION 83. The department of medical services shall establish a fund for the purposes of addressing the critical labor shortage facing hospitals. Said fund shall be administered by the department according to regulations promulgated by the department and approved by the secretary of the executive office of human services and by the secretary of administration and finance. Projects financed through said fund shall include, but not be limited to, training of health care workers, the development of career ladders within the health care professions, and the establishment of day care programs at hospitals and other health care facilities.

Funds for this pool shall be provided for by an assessment on each acute-care hospital equal to one-tenth of one per cent of the gross patient service revenues of such hospital approved under chapter six A of the General Laws.

SECTION 84. The secretary of human services shall, following consultation with the statewide health coordinating council, the Massachusetts league of community health centers, the Massachusetts Medical Society, the Massachusetts Hospital Association, the statewide area health education center program, the deans of the Massachusetts medical schools, members of the general court and any other groups the secretary deems appropriate, develop criteria within one hundred and twenty days of the effective date of this act, regarding the identification and designation of medically underserved and health manpower shortage areas in the commonwealth.

The secretary of human services shall convene and chair a task force which shall include the commissioner of education, the chancellor of the board of regents, and representatives from the New England board of higher education, the statewide Massachusetts area health education center program, the deans of the Massachusetts medical schools and any other groups the secretary deems appropriate. Said task force shall, within one hundred and eighty days of the effective date of this act, report back to the legislature on recommendations for legislation with respect to the development of a Massachusetts Health Service Corps. Such recommendations shall, at a minimum, include a provision whereby individuals enrolled in medical schools whose education is supported by state funds shall be required to sign a contract whereby the student agrees to a service or monetary payback. Such service payback shall be completed in placement sites or areas designated and approved by the secretary of human services pursuant to this section. Such recommendations shall also include

guidelines regarding the duration of such service payback and the amount of alternative monetary payback. Such recommendations shall include a provision whereby individuals enrolled in medical schools whose education is supported by state funds shall be required to register with the department of public welfare as a provider in the commonwealth's medicaid program for the same number of years as the physician received state financial assistance.

SECTION 85. There is hereby established a special commission to consist of the commissioner of administration, the secretary of the executive office of human services, the secretary of the executive office of elder affairs, the commissioner of the group insurance commission, a representative of the life insurance association of Massachusetts, a representative of the hospital association of Massachusetts, a representative of the Massachusetts Medical Society, a member of the business roundtable, a representative of the Massachusetts federation of nursing homes, a representative of the Massachusetts league of community health centers, a representative of the Massachusetts association of health maintenance organizations, and a recipient of medicaid; provided, however, that each representative shall be designated by the respective organization represented and the medicaid recipient shall be appointed by the governor.

Said commission is hereby authorized and directed to investigate, study and prepare plans relative to the complete or partial consolidation of the medicaid program, the department of medical security, and the group insurance commission.

Said commission may travel within the commonwealth and may conduct public hearings. Said commission shall file its recommended plan, including recommended legislation, regarding such consolidation with the clerks of the house and senate no later than January first, nineteen hundred and eighty-nine. Said plan shall contain a proposal capable of being implemented upon July first, nineteen hundred and eighty-nine, in the event that such recommended legislation is enacted.

Said commission shall develop recommendations to allow the commonwealth to utilize resources more efficiently through the exercise of consolidated purchasing power, without jeopardizing the quality of medical care provided to participants in the medicaid program, the department of medical security, and the group insurance commission.

SECTION 86. In the event of enactment of federal legislation to establish a national health insurance program, the department of medical security shall, within sixty days of such enactment, submit a report to the house and senate committees on ways and means analyzing the relationship of such national program to the programs of the department and recommending legislation to eliminate any duplication between such state and national programs or to provide that such programs are coordinated in such a manner as to ensure maximum, cost-efficient access to health care for the citizens of the commonwealth.

SECTION 87. The provisions of section seventy shall not be construed to amend or alter in any way the provisions of chapter one hundred and ninety-two of the acts of nineteen hundred and eighty-four including the prohibition on "balance billing", so-called provided by section seven of chapter one hundred and seventy-six B of the General Laws.

SECTION 88. The commonwealth's cost for implementation of this act shall not exceed two hundred and sixty-one million dollars for the fiscal year nineteen hundred and ninety and the cost for implementation shall not exceed four hundred and seventy-seven million dollars for the fiscal year nineteen hundred and ninety-two, except by vote of the general court.

SECTION 89. There is hereby established a special commission to consist of six members of the house of representatives and three members of the senate for the purpose of making an investigation and study relative to health maintenance organizations in the commonwealth to ascertain whether any such health maintenance organizations utilize financial incentives with respect to doctors which could induce a compromise of patient care and could adversely affect the quality of patient care. Said commission shall also ascertain whether health maintenance organizations should be required to inform subscribers about the financial incentives and penalties that are placed on doctors who care for them. Said commission shall report to the general court the results of its investigation and study, and its recommendations, if any, together with drafts of legislation necessary to carry its recommendations into effect, by filing the same with the clerk of the house of representatives on or before the last Wednesday of April, nineteen hundred and eighty-nine, who shall forward the same to the joint legislative committee on health care.

SECTION 90. The rate setting commission is hereby authorized and directed to study the desirability and feasibility of establishing reasonable maximum rates of reimbursement which nursing pools, so-called, may be allowed to

charge. Said commission shall file a report of the study, including recommended legislation, if any, with the joint committee on health care no later than October first, nineteen hundred and eighty-eight.

SECTION 91. The department of public health is hereby authorized and directed to study the desirability and feasibility of establishing minimum standards for the registration and operation of nursing pools, so-called. Said department shall file a report of the study, including recommended legislation, if any, with the joint committee on health care no later than October first, nineteen hundred and eighty-eight.

SECTION 92. Sections two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen, fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, fifty, seventy-two, seventy-three, seventy-seven, eighty, and eighty-three of this act shall take effect as of October first, nineteen hundred and eighty-seven; provided, however, acute hospitals with fiscal years beginning on July first shall be governed through June thirtieth, nineteen hundred and eighty-eight by the provisions of chapter six A of the General Laws as it read immediately prior to the passage of this act; and provided, further, that the provisions of said chapter six A as it read immediately prior to the passage of this act shall govern issues concerning hospital rates for fiscal years to which they applied. Sections one, twenty-one, twenty-three, thirty-one, thirty-eight, forty-five, forty-seven, fifty-one, seventy-four, seventy-five, seventy-six, seventy-eight, seventy-nine, eighty-one, eighty-five, ninety, and ninety-one of this act shall take effect upon its passage. Sections forty and forty-one of this act shall take effect on July first, nineteen hundred and eighty-eight. Sections fifty-four, fifty-five, fifty-six, fifty-seven, fifty-eight, fifty-nine, sixty-two, sixty-three, sixty-five and eighty-seven of this act shall take effect on January first, nineteen hundred and eighty-nine. Section twenty-two of this act shall take effect on September first, nineteen hundred and eighty-nine. Sections twenty-eight and twenty-nine of this act shall take effect for taxable years beginning on or after January first, nineteen hundred and ninety, but shall not ap-

ply to tax years beginning on or after January first, nineteen hundred and ninety-two. Section forty-six of this act shall take effect on January first, nineteen hundred and ninety, subject to the provisions of section seventy-nine of this act.

House of Representatives, April 13, 1988.

Passed to be enacted, George Lenecan, Speaker.

In Senate, April 13, 1988.

Passed to be enacted, William M. Bulger, President.

April 21, 1988.

Approved,

at One o'clock and 25 minutes, P. M.

Michael S. Dukakis, Governor.

STATE OF NEW YORK

3d Rdg. 1976 Print. 5812, 5970 Intro. 4656

IN SENATE

June 3, 1965

Introduced by COMMITTEE ON RULES—read twice and ordered printed, and when printed to be committed to the Committee on Rules—reported favorably from said committee, committed to the Committee of the Whole, ordered to a third reading, amended and ordered reprinted, retaining its place in the order of third reading

AN ACT

To amend the public health law, in relation to the regulation of hospitals and health services, repealing section twenty-eight hundred, subdivision [illegible] and four of section thirty-seven hundred [illegible] of section thirty-seven of the social welfare law, and subdivision one-a of section two hundred fifty of the insurance law relating thereto

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The public health law is hereby amended by inserting therein a new article, to be article twenty-eight, to read as follows:

ARTICLE 28

HOSPITALS

Section 2800. Declaration of policy and statement of purpose.

2801. Definitions.

2802. Approval of contracts.

EXPLANATION—Matter [illegible]

FACTS ABOUT HANYS' MEMBERS

Voluntary and Public Hospitals	224
Acute Care Beds (Acute and Pediatric)	59,250
Discharges	2,078,387
Total Number of Patient Days	17,497,323
Average Length of Stay	8.4
Average Occupancy Rate	80.9%
Clinic Visits	5,599,163
Emergency Service Visits	5,306,175
Voluntary and Public Residential Health Care Facilities	94
RHCF Beds	12,072
Total Employees (Full-Time Equivalents)	240,391
Total Salaries ($ Million)	$5,776.5
Total Expenses ($ Million)	$11,300.3
Ratio of Salaries to Expenses	51.1%

Source: HANYS' *Fiscal Pressures Survey, 1987* (1986 Data)

Introduction

The mission of health care facilities in New York State is to provide access to high quality, cost-effective health care services for all citizens of this state. This mission is also shared by the Hospital Association of New York State whose primary goal is the promotion of better health care for all the people of the State of New York through the coordinated efforts of its membership. Each year the delivery of health care services to all residents becomes more complex and challenging. Hospitals and other health care providers are continually confronted with new challenges as they strive to fulfill their mission.

The three major factors shaping health care in New York State are access to services, quality of care, and financing. Access encompasses both the physical availability of health care services and the financial ability to secure those services. In this respect, the economic viability of our society and our willingness to commit sufficient funds to the poor are key to ensuring access for all residents of our state.

Another immediately apparent factor affecting access is demographics. New York State, like the rest of the country, has a growing population of elderly who are living longer and requiring more health care services. Methods must be found to reconfigure the health care system so that sufficient services are available in the most cost-effective and efficient settings. It is becoming increasingly important for health care facilities to not only meet the medical and social needs of the elderly, but also to serve as the major link in an evolving continuum of care.

Health care services are delivered by an array of professionals including physicians, nurses, and various specialized technicians. The increased severity and complexity of patient care needs require even more professional care, particularly nursing care. At the same time that demand is increasing for specialized staff, the supply of available nurses and other allied health professionals is rapidly decreasing. This shortfall poses serious access problems and challenges for health care facilities as they seek to recruit and retain health care professionals.

The second major factor shaping the future of health care delivery is the quality of health care services and patients' perception of that care. The pressure on health care providers to contain costs has led to questions about its impact on quality of care. Today's health care consumers — both patients and their insurers — are better informed and more prudent in their decision-making. They are demanding to be shown the value of services provided for their money, and this in turn has contributed to increased scrutiny of the quality of health care services.

Financing is the factor which has the most obvious impact on health care delivery. The financial stresses on state governments and concerns over the effect of health care costs upon the ability of businesses to remain competitive have led to strong cost containment pressures by both public and private payors. Thus, the pressures on health care facilities to do more with less have increased substantially and will continue to increase.

Medical technology, among other issues, is impacted by all three factors — access, quality and financing. Medical science has developed extraordinary capabilities in the diagnosis and treatment of illness, effectively managing diseases which 20 or even 10 years ago would have been fatal. These capabilities have added immeasurably to the cost of health care and have created new dilemmas concerning the relative allocation of resources and the extent of patients' rights. Special populations such as the mentally ill, substance abusers, and persons with AIDS are particularly hard-hit by decisions hinging on the relative allocation of resources.

The interaction of access, quality and financing issues are creating severe stresses for health care facilities. However, the hospital community is committed to working with the Legislature to confront these challenges and meet the shared goal of ensuring access by all residents to high quality health care services.

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Shortage of Professional Health Care Personnel

Proposals

- Enhance the reimbursement formula to enable New York State hospitals to offer competitive salaries with which to recruit and retain health care professionals such as nurses, physical therapists, respiratory therapists, pharmacists, and radiology technicians.
- Develop solutions, such as increasing educational programs and scholarship incentives, to address areas where shortages and retention of existing health care professionals are an issue.

Demand for health care workers has increased dramatically due to the growth in the elderly population and the need for medical services for more critically ill patients, including AIDS victims. At the same time demand is increasing, the supply of available health care professionals — both nurses and allied medical personnel — is declining alarmingly. In the area of nursing, qualified personnel are leaving this state's hospitals at a rate 14% higher than the national average. Nursing school enrollments have also declined precipitously, a phenomenon which reflects expanded opportunities for women and the less attractive image and salaries provided by the profession. Declining enrollments are also occurring in educational programs for other health care professionals such as physical therapists, respiratory therapists, pharmacists, and radiology technicians.

In order to resolve this increasing problem of the shortage of health professionals, a partnership between the health care community, the Legislature, regulatory agencies, and the educational system is needed. A program to inform students about the variety of health care careers available to them is a first step in attempting to increase enrollment into these professions. To develop such programs, relationships must be strengthened with high school science teachers, school nurses, and guidance counselors. Increasing targeted scholarships, low-cost loans, and other financial incentives for students interested in health care careers may also improve enrollments in these fields. Financial incentives such as scholarships and tuition reimbursement should encourage high school graduates to enter health care professions and also encourage existing employees to seek educational advancement. In order for health care facilities to offer these financial incentives, however, the reimbursement formula for these facilities must be enhanced.

The above proposals are a critical first step in attempting to resolve the growing shortage of health professionals. However, in order to begin to resolve this problem, we must shape these proposals and other solutions as a comprehensive package, and avoid implementing short-term solutions in a piecemeal fashion.

Medicaid Income Eligibility Levels

Proposal

Amend the Social Services Law to provide for Medicaid income eligibility standards which establish a consistent relationship between eligibility levels and poverty income levels.

In 1970, income eligibility levels for the Medicaid program equaled poverty income levels. In recent years, eligibility levels for one-and two-person families have been raised so that persons receiving Supplemental Security Income (SSI) payments can retain eligibility for Medicaid. However, this has not been the case for larger families where expenditures have been contained by keeping income eligibility levels low, resulting in fewer families eligible for Medicaid program coverage. In 1987, Medicaid income eligibility levels, as a percent of poverty income, ranged from 80% for three-member households to 46% for seven-member households. In addition, the existing income eligibility level differentials of $100 between three or more member families are so small that they are relatively insignificant. As a result, a growing number of the poor — 80% of which are part of working member households — have been disenfranchised from health insurance coverage and from access to cost-effective primary and preventive care services.

According to a report released this year by Hospital Trustees of New York State, between 1980 and 1984 the number of New Yorkers lacking health insurance increased by 255,800, or 24%, to 2.4 million. The largest increases in the uninsured population between 1980 and 1984 occurred in rural (57%) areas with smaller increases in urban (20%) and suburban (17%) areas. The largest single increase in those without insurance was among those with incomes below the poverty level; this population increased by 51%, from 507,000 in 1980 to 765,000 in 1984.

As New York's health care delivery system moves toward a more competitive environment, in both its payment and regulatory approach, the long-range access needs of the uninsured must be addressed. One of the most cost-efficient and administratively feasible methods of meeting the needs of those living in poverty is the expansion of Medicaid program eligibility. In 1987, legislation to reform this area through a two-step process was introduced in both houses, and passed in the Assembly. As a first step in Year one (1), this proposal would have cut the difference between the income eligibility level and the poverty level by 50%; in the next year, income eligibility levels would be increased to be consistent with the poverty levels. Future income eligibility levels would be adjusted to assure consistency as the poverty level changed. As part of the post-1987 hospital reimbursement agreement, a study will be conducted and a demonstration project established to address the indigent care insurance issue. In 1988, efforts must continue to ensure increases in the Medicaid income eligibility level to make them consistent with the poverty levels. It is also imperative that steps be taken to find a comprehensive solution to the ever worsening problem of the medically uninsured.

Health Planning

Over the past decade, health planning has evolved into a regulatory construct whose major emphasis has been cost containment and control. With the new emphasis on quality of care and access, the current health system agency (HSA) network as a statewide entity needs reform. Most importantly, with few exceptions, health planning does not reflect local concerns. Most HSAs are viewed as merely branch offices of the Department of Health, rather than as advocates on behalf of the local residents. The loss of federal funding for HSAs and the increased reliance on State funding has reinforced this view of the local planning bodies.

While there is a need to create a linkage between local and state planning, State-level planning must be distanced from the State's ongoing regulatory mission. In addition, input from other relevant State agencies engaged in important aspects of health planning, such as addiction services and mental hygiene, must be an integral part of the planning process, not just viewed as peripheral local concerns.

Primary activities of a health planning entity should be to provide a public forum for debating health care issues, to advocate on behalf of local communities, to facilitate communication among providers, and to manage data for the purpose of evaluating resources and identifying community needs and trends. Local planning agencies should be involved in identifying and eliminating barriers to care, as well as identifying excess resources in the system. They should also focus on the mix of services as they relate to overall community needs, access points and coordination among providers.

Proposals

- Retain health planning on a local and regional basis, revamping the governance structure of local planning agencies to make the planning process more independent, credible, and objective.
- Uncouple planning agency funding sources from the control of the Department of Health (DOH), de-emphasizing the regulatory function in favor of the planning function.
- Re-establish a coordinating body at the statewide level, independent of the Department of Health, and with funding in the State budget to support its own staff.
- Reform the certificate of need (CON) process by limiting the review and comment of local planning agencies and limiting regulatory intervention of applications to those projects which require major expenditures or the provision of substantially new services.

A necessary component of the future health planning system would be either a reformatted State Hospital Review and Planning Council or a new coordinating body, with its own staff, separate from existing State regulatory agencies. The planning and policy function of the Department of Health would report directly to this body, which would include full health-related industry representation, appointed by both the Governor and the Legislature. The primary mission of this Council would be to review and evaluate local health plans and develop a State Health Plan which would integrate all existing health care providers in all types of delivery settings. At the same time, the role of the State Council is being re-evaluated, the role, funding, and membership of the Public Health Council should also be re-examined, as this Council has also assumed a greater and more direct role in the planning of this State's health care system.

In regard to reforming the State's CON process, it appears that the only appropriate justification for regulatory intervention is the expenditure of major capital or the provision of a new service whose annual operating costs exceed 1% of the provider's operating budget. A continued role for the local planning agency is not essential to the new planning system.

The future of this State's health planning system is currently being evaluated by the Council on Health Care Financing (CHCF) in conjunction with an Advisory Committee established to examine this issue. Throughout 1988, the Hospital Association of New York State will continue to work with the Council on Health Care Financing to support measures which promote local autonomy and community input regarding the future of the health planning process.

Mental Health Insurance

Proposal

Amend the Insurance Law to mandate the provision of mental health insurance benefits comparable to those enacted for alcoholism services in 1983 and 1987.

Traditionally, insurance coverage for mental or emotional disorders and alcoholism has not been comparable to other health benefits for services such as medical, surgical, and obstetrical care. However, in 1983, legislation was signed into law (Chapter 595 of the Laws of 1983) mandating that outpatient visits for alcoholism show a parity with other health visits.

Under Chapter 595, coverage is provided for at least 60 outpatient visits in any calendar year for the diagnosis and treatment of alcoholism. Chapter 444 of the Laws of 1987 provides inpatient insurance coverage for alcoholism. Since this coverage must be consistent with that provided for other benefits within a given health insurance policy, this has led to disparate benefits for those people with a diagnosis of alcoholism and those with a diagnosis of mental illness. While alcoholism benefits have increased to meet the requirements of the new law, mental health benefits have decreased. Revised health insurance policies, as well as many new health maintenance organization (HMO) policies, have limited mental health insurance coverage or set coverage below the levels of older policies. A survey of major private employers, conducted by the American Psychiatric Association, found an erosion of mental health benefits between 1981 and 1984. Fewer plans had inpatient coverage equivalent to that for general medical conditions (48% vs. 58% earlier), fewer had the same dollar maximums for mental health care (31% vs. 39%), and fewer covered psychologists (29% vs. 36%).

In 1988, it is time to remedy the difference that exists between coverage for these two disabilities — mental illness and alcoholism — and to provide comparable care for neglected mental health problems.

Organ Transplantation

Proposals

- Develop a comprehensive statewide organ procurement system consistent with federal guidelines which will coordinate activities between regional and national procurement systems.
- Protect health professionals from mischievous lawsuits stemming from organ and tissue transplantation.

Major medical technological advances within the past decade have enabled medical professionals to successfully procure and transplant organs. Public pleas from individuals who require a life-saving organ or tissue transplant are commonplace, and the list of people awaiting transplants continues to increase. The reasons for the severe shortage of transplantable organs and tissue are many, ranging from the lack of public understanding to legal complications concerning the transplant procedure.

While legislation establishing the required request law for donations will increase the availability of organs, additional efforts must be undertaken to enhance public and professional understanding, awareness and participation in organ and tissue donation. Efforts must also be undertaken to clarify legal ambiguities within the existing law.

Among the issues which must be addressed this year are expansion of the number of procedures covered by Medicaid; statutory protections for health care professionals from mischievous lawsuits stemming from transplation; development of a comprehensive statewide organ procurement system able to coordinate acitvities of existing and emerging regional and national procurement agencies; and support for public and professional programs relating to the issue of organ or tissue transplantation.

Enactment of the above proposals would foster greater public and professional participation; ensure equal availability of needed organs and tissues to individuals regardless of the ability to pay; protect the financial and regulatory needs of hospitals and transplant centers; and create an environment more conducive to the development of organ and tissue transplantation in New York State.

AIDS

Acquired immunodeficiency syndrome (AIDS) — virtually unknown six years ago — has become a public health crisis of catastrophic proportions. The New York State Department of Health has predicted that by 1991, the spreading AIDS epidemic will cost more than $1 billion per year in New York State for hospital expenses alone. Currently, New York State has an estimated 11,000 cases, 90% of them in New York City. By 1991, the prediction is that the caseload will quadruple, with the proportion in New York City remaining about 90%. The average number of hospital admissions, each lasting 22-23 days, is expected to be 1.7 per patient per year, according to the Centers for Disease Control (CDC).

The regulatory planning process has responded to the AIDS epidemic and the resulting increase in inpatient utilization, particularly in New York City, through the proposed addition of hospital beds. While the practical and financial aspects of treating AIDS patients are of paramount importance, there are many other societal problems associated with the disease. Education, for instance, will be crucial, both to control the further spread of AIDS, and to help the general public come to grips with the problem. One of the populations to be education is health care providers who are currently dealing with a growing number of AIDS patients.

Proposals

- Provide educational information to the public and health care providers which distinguishes the myths from realities.
- Develop and provide education and prevention strategies for young women about the consequences of high-risk behavior, such as IV drug use, that may lead to AIDS transmission to themselves and the children they may bear.
- Evaluate the need for additional confidentiality statutes for all medical records.
- Ensure that health insurers do not impose the HIV antibody test as a condition of coverage or denial of coverage based on positive test results.
- Establish a "Nursery Without Walls Program" for children with AIDS, which would provide comprehensive case management and the availability of respite services, similar to the services provided under the Nursing Home Without Walls Program.

Two of the most recent controversial issues, as they relate to health care providers, are the confidentiality of AIDS patients' medical records and the potential discrimination against AIDS patients by health insurers. With regard to the confidentiality of AIDS patients' medical records, the hospital community firmly supports current statutes which stipulate that all medical records are confidential and as such unavailable to those who would use them as weapons against persons with AIDS. At this point, it does not seem that additional confidentiality statutes which may be applicable to hospitals and other health care providers are needed. If it is concluded that such statutes are needed, however, we urge that consideration be given to generic, rather than AIDS-specific proposals so as not to further stigmatize or segregate AIDS patients. Regarding health insurance coverage, the Hospital Association of New York State firmly supports the actions of the State Insurance Department to prevent health insurers from imposing the HIV antibody test as a condition of coverage or denial of coverage based on positive tests results.

One segment of the AIDS population which poses special demands on health care facilities is children. Recent studies indicate that pediatric cases constitute about 1.8% of all AIDS cases. In a recent survey performed by the Association, 31 hospitals reported that pediatric AIDS cases consumed about 11,500 inpatient days in 1986. By the end of 1987, that number of days was projected to rise to 21,600, an increase of 89% over last year. In 1986, the direct cost of hospitalization for pediatric AIDS patients was between $6.5 and $9 million. In 1987, the cost was projected to total $12 million.

The range of health care providers potentially involved with AIDS patients, particularly children, includes outpatient departments, neighborhood health centers, private physician's offices, residential facilities, hospices, nursing homes, and home care agencies. Clearly, an effective case management system is needed which can optimize the coordination of care and encourage the cooperative development of a network of providers and caregivers encompassing both the private and public sectors.

The Nursing Home Without Walls Program, sponsored by Senator Lombardi, has proven that many individuals requiring institutional-level care may appropriately receive that care at home, and has also demonstrated high quality care, patient satisfaction, and cost savings. An effective method to deal with pediatric AIDS cases would be an extension of this program into a "Nursery Without Walls" that would provide comprehensive case management and the availability of respite services, both of which are especially pertinent to pediatric AIDS cases.

These proposals are but first steps in confronting the many complex problems and issues surrounding the AIDS epidemic. The hospital community will continue to work closely with the Legislature and other involved groups to evaluate these problems and develop carefully reasoned policies to deal with these issues.

Rural Health Care

The health care needs of New York State's rural population are among the major challenges confronting the Legislature in the year ahead. Efforts required to maintain essential services (e.g., transportation and education) in the rural environment are compounded for health care providers because of the rapid and unpredictable changes occurring in the health care delivery system.

In 1985, the Legislative Commission on Rural Resources developed an extensive package of legislative proposals, and several bills relating to rural health care needs became law. Chapter 890 of the Laws of 1986 created a State office to coordinate programs with State agencies and public benefit corporations to remedy existing problems in rural areas. Chapter 624 of the Laws of 1986 established pilot projects in rural areas to create cooperative service programs and networks among rural health care providers. Chapter 533 of the Laws of 1987 expanded the primary health care services initiative grant program to include rural hospitals. Through enactment of these proposals, mechanisms have been established through which concerns of rural areas can be addressed. However, more needs to be done.

Proposals

- Provide funding to encourage development of health care models which offer broader system alternatives in the rural setting.
- Exempt small and rural hospitals from regulations requiring certain educational and technical requirements in special areas where there is an insufficient work pool to meet such requirements.
- Establish a health care specialist position within the State Office of Rural Affairs and establish a legislative advisory group to guide such a specialist.

HANYS supports continued funding for demonstration projects which encourage development of alternative models for delivery of health care in the rural setting. We believe that such programs can promote cooperation at the community level where planning is best initiated and where implementation of a true health care continuum is best addressed.

In 1988, the need for flexibility in regulations affecting small and rural hospitals must also be recognized. In that respect, a mechanism, such as a legislative advisory group to evaluate such regulations, must be developed to exempt some hospitals from regulations requiring certain educational and technical requirements in areas where a sufficient work pool does not exist to meet those requirements.

Finally, we must begin the process of creating a systematic approach to rural health care development. Among the initiatives to be undertaken is the establishment of a health care specialist position, within the State Office of Rural Affairs, to identify financing and health care delivery mechanisms to address rural health needs. We must also establish a legislative advisory group, to work with such a specialist, in order to provide broad input into the process.

II. QUALITY

Transfer of Patient Care Information

Issues of Medical Ethics

Pharmacy Services Protocol

PRO Corporate Liability

Accountability in RHCF Survey Process

Transfer of Patient Care Information

Proposal

Amend the Public Health Law to allow for equal access to patient information by institutions in a case where a patient transfer occurs. This would enhance an institution's quality assurance system by allowing for a comprehensive overview of a patient's progress and outcome, while at the same time continuing the protection of confidentiality of patient information.

When a patient is transferred from one hospital to another, it is vital that medical records concerning treatment to date accompany the patient. This ensures that the quality assurance system of the receiving hospital reviews all records to ensure the continuity and appropriateness of care. The transferring hospital, on the other hand, can only review the care it provided. It cannot review the records of the second facility to see how the care provided at the second facility affected the outcome. This may leave a gap in the overall quality assurance process for patients being transferred from one facility to another. It is critical that the quality assurance process review total patient care from the time of admission to one hospital, to the care provided at the second hospital, to the outcome of this continuum of care. The transfer of records to the first hospital is currently not possible because of statutes which protect confidentiality of patient records.

Section 17 of the Public Health Law allows for the release of records from one physician or hospital to another, but only at the written request of the patient. It is proposed that Section 17 be amended to allow release of medical records from the second facility upon the written request of the transferring hospital and solely for the purposes of quality assurance activities by the transferring hospital. Since the records would be used only for quality assurance purposes, they would be confidential due to the applicability of Public Health Law Section 2805-m, which requires that quality assurance records be kept confidential.

Issues of Medical Ethics

Proposals

- Expand the authority of the durable power of attorney to include medical decisions.
- Work with the Governor's Task Force on Life and the Law, the Legislature, and other affected parties to address pertinent ethical issues.

Advances in medical technology have moved matters that were once the province of fate into human hands. According to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavorial Research, about 80 percent of Americans now die in a hospital or nursing home, compared to 50 percent in 1949. Few others die without a substantial period of illness and some form of medical care. Health care professionals are confronted daily with the legal and ethical implications of providing, withdrawing, or omitting life-sustaining treatment for both mentally competent and incompetent patients. Consequently, there have been continuing disputes among the courts, state legislatures, and the medical profession about the rights, duties, and liabilities of patients and health professionals. In 1987, legislation — the first of its kind in the nation — was passed in New York State setting up guidelines for the issuance of do-not-resuscitate (DNR) orders. Also in 1987, regulations were adopted in New York State establishing a statutory definition of death consistent with modern technological advances. Issues such as living wills, durable power of attorney, and surrogate decision-making remain under debate on both the State and federal levels as well as within the judicial system. Because there are no universally accepted guidelines, legal clarification lags and confusion abounds.

It is time to establish a legal mechanism whereby a competent individual may delegate decisions regarding the course of medical treatment to another individual during periods of incompetency. This can best be achieved through expansion of the existing durable power of attorney statute to include medical decision-making. We must also move carefully yet decisively to provide clarification in a variety of other areas in the medical ethical arena. This initiative must be undertaken through the direction of the Governor's Task Force on Life and the Law and must include the input and views of all involved segments of our society.

Pharmacy Services Protocol

Proposal

Clarify regulations legislatively which would allow a registered hospital pharmacist to develop a protocol or plan, approved by the hospital governing body, to permit the hospital nurse supervisor or other designated licensed personnel limited access to the pharmacy for appropriate reasons when the registered pharmacist is not on duty.

Historically, the nurse supervisor or other appropriate licensed individual(s) have had the ability to enter a facility's pharmacy for specified reasons when a registered pharmacist was not on duty. Recent citations issued by the Department of Health indicate that the interpretation of the regulations would preclude the use of designated personnel in this way. Currently, there are large numbers of vacancies of registered pharmacists for the evening and late night shifts in many areas of the State. Even if there were sufficient registered hospital pharmacists to accommodate all shifts, the attendant costs of a 24-hour licensed pharmacist coverage would significantly increase hospital expenses. Due to the lack of sufficient numbers of registered pharmacists, the very ability of hospitals to offer comprehensive pharmacy services could be jeopardized.

Legislation needs to be enacted to clarify regulations allowing a registered hospital pharmacist to develop a protocol or plan, approved by the appropriate hospital governing body, permitting the hospital nurse supervisor or other designated licensed personnel, limited access to the pharmacy for appropriate reasons when the registered pharmacist is not on duty. Enactment of this proposal would allow for the provision of comprehensive pharmacy services by registered pharmacists or appropriately licensed and approved personnel in limited access cases, without jeopardizing a hospital's ability to provide these needed services.

PRO Corporate Liability

Proposal

Require that the Peer Review Organization (PRO) be held corporately responsible for any damages or harm caused to a person as a result of a determination made by the review organization that medical care was unnecessary or inappropriate.

With enactment of the federal Peer Review Improvement Act of 1982, peer review organizations (PROs) replaced professional standards review organizations (PSROs) as the body responsible for reviewing the medical necessity and appropriateness of care rendered to Medicare inpatients. Generally, each state is a designated PRO review area. After three years of PRO operations, it is apparent that utilization review in New York State is undergoing more of a revolution than a transition. Increasingly, the type and extent of treatment is pre-determined by the PRO and its regional subcontractors. For example, there are surgical procedures that will not be certified for reimbursement when performed on an inpatient basis. Since New York State moved to a case payment system for Medicare, the focus of PRO review has shifted to admission review including transfers, re-admissions, and pre-admissions.

It is crucial that legislation be enacted in 1988 which places a corporate check on the overriding authority of PROs to determine the nature of inpatient care. Legislation establishing PRO corporate liability for any damages or harm caused to a person as a result of a determination that medical care was unnecessary or inappropriate has already been enacted in Minnesota. Similar statutory responsibility should be established in New York State as well.

This proposal would help to ensure that all persons needing care will gain admission to a hospital. There is a growing concern that as PRO review shifts to controlling hospital admissions, inflexible criteria will continue to be applied which does not recognize unique circumstances such as a patient's particular social condition.

In addition, this proposal would alleviate problems associated with reconsideration reviews. Hospitals continue to feel stranded by the lack of an appeals process beyond the PRO itself. There is increasing evidence that the PRO and its subcontractors are taking advantage of the limited appeal mechanisms available to hospitals. The proposed amendment would encourage more reasonable and justified initial determinations by PRO reviewers.

Accountability in RHCF Survey Process

Proposal

Create an appeals board, appointed by the Legislature, which would allow residential health care facilities (RHCFs) to appeal quality of care survey citations. The board would meet at the request of the provider to review the basis for noncompliance decisions and would either confirm or overturn the survey decisions.

In order to receive Medicare and Medicaid funding, each residential health care facility (RHCF) must meet federal guidelines (referred to as "conditions of participation") which delineate the standards for each type of service provided by the facility, such as nursing care. The State Department of Health surveys RHCFs to determine compliance with both federal and State requirements so that these facilities can continue to participate in the Medicare and Medicaid programs and can be granted a State license to operate the facility.

If RHCFs are found to be out of compliance with the federal conditions of participation (the most serious level of deficiency is referred to as "condition-level noncompliance") during two consecutive surveys, facilities can be closed, a ban on admissions of Medicare and Medicaid patients can be established, or the State can decide not to issue a license to operate. While the conditions of participation are defined in federal regulations, there are no State or federal regulations or statutes which define what constitutes condition-level noncompliance.

Because there are no clear criteria regarding what constitutes noncompliance with conditions of participation, different surveyors may arrive at very different conclusions during the Department of Health survey process. In order to promote consistency, HANYS believes that an independent appeals board should be established to review noncompliance notices. At a facility's request, this board would review the survey decisions and would either confirm or overturn the determination. Through this independent appeals board, decisions critical to the future of a facility would be made in a more objective, consistent manner.

III. FINANCING

Inpatient Hospital Reimbursement: 1988 and Beyond

Proposal

Establish a task force, composed of representatives from the Legislature, Department of Health, and health care community, to address issues which may arise from the implementation of the new hospital payment system.

With passage of the post-1987 inpatient hospital reimbursement system comes the need for legislative oversight and refinement. Additional legislative action will be required on a number of outstanding issues. One piece of unfinished business is the creation of two pilot programs authorized by the legislation: one on catastrophic health insurance and the other on care for the uninsured. These two issues are of vital importance to the health of all New Yorkers, and the hospital community believes that these demonstration programs can lead to more far reaching legislative initiatives.

Whenever a completely new reimbursement methodology is implemented, such as that for 1988, many problems and issues may arise which were not anticipated during the development stages of the methodology and subsequent legislation. Issues such as the final regulations to implement the legislation, rate calculations, and the discharge planning component of the legislation will need to be addressed. Senator Lombardi and Assemblyman Tallon have proposed that a task force, composed of members of the Legislature, the Department of Health, and the health care community, be established to address these concerns. For example, this task force would evaluate and, if necessary, recommend chapter amendments to the discharge planning component of the legislation to address the incremental costs and procedural difficulties facilities may encounter in meeting new requirements. The task force would also review the financial difficulties facilities may face under a new method of rate calculation. The Hospital Association of New York State supports the concept of such a task force to ensure a smooth transition to this revolutionary new payment system.

Ambulatory Care Financing

Proposal

Amend the Public Health Law, consistent with the 1983 report of the Council on Health Care Financing ("Recommendations for Financing Hospital Ambulatory Care") to eliminate the payment caps for hospital emergency room and clinic services.

In addition to the recently developed hospital inpatient reimbursement system, the issue of financing hospital ambulatory care services should be addressed in 1988. These efforts must produce long-range financial reforms which recognize the importance of hospital-sponsored ambulatory services to the entire health care delivery system.

Under current law, Medicaid rates of payment for operating costs per hospital ambulatory care visit are calculated on the basis of average costs per visit up to a maximum ceiling. For emergency rooms, rates are capped at $60 per visit plus 80% of the difference between $60 and $75. In 1987, regulations were adopted mandating increased staffing levels for emergency rooms. Hospitals required to meet such standards will be allowed to appeal the rates of payment and may be granted emergency room rates not to exceed $90. Clinic rates of payment remain capped at a flat $60. In both cases, capital costs are passed through as a separate adjustment to the rate. In addition, the rate year for ambulatory care services is based on the State's fiscal year (April 1 — March 31), while hospital fiscal years are based on the calendar year.

The current payment system dates back to the State fiscal crisis of the mid-70s. In 1976, the rate period for hospital ambulatory care services was moved from a calendar year basis to a State fiscal year basis, and payment rates were frozen at 1975 levels. In 1977, the freeze continued and maximum allowable payments were capped at $50 per visit. In the intervening years, hospitals have sought incremental statutory increases in the cap during legislative consideration of the State budget. The current cap on emergency room rates was last adjusted in 1984 for all hospitals and in 1987 for hospitals which must meet expanded staffing requirements. The clinic cap has not been adjusted since 1981. Despite overwhelming approval by the Legislature, a $5 increase in the clinic cap was successively vetoed by the Governor in 1985, 1986, and 1987.

In 1981, the Council on Health Care Financing was charged with developing new mechanisms for financing ambulatory care that would encourage more efficient and more economical provision of services. That mandate was fulfilled with publication of the Council's report in 1983. Since that time, changes in the health care environment have made it even more imperative to reform the method of financing ambulatory care. Improvements in medical technology and state-of-the-art medical practice have enabled hospitals to offer a wider range of services on an outpatient

basis. These services cost far more than the capped reimbursement rate, but appreciably less than the same services provided on an inpatient basis. The current payment system, however, provides no incentives for hospitals to move services to an ambulatory basis.

The Council's comprehensive report noted that hospitals are an important component of the ambulatory care delivery system and will continue to provide a significant portion of ambulatory care in the future. The report further noted that while many ambulatory services can be provided in various settings, certain ones can be most appropriately provided in hospitals. The maintenance of a strong network of hospital ambulatory care providers is threatened, however, under the increasing financial burden created by the existing payment system. For hospital clinics alone, the reimbursement system in 1986 resulted in over a $66 million annual payment shortfall for services rendered to Medicaid patients. In effect, this shortfall represents a voluntary, not-for-profit, and public hospital subsidization of New York State's Medicaid program.

The Department of Health is currently conducting a three-year demonstration project which incorporates an experimental pricing system for clinic services. While this demonstration project is an initial step in reforming the financing of ambulatory care, it is imperative that additional reforms be developed and implemented this year.

Medical Liability Reform

The impact of skyrocketing costs of liability insurance on physicians, municipalities, and others has affected New York State hospitals. Legislation meant to address the medical liability "crisis" in New York has had major financial consequences for this state's health care facilities.

Hospitals are suffering from the impact of spiraling insurance premium costs in three major areas. First, hospitals have had to assume a portion of the liability for their physicians due to the doctrine of joint and several liability. Second, hospitals have been faced with significant preumium increases when purchasing directors' and officers' (D & O) liability insurance to protect those individuals who volunteer their time to act as trustees of hospitals. Third, hospitals which employ physicians directly have been forced to bear the burden of increased costs for these full-time employees.

During the 1987 legislative session, laws which established an excess malpractice insurance program and provided funding for a comprehensive study of the medical liability system were extended for an additional year. This extension of the excess malpractice insurance program is scheduled to expire in 1988. In the meantime, additional consideration must be given to legislation included in the Association's proposals which would aid in the continuing process toward meaningful reform of the medical liability system.

Proposals

- Cap the amount of an award attributable to non-economic losses at $250,000.
- Eliminate the concept of joint and several liability.
- Create a medical and custodial cost compensation fund for those specific costs which exceed $100,000.
- Tighten the qualifications for expert witness testimony including the requirement that expert witnesses be Board certified.
- Establish periodic payment for award levels at or above $100,000, as opposed to the existing level of $250,000.
- Allow for the disclosure of the identity of an expert witness before trial.
- Encourage channeling programs, including programs sponsored by health care institutions, as an alternative to the present insurance mechanisms.

Accountability in RHCF Reimbursement

Proposals

- Conduct a legislative study of the impact of reimbursement systems on quality of care and access by Medicaid patients to residential health care facilities (RHCF) and certified home health care agencies (CHHAs).
- Statutorily mandate that an appeals process be developed for all RHCF and CHHA Medicaid reimbursement systems.
- Establish a legislative body, similar to the Council on Health Care Financing, to address long-term care issues.

Reimbursement for RHCFs and CHHAs is currently delineated in regulation, not legislation, and the Hospital Association of New York State believes that the Legislature should play a role in the larger *policy* issues of reimbursement. Legislative oversight and involvement in the long-term care area could be accomplished through the formation of a legislative body, similar to the Council on Health Care Financing, which would address issues relating to RHCFs, CHHAs, and other continuing health care services. The Department of Health should be held accountable for the impact of pricing systems and reimbursement incentives on quality of care and Medicaid access. Also, the decision to modify the reimbursement system should be part of a larger public debate regarding the fiscal and operational impact of modified pricing.

Prior to the introduction of modified pricing approaches, providers could appeal reimbursement rates, based on unique conditions, patient attributes not sufficiently accounted for in the larger system, or deleterious impacts on quality of care. Both the 1986 implementation of a new reimbursement system for RHCFs — resource utilization groups (RUGS) — and recent pricing proposals for CHHAs by the Department of Health have taken away this ability to appeal, leaving providers with no opportunity to rectify deleterious impacts of reimbursement. Yet, it is well established that pricing systems, such as the RUGS system, cannot account for all the possible reasons for variation in facility costs of providing services. Establishment of an appeals process should be accompanied by strong incentives for the Department of Health to process appeals promptly; any appeals held over for more than one year should automatically be granted and rates of payment adjusted accordingly. In addition, the Department of Health should be required to submit quarterly progress reports and be in periodic communication with the provider regarding the status of the appeal.

RHCF Bad Debt Recoupment

Proposal

Allow reimbursement for bad debts resulting from Net Amount Monthly Income (NAMI) payment defaults in residential health care facilities (RHCFs). This proposal would give RHCFs the ability to write off nonpayment of NAMI as bad debts whenever Medicaid fails to cover the nonpayment.

In the residential health care facility setting, many patients who are Medicaid-eligible are responsible for a partial payment from personal funds (e.g., pension funds). This partial payment of their care is called Net Amount Monthly Income (NAMI). The NAMI is set by the local social services district as part of the Medicaid eligibility process. In these situations, the RHCF receives part of the daily rate from Medicaid and part from the patient. The funds may come from the patient, the patient's spouse, or others responsible for the patient.

There are situations when facilities do not receive the NAMI payment, which can amount to thousands of dollars. Federal regulations allow the local district to adjust the Medicaid rate only if payment has not been made by the person responsible for the patient, not by the patient. Even in these situations, facilities experience shortfalls waiting for the adjustment.

Nonpayment of NAMI not only jeopardizes the facility's financial viability, it directly threatens a patient's continuing stay since a patient can be discharged for non-payment; yet neither the patient nor the facility may be at fault. This proposal will allow facilities to recoup their losses and will facilitate continuing placement of Medicaid patients.

About the Hospital Association of New York State

The Hospital Association of New York State serves as the key advocate for over 300 voluntary and public hospitals and related health care facilities in New York State. The Association, established in 1925 to represent the interests and concerns of its members, is recognized today as one of the most active organizations of its kind in the nation.

Included among the Association's major functions are representation, communication, and advocacy. Further, the Association's Management and Planning Services and Utilization Information Service divisions provide specialized consultation on a fee-for-service basis to enhance the efficient delivery of quality patient care. Association activities are directed by its members through the Board and committee structure, regional representation, and statewide meetings and conferences. The ultimate goal of all these activities is to achieve a stronger, more stable health care system where individual members can pursue their fundamental mission of providing cost-effective, high quality health care to the residents of their communities.

The Association's main offices are located in Albany. In addition to HANYS, the main offices also house the Hospital Educational and Research Fund, HANYS' Group Insurance Agency, Inc., and Hospital Trustees of New York State. The Association is also closely allied with eight autonomous regional hospital associations which represent the various regions in the state.

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October 4, 1988

Annika Lane
Blue Ribbon Commission
Office of Policy and Legal Analysis
Room 107
State House Station 13
Augusta, ME 04333

Dear Annika:

My staff contacted Blue Cross and Blue Shield of New Hampshire to learn more about how the Certificate of Need Program works in New Hampshire. At their suggestion we also discussed the program with Susan Palmer Terry, Director of the State's CON program.

Attached you will find a summation of our discussions with each of them. I thought it would be helpful to share this information with the members of the Blue Ribbon Commission.

Sincerely,

Wayne R. Webster
Senior Vice President
Corporate Resources

WRW:mm

Attachment

OVERVIEW OF NEW HAMPSHIRE'S CON PROGRAM

Conceptually N.H.'s CON program differs from Maine's in two important aspects:

1. It covers all persons, including physicians and investor groups, and

2. It prevents the submission of CON applications until the Health Services Planning and Review Board has developed specific review standards for the proposed service or formally elected not to do so.

All Persons Covered by CON

N.H.'s CON program provides for a "level playing field" between hospitals and physicians by requiring any person proposing a new institutional health service (as defined) to obtain a CON. This is accomplished by placing enforcement sanctions (see Chapter 151-C:14) on any "person" (see 151-C:2 - XXVIII), defined as any "individual, trust, state, partnership, committee, corporation, non-profit health service corporation, association or other organization such as a joint stock company, insurance company or a political subdivision or instrumentality of a state, includ-

ing a municipal corporation" who wishes to develop a new institutional health service. The enforcement sanctions include a statutory prohibition against licensing facilities (which otherwise require a license) which did not obtain a CON and a prohibition against the furnishing of any reimbursement from any program administered by the state or from "any entity chartered under the laws of New Hampshire or any person licensed and doing business in the state" [(see 151-C:14-I(b)] to any person who fails to obtain a CON when required to do so. Finally, major medical equipment having a capital cost in excess of $400,000 is subject to review within the scope of the Act (see 151-C:5-II). In short, any "person" proposing to acquire and operate major medical equipment must obtain a CON or be prohibited from receiving payment from any payor doing business in N.H.

Prior Development of Review Standards

The N.H. CON program prohibits the granting of a CON "unless a standard has been developed which delineates the need for the service and outlines the criteria which must be met by any person proposing such a service" (see 151-C:4-II). It then proceeds to set up two paths by which those standards can be developed:

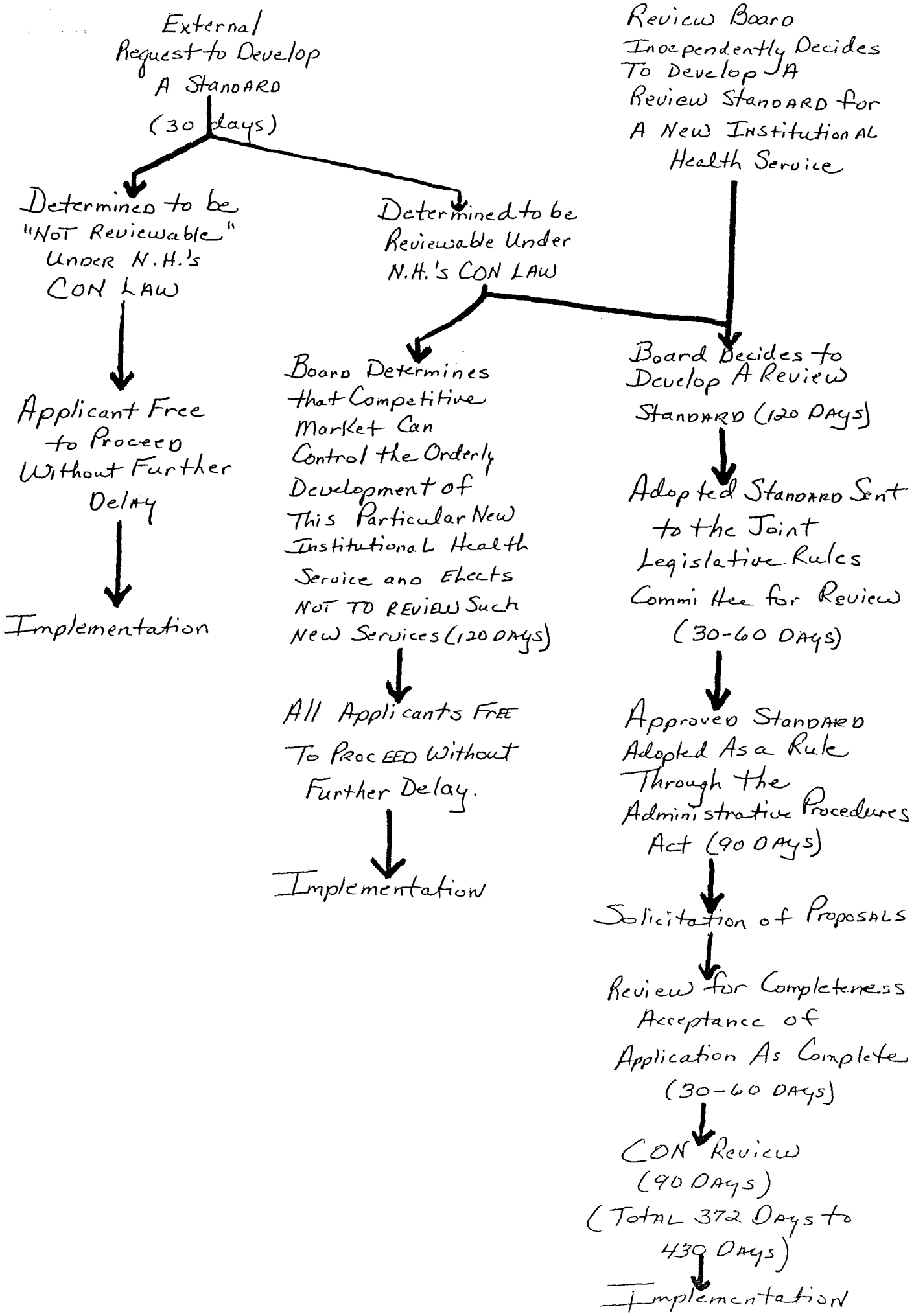
1. The Board is directed to develop review standards for the defined "new institutional health services". Applications are neither entertained nor reviewed during this "standard development" process. At the conclusion of the process, once the standards are adopted pursuant to

the Administrative Procedures Act, the Board solicits applications and conducts a competitive review.

2. Proponents may petition for the development of standards for certain categories of projects. Once they do so the Board has 30 days to decide if it will develop standards. If it chooses not to do so, such projects are free to proceed without further delay (in effect this is an "elect not to review" decision). If the Board chooses to develop review standards, all applications are held in suspense, and the Board has 120 days to adopt the standards. They are then adopted through the APA process (90 days) and the Review Board then solicits applications and conducts a competitive review against its adopted standards.

The N.H. statute thus mandates that "comprehensive health planning" (standard setting) precede regulatory action and provides the time for the N.H. agency to develop such review standards unencumbered by the time pressures associated with the CON decision-making process. Also, all of N.H.'s CON reviews are, by definition and structure, competitive reviews (or potentially competitive) because such reviews only occur after the review agency solicits applications in response to its adopted review standards.

The following diagram gives you a schematic overview of N.H.'s process.


External Request to Develop A Standard (30 days)
Review Board Independently Decides To Develop A Review Standard for A New Institutional Health Service
Determined to be "Not Reviewable" Under N.H.'s CON Law
Determined to be Reviewable Under N.H.'s CON Law
Applicant Free to Proceed Without Further Delay
Implementation
Board Determines that Competitive Market Can Control the Orderly Development of This Particular New Institutional Health Service and Elects NOT TO REVIEW Such New Services (120 days)
All Applicants Free To Proceed Without Further Delay.
Implementation
Board Decides to Develop A Review Standard (120 days)
Adopted Standard Sent to the Joint Legislative Rules Committee for Review (30-60 days)
Approved Standard Adopted As a Rule Through the Administrative Procedures Act (90 days)
Solicitation of Proposals
Review for Completeness Acceptance of Application As Complete (30-60 days)
CON Review (90 days) (Total 372 Days to 439 days)
Implementation

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SUMMARY OF
AN ACT Amending the Certificate of Need Law
RSA 151-C
CERTIFICATE OF NEED REVIEW OF PROPOSED
NEW INSTITUTIONAL HEALTH SERVICES
NEW HAMPSHIRE, 1988

KEY PROVISIONS:

1.HEALTH POLICY PLANNING AND REVIEW BOARD:

The Act establishes an 11-member Health Services Planning and Review Board, which is comprised of state representatives of the departments of Health and Human Services, Insurance, and Administrative Services, as well as consumer, labor, business and health provider representatives.

The Board is independent, although administratively attached to the Division of Public Health Services.

The Board's main duties are to establish a series of standards of need, or health policy guidelines, that set limits on expansion of the health care system and the appropiate location of expensive services. The standard delineates the need for the service and outlines the criteria which must be met by any person proposing such a service.

Once a standard is developed, a request for application may be published, inviting all interested providers to apply to fill this predetermined need.

Existing standards can be reviewed upon request, to determine whether or not they should be continued. In the case of a service for which there is no standard, any person may request that the board develop a standard.

Review of an existing standard or development of a new one should not take any longer than 120 days. The standard can either allocate the service by number, type and location, or indicate that the service is in the best competitive interest of health care in the state and therefore not subject to regulation. If the board does not provide a standard or a statement on competition within 180 days, the service in question is exempt from regulation.

Some Examples of Standards are:

Standards for MRI Mobile Unit Services:

a) Limitation on Vendors - a hospital cannot be a vendor

b) Limitations on Use - only acute care hospitals can buy or contract to use services.

c) Limitations on Service Locations - only on the premises of an acute care hospital.

2. CRITERIA FOR STANDARDS:

Every standard devloped by the board has to stipulate the criteria which must be met by any successful applicant applying to fill a need identified in the standard. These criteria include:

- The immediate and long range financial feasibility of the proposed project, including the probable impact of costs and charges of the facility on health insurance premiums and personal health expenditures in the state or in the region of the state.

- The availability of resources for the proposed project including health and management personnel and funds, capital, and operating needs.

- The degree to which the proposed project will be accessible to persons who are medically underserviced, including, but not limited to, handicapped persons and indigent persons.

- In the case of existing facilities or entities with other facilities, records of the quality of care which may include records from state, federal, and private licensing and accreditation facilities. In the case of new entities, assurance of the quality of care stated in measurable terms.

3. SERVICES REQUIRING CoN:

The act requires "New Institutional Health Services" to have a certificate of need as well as a set of standards before they can be developed or offered within the State.

These services include:

- Capital expenditures of more than $1,000,000 (construction, development, expansion or alteration)

- Transfer of ownership of an existing health care facility

- New inpatient services

- Purchase, lease, donation, transfer of diagnostic or theraputic equipment in excess of $400,000 (i.e. Major Medical Equipment). Not required for the purchase of equipment which is substantially similar to equipment owned by the provider within the preceding 12 months, provided the equipment will not result in a substantial increase in the operating costs above that of the existing or replaced equipment.

- The increase or conversion of inpatient beds, resulting in an increase of more than 10 beds or 10 percent of the total bed complement, whichever is less, during a 5-year period.

The CoN review process should not take longer than 90 days. However, if an application meets certain exception criteria, an extension period is allowed. The total review for CoN is not to exceed 120 days.

4. Decision Regarding CoN; Issuance of CoN; Reconsideration:

An approval of a certificate of need must be in accordance with the standard used as the basis for request for application.

Competing applicants are considered in relationship to each other. The decision is based on the applicant who demonstrates superiority in cost effectiveness, quality and affordability, and who will best meet the specifications and criteria outlined in the standard.

There are provisions in the statute for reconsideration hearings and appeals to the supreme court.

5. Rules

The board has rules governing the review of certificate of need, which are distributed to statewide health agencies and organizations, all health care facilities, health maintenance organizations etc.

6. Validity of CoN; Compliance; Sanctions:

If the applicant fails to commence or complete the project authorized within the time periods specified below, the CoN expires, and the applicant has to resubmit an application for a certificate of need. Project completion dates are:

1. Projects which solely involve the acquisition and installation of equipment must be completed within 2 years from the date of issuance of a certificate of need or certificate of exemption

2. For construction projects:

a) If the total estimated cost of the project is less than $1,000,000, the project must be commenced within one year of, and completed within three years of, the date of issuance of a certificate of need.

b) If the total estimated cost of the project is greater than $1,000,000, the project must be commenced within 18 months of, and completed within 5 years of, the date of issuance of a certificate of need.

c) In the case of any plan for capital expenditures proposed by or on behalf of a health care facility, health maintenance organization, or health care provider under which a series of obligation for capital expenditures for discrete components of a plan is to be incurred over a period longer than one year, the board may allow up to 3 years following the date of approval for incurring such capital expenditures

A maximum of two, 6-month extensions are allowed pursuant to showing of good cause.

7. Exemptions:

a) Private offices or clinics of physicians, dentists, or other practitioners of healing, meaning the physical places where diagnostic and treatment services are offered on an outpatient basis.

b) Dispensaries and first aid stations in business or industrial establishments for employees

c) Infirmaries owned and operated by education institutions

d) Institutions or homes which provide remedial care or treatment only to residents or patients who rely solely upon treatment by prayer or spiritual means in accordance with the creed of any recognized church or religious denomination

e) The increase or conversion of 9 beds or fewer or less than 10 percent of the bed complement, whichever is less.

f) Facilities and services which are intended to serve only outpatients and which do not require construction of greater than $1,000,000 or new equipment costing more than $400,000.

N.B. Exclusions do not include any diagnostic or theraputic equipment located or used in any facility.

8. Fees:

Each acute care hospital, specialty hospital and nursing home must pay an annual administrative fee of up to 1/10 of one percent of their previous year's revenue minus contractural allowances.

If it is a new facility, must pay up to 1/10 of one percent of their project first year revenue minus contractural allowances.

The total amount collected should not exceed $400,000 per year, to be prorated at the end of each fiscal year among all acute care hospitals, specialty hospitals and nursing homes.

All applicants must pay a fee of 1/4 of one percent of the total capital cost of the project with a minimum fee of $500, and a maximum of $12,000

Persons requesting a standard development or standard review must pay a fee of $1,000 if the health services planning and review board determines that a standard review or a standard development process shall occur.

Fees collected are deposited in the general fund.

APPENDIX

SUMMARY OF THE PROCESS: (1)

The New Hampshire process has essentially three components:

DATA COLLECTION

STANDARDS DEVELOPMENT

REVIEW (CoN) PROCESS

The current system combines a regulatory component with a competitive component. The established policy board uses existing data to predetermine health service needs in specific locations. It then develops standards, or policy guidelines for services which may meet those needs. Once standards are developed, the Board can announce the need for a service, along with the standards, so that providers/developers compete to provide the service.

There are a number of steps to the process:

1. The Board may receive a request to review an existing standard, or for developing new standards.

The Board then has 120 days to:

a) Produce a statement to the effect that the service is not subject to review - i.e. conforms to certain competitive criteria or:

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NOTE: This is quite an open process, task forces are often formed, developers can be part of the process, specialized committees can be formed.

2. Once standards have been developed, the rules for establishing those standards are sent to review by the Legislature - (all rules adopted by state departments are reviewed by the Legislature in New Hampshire). This often takes 30-60 days.

3. Once the rules are accepted by the Legislative process, they are sent back to the Board. Staff then goes through a data analysis process to determine if the service is needed, where, amd how much. New Hampshire has an extensive data collection process, which is currently being expanded. Staff makes a recommendation to the Board regarding the feasibility of developing the service and the Board can decide whether or not to seek applications from providers to establish the service.

4. The application process is quite complicated - providers get technical assistance from staff to ensure their proposals comform to the established standards. All providers must submit proposals before the CoN review process can begin.

5. The CoN review process is a 90 day process, with a 30-day extension provision. It cannot exceed 120 days.

6. Once the Board makes a decision providers can go through an appeal process - including going to the Supreme Court.

NOTE:

a) Any "person" is subject to a review process. This means obtaining a letter of intent from the Board, which states that the service is not subject to review or providers have to go through the CoN review process.

b) "Person" is defined as: an individual, trust, state, partnership, committee, corporation, nonprofit health service corporation, association and other organization such as joint stock companies and insurance companies, or a political subdivision or instrumentality of a state, including a municipal corporation. (RSA 275 151-C:1 28).

This means that physicians <u>are</u> included in the review process. This is a gray area in the law, however, because the exemption clause creates some confusion (RSA 151-C:13). Conversations with division staff indicate that the process functions very much on a case-by-case basis.

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CoN REQUIRED FOR:

NEW HAMPSHIRE	MAINE
Capital expenditures of $1,000,000 or more	Capital expenditures of $350,000 or more Nursing homes = $500,000
Acquisitions by a facility of major medical equipment costing $400,000 or more	Acquisitions by a facility of major medical equipment $300,000 or more
New inpatient services	Creation of certain new health services, principally those annual operating costs of $155,000 or more or involving capital expenditures of any amount.
Transfer of ownership of an existing health care facility	Any transfer of ownership of a nursing home
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CHAPTER 151-C
CERTIFICATE OF NEED REVIEW OF PROPOSED NEW INSTITUTIONAL HEALTH SERVICES

(HB 476) Health Services Competition Law

CHAPTER 275 (SB 342)

STATE OF NEW HAMPSHIRE

In the year of Our Lord one thousand
nine hundred and eighty-eight

AN ACT

amending the certificate of need law.

Be it Enacted by the Senate and House of Representatives
in General Court convened:

CHAPTER 151-C
CERTIFICATE OF NEED REVIEW OF PROPOSED NEW INSTITUTIONAL HEALTH SERVICES

151-C:1 Legislative Findings; Public Interest; Review and Assessment of New Health Services. It is declared to be the public policy of this state that:

I. The general welfare and protection of the lives, health, and property of the people of this state require that all new institutional health services be offered or developed in a manner which avoids unnecessary duplication, contains or reduces increases in the cost of delivering services, and promotes rational allocation of health care resources in the state;

II. The state has a compelling interest in working with the health care delivery system to set standards relative to the size, type, level, quality, and affordability of health services offered in New Hampshire; and

III. The state has an interest in promoting and stimulating competition in the health care marketplace as a means of managing the increasing in health care costs.

151-C:2 Definitions. As used in this chapter:

I. "Ambulatory surgical facility" means a facility which is not physically attached to a health care facility and which provides surgical treatment to patients not requiring hospitalization, and does not include the offices of private physicians or dentists, whether in individual or group practices.

II. "Applicant" means a person responding to a request for application for certificate of need.

III. "Bed capacity" means the total number of licensed beds in a facility licensed under RSA 151; or in the case of state facilities, it means the total number of beds in service (staffed).

IV. "Board" means the health services planning and review board established in RSA 151-C:3.

V. "Business day" includes any day, Monday through Friday, except legal holidays.

VI. "Capital expenditure" means an expenditure which, under generally accepted accounting principles consistently applied, is not properly chargeable as an expense of operation or maintenance, and includes acquisition by purchase, by transfer, or by lease or comparable arrangement, or through donation, if the expenditure would have been considered a capital expenditure if acquisition had been by purchase.

VII. "Categories of service" means health services offered in or through a health care facility which were not offered on a regular basis in or through such health care facility within the 12 month period before the time such services would be offered.

VIII. "Certificate of need" means a certificate issued by the state agency approving the offering or development of a proposed new institutional health service.

IX. "Certificate of need review" means the review of applications submitted in response to a request for application published by the health services planning and review board.

X. "Confidential commercial information" means any information filed either by a hospital or nursing home in an application for certificate of need or data disclosure under RSA 126:25 that contains either a trade secret or other commercial information: (Amended 6/29/88 Chapter 275:1)

(a) that has not yet been revealed to persons other than (i) employees, agents, or attorneys of the filing party, (ii) other persons or entities with which the filing party is engaging in a joint venture or other commercial action in concert; and (iii) other persons or entities with which the filing party is actively negotiating for the purchase or sale of goods or services; and

(b) that would, if revealed, substantially and adversely affect the ability of the filing party or its affiliated interests to compete with other entities offering or proposing to offer the same goods and services in the same market.

XI. "Confidential financial information" means any financial information filed either by a hospital or nursing home in accordance with an application for certificate of need or data disclosure under RSA 126:25: (Amended 6/29/88 Chapter 275:2)

(a) that has not yet been revealed to persons other than (i) employees, agents, or attorneys of the hospital; (ii) other persons or entities with which the hospital is jointly participating in an effort to obtain financing; and (iii) other persons or entities to which the hospital has applied for financing;

(b) that would, if revealed, substantially, predictably, and adversely affect the ability of the hospital or its affiliated interests to obtain financing on reasonable terms in competition with other seeking similar types of capital; and

(c) that could lawfully be concealed under applicable laws governing financial transactions.

XII. "Construction" includes actual commencement of any construction or fabrication of any new building, or addition to any existing facility, or any expenditure of more than $1,000,000 relating to the alteration, remodeling, renovation, modernization, improvement, relocation, repair, or replacement of a health care facility or health maintenance organization, including expenditures necessary for compliance with life and health safety codes.

XIII. "Consumer of health care" means a person who is not a provider of health care.

XIV. "Conversion" means change of the distribution of existing beds in a health care facility affecting acute care, skilled nursing care, intermediate care, psychiatric care, and substance abuse care as defined in the applicable state or federal law.

XV. "Days" means calendar days, unless otherwise specified.

XV-a. "Health care facility" means hospitals, specialty hospitals and licensed nursing homes including all services and property owned by such. Health care facilities shall include facilities which are publicly or privately owned or for-profit or not-for-profit, and which are licensed or required to be licensed in whole or in part by the state. (Amended 6/29/88 Chapter 275:3)

XVI. "Health maintenance organization" means a public or private organization, organized under the laws of any state or the federal government which:

(a) Provides or otherwise makes available to enrolled participants health care services including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage; and

(b) Is compensated, except for co-payments, for the provision of the basic health care services listed in subparagraph (a) to enrolled participants on a predetermined periodic basis without regard to the date on which health care services are provided; a predetermined periodic basis shall be fixed without regard to the frequency, extent, or kind of health care service actually provided; and

(c) Provides physician services primarily (1) directly through physicians who are either employees or partners of such organization, or (2) through arrangements with individual physicians or one or more groups of physicians organized in a group practice or individual basis, or (3) a combination of (1) and (2), as provided herein.

XVII (Repealed 1988, 275:23, I, eff. June 29, 1988)

XVIII. "Health services" means clinically related diagnostic, treatment, or rehabilitative services, as well as preventive services, and includes, without limitation, alcohol, drug abuse, and mental health services.

XIX (Repealed 1988, 275:23, II, eff. June 29, 1988)

XX. "Hospital" means an institution which is engaged in providing to patients, under supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of such persons. The term "hospital" includes psychiatric and substance abuse treatment hospitals. (Amended 6/29/88 Chapter 275:4)

XXI. (Repealed 1988, 275:23, III, eff. June 29, 1988)

XXI-a "Inpatient services" means all care delivered to patients staying more than 24 hours in a health care facility, including, but not limited to, alcohol and drug dependency, psychiatric services, physical rehabilitation, cardiology services, obstetrical services, and general medical and surgical services. (Amended 6/29/88 Chapter 275:5)

XXII. "Institutional health service" means any proposed project for which a standard must be developed under RSA 151-C:5, II. (Amended 6/29/88, Chapter 275:6)

XXIII. "Intermediate care facility" means an institution which, on a regular basis, provides health-related care and services of a lower level than those provided by a hospital or skilled nursing facility but above the level of room and board.

XXIII-a. "Location" means service area.

XXIV. "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions which is used to provide medical and other health services and which costs more than $400,000. In determining whether medical equipment costs more than $400,000, the cost of studies, surveys, designs, plans working drawings, specifications, and other activities essential to acquiring the equipment shall be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value.

XXV. "Major new facilities" means the construction, development, or other establishment of a new health care facility, the total cost of which is in excess of $1,000,000.

XXVI. "Nursing home" means a place which shall provide, for 2 or more persons, basic domiciliary services (board, room, and laundry), continuing health supervision under competent professional medical and nursing direction, and continuous nursing care as may be individually required.

XXVII. "To offer", when used in connection with health services, means that a health care provider holds itself out as capable of providing, or as having the means for the provision of, specified health services.

XXVII-a. "Outpatient services" means all care delivered to patients who are not required as a part of treatment to stay overnight in the hospital. (Inserted 6/29/88 Chapter 275:7)

XXVIII. "Person" means an individual, trust, state, partnership, committee, corporation, nonprofit health service corporation, association and other organization such as joint stock companies and insurance companies, or a political subdivision or instrumentality of a state, including a municipal corporation.

XXIX. "Physical facility or site" means the total buildings, structures, and land of a health care facility.

XXX. "Provider of health care" means a person:

(a) Who is a direct provider of health care, including a physician, dentist, nurse, podiatrist, optometrist, physician assistant, or ancillary personnel employed under the supervision of a physician, in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions, including hospitals, rehabilitation facilities, alcohol and drug abuse treatment facilities, long-term care facilities, outpatient facilities, and health maintenance organizations, in which such care is provided and, when required by the laws of this state, who has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration;

(b) Who holds a fiduciary position with, or has a fiduciary interest in, any entity described in subparagraph (c)(2) or (c)(4) of this paragraph other than an entity described in either such subparagraph which is also an entity described in section 501(c)(3) of the Internal Revenue Code of 1954 and which does not have as its primary purpose the delivery of health care, the conduct of research, the conduct of instruction for health professionals, or the production of drugs or articles described in subparagraph (c)(3) of this paragraph;

(c) Who receives (either directly or through the person's spouse) more than 1/5 of his gross annual income from any one or combination of the following:

(1) Fees or other compensation for research into or instruction in the provision of health care;

(2) Entities engaged in the provision of health care or in research or instruction in the provision of health care;

(3) Producing or supplying drugs or other articles for individuals or entitles for use in the provision of or in research into or instruction in the provision of health care; or

(4) Entities engaged in producing drugs or such other articles;

(d) Who is the member of the immediate family of an individual described in subparagraph (a), (b), or (c); or

(e) Who is engaged in issuing any policy or contract of individual or group health insurance, hospital, or medical service benefits. An individual shall not be considered a provider of health care solely because the individual is a member of the governing board of an entity described in subparagraph (c)(2) or (c)(4).

XXXI. "Psychiatric hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis, treatment, and rehabilitation of mentally ill and emotionally disturbed persons.

XXXII. (Repealed 1988, 275:23, IV, eff. June 29, 1988)

XXXIII. "Rehabilitation facility" means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

XXXIV. "Request for application" means a formal publication of need for a specific service based on an existing standard, revised standard, or new standard as developed pursuant to RSA 151-C:5 and 6.

XXXV. "Skilled nursing facility" means an institution or a distinct part of an institution which is primarily engaged in providing to injured, disabled, or sick inpatients skilled nursing care, and rehabilitative and related services.

XXXVI. "Standard" means a health policy guideline developed by the health services planning and review board and instituted under the provisions of RSA 541-A.

151-C:3 Health Services Planning and Review Board.

I. (a) There is hereby established a health services planning and review board composed of 11 members to include the following:

(1) The commissioner of health and human services or his designee;

(2) The commissioner of insurance or his designee; and

(3) The commissioner of administrative services or his designee.

(b) The remaining 8 shall be appointed by the governor and shall include:

(1) 5 purchasers or consumers of health care services, including a representative of labor and a representative of business or industry.

(2) One representative from the hospital provider community.

(3) One representative from the nursing home community; and

(4) One representative of any other health provider group.

II. Each member appointed under subparagraph I(b) shall serve for 3 years and may be reappointed.

III. A member of the board may resign upon written notice to the governor. The governor shall appoint a replacement to fulfill the unexpired term. A member of the board may be discharged pursuant to RSA 4:1.

IV. The governor shall appoint a chairman of the board, who shall serve at the pleasure of the governor, from among its members.

V. Members of the board shall be reimbursed for reasonable expenses incurred in carrying out their duties under this chapter.

VI. The board shall be administratively attached, pursuant to RSA 21:G:10, to the division of public health services and shall exercise its powers, duties, functions, and responsibilities independently of the division and the department of health and human services, except as specifically provided by law. The board shall submit its budget requests and such reports required of it by law through the division of public health services.

VII. (a) The director of the division of public health services shall provide staff to support the work of the board and shall appoint, from among the staff, a person to serve as staff director who shall oversee the staff and act as liaison between the director and the board. The director shall also provide space for the board and staff and other assistance and materials as necessary.

(b) The staff director shall account to the director of the division of public health services for the administration of funds allocated under this chapter, for the conduct of the staff, and shall timely and appropriately execute his duties.

151-C:4 Prohibitions:

I. No institutional health service shall be offered or developed within the state, nor shall any arrangement or commitment for financing the offering or developing of a new institutional health service be made, except pursuant to obtaining a certificate of need for such service.

II. No certificate of need shall be granted by the board unless a standard has been developed which delineates the need for the service and outlines the criteria which must be met by any person proposing such a service.

151-C:5 Standard development.

I. Prior to development or review of any new institutional health service the board shall:

(a) Develop a comprehensive mailing list of the state's health care facilities, health maintenance organizations, and any other person who, annually and in writing, requests inclusion on the list. The board shall maintain this comprehensive mailing list and shall make revisions to update it annually; and

(b) Disseminate to all health care facilities, health maintenance organizations, and other persons included on its comprehensive mailing list, and shall publish in one or more newspapers of general circulation within each county, a description of the scope of coverage of its program for development and review of standards and the review of applications responding to requests for proposals (RFP's) including the activities covered in RSA 151-C:5, II and 151-C:13. Whenever the scope of such coverage is revised, the board shall disseminate and publish a revised description thereof, as provided in this subparagraph.

II. The board shall develop standards for new institutional health services. These include the following:

(a) The construction, development, expansion, or alteration of any health care facility requiring a capital expenditure of more than $1,000,000;

(b) The transfer of ownership, in whole or in part, of an existing health care facility, or the acquisition of all or substantially all of its assets or stock, except where the transfer of ownership would be subject to the provisions of reevaluation of assets as outlined in the Federal Deficit Reduction Act of 1984;

(c) The development and offering of new inpatient services. (Amended 6/29/88 Chapter 275:8)

(d) The purchase, lease, donation, transfer, or other comparable arrangement by or on behalf of a health care provider of diagnostic or therapeutic equipment for which the cost or, in the case of donation, the value is in excess of $400,000, including standards for one or more articles of diagnostic or therapeutic

equipment which are necessarily interdependent in the performance of their ordinary functions as determined by the Board. The board shall not develop standards for the purchase of equipment which is substantially similar to equipment owned by the provider within the preceeding 12 months, provided the equipment will not result in a substantial increase in operating costs above that of the existing or replaced equipment;

(e) The increase or conversion of inpatient beds resulting in an increase of more than 10 beds or 10 percent of the total bed complement, whichever is less, during a 5 year period.

III. The board shall develop, pursuant to rules adopted under RSA 541-A, standards of need on health care services listed in paragraph II of this section. All persons enumerated in paragraph I of this section shall receive notice of the standards and public hearings relative to the standards. The board shall publish notice of proposed standards in a state-wide newspaper and at least one newspaper in each county of the state. Each notice shall include dates and locations of public hearings.

151-C:6 Procedures for Existing Standards; No Standards:

I. If a standard of need, which precludes additional services, has existed for longer than 24 months, any person may request that the standard be reviewed to determine whether the standard should be continued. The 24 month requirement may be waived if it can be demonstrated that there has been a change in technology, market, or price which would warrant review of the standard. Notwithstanding RSA 541-A:6, the procedure shall be as follows:

(a) A request for a standard review shall be submitted in writing to the chairman of the board.

(b) Within 30 days of the receipt of the request, the board must notify, in writing, the person making the request of the commencement of the 120 day standard review process or that the proposed project is not in accordance with 151-C:5, II and no standard review shall take place.

(c) The review of an existing standard shall take no longer than 120 days. Adoption of the standard shall be in accordance with RSA 541-A. (Amended 6/29/88 Chapter 275:21)

(d) The board shall notify persons, pursuant to RSA 151-C:5, I, of the beginning of the standard review period and the schedule for the review.

(e) If the board does not provide a standard allocating the new service or a statement on competition within the allotted 180 days, the proposed service shall not be required to obtain a certificate of need and shall not be subject to regulation under RSA 151-C.

II. In the case of a service for which there is no standard, any person may request, in writing, that the board develop a standard. Notwithstanding RSA 541-A:6, the procedure shall be as follows:

(a) A request for a standard development shall be submitted in writing to the chairman of the board.

(b) Within 30 days of the receipt of the request, the board shall notify, in writing, the person making the request of the commencement of the 120 days standard development process or that the service is not in accordance with 151-C:5, II and no standard development shall take place.

(c) The development of a new standard shall take no longer than 120 days. Adoption of the standard shall be in accordance with RSA 541-A. (Amended 6/29/88 Chapter 275:22)

(d) The board shall notify persons, pursuant to RSA 151-C:5, I, of the beginning of the standard development period and the schedule for the review.

(e) The standard shall be either a standard allocating the new service by number, type, and location or a statement that the proposed new service is in the best competitive interest of health care in the state and shall not be subject to the provisions of RSA 151-C:8. The decision of the board shall be considered a final decision.

(f) If the board does not provide a standard allocating the new service or a statement on competition within the allotted 180 days, the proposed service shall not be required to obtain a certificate of need and shall not be subject to regulation under RSA 151-C.

151-C:7 Criteria. Every standard developed by the board shall stipulate the criteria which must be met by any successful applicant applying to fill a need identified in the standard. At a minimum these shall include:

I. The immediate and long range financial feasibility of the proposed project, including the probable impact of costs and charges of the facility on health insurance premiums and personal health expenditures in the state or the region of the state.

II. The availability of resources for the proposed project including health and management personnel and funds, capital, and operating needs.

III. The degree to which the proposed project will be accessible to persons who are medically underserviced, including, but not limited to, handicapped persons and indigent persons.

IV. In the case of existing facilities or entities with other facilities, records of the quality of care which may include records from state, federal, and private licensing and accreditation facilities. In the case of new entities, assurance of the quality of care stated in measurable terms.

151-C:8 Procedures for Certificate of Need.

I. If a standard developed through RSA 151-C:5 or 151-C:6, indicates a need for additional health services, the board shall issue a request for applications. The board shall publish, in other than the legal notices section, in a newspaper of statewide distribution and in at least one newspaper in every county, as well as notify all affected persons as defined in paragraph VI(b) of this section, a notice that the board is accepting applications for certificates of need for the specified service. At a minimum the notice shall include:

(a) A brief description of the service to be provided, including the amount, type, and location as established by the standard.

(b) The final date that applications are to be submitted which shall be no sooner than 60 days from the date of publication. An application in response to a request for applications may be submitted prior to the deadline, but no review shall commence prior to the deadline.

(c) An address at which applicants may obtain copies of the application format as well as the minimum criteria and specifications which shall be the basis for judging the merits of each application.

II. The board shall be available to provide technical assistance to any applicant submitting an application in response to a request for applications. (Amended 6/29/88 Chapter 275:9)

III. All applications received in response to a single request for applications shall be reviewed simultaneously and shall be considered in relationship to each other.

IV. Every application shall contain such information as the board adopts by rule. The board shall not require any information which it has not adopted by rule. The information requirements established by the board may vary according to the purpose of the review or the type of health service being reviewed. In addition to the information required for submission to the board, any applicant may submit, and the board shall duly consider, any other information.

V. (a) The board shall examine every application for form and completeness, and the information required by RSA 151-C:7 as well as the specifications and standards outlined in the request for application. If an application is determined incomplete by the board, it shall notify the applicant by certified mail within 15 business days of receipt of the application. Such notification shall include a full explanation of the reasons for incompleteness. If no request for additional information is made by the board within the 15 business days, the application shall be considered complete.

(b) An applicant whose application is incomplete shall be allowed a maximum of 15 business days, from the date of receipt of notification of incompleteness, to provide the required additional information. The applicant shall not provide more than the required additional information The board shall then review the additional information provided by the applicant; and, if satisfactory, the application shall be considered complete and the applicant shall be notified by certified mail. If the application is still found to be incomplete, the board shall mail the applicant a notification within 10 business days of receipt of the additional information. If no such notification is mailed to the applicant by the board within the 10 business days period, the application shall be considered complete. Within 5 business days of the receipt of any information submitted pursuant to the second completeness notice, the board shall notify the applicant as to whether such information is satisfactory and the application shall be considered complete. (Amended 6/29/88 Chapter 275:11)

(c) Any applicant whose application is incomplete following the second completeness review under subparagraph (b) may, by certified mail, within 5 business days of receipt of the second notice of incompleteness:

(1) Provide the additional required information; or

(2) Stipulate that it wishes to have its application reviewed by the board notwithstanding its incompleteness. Any applicant whose application is incomplete and who fails to either provide the additional required information or stipulate that it wishes to have its application reviewed notwithstanding its incompleteness shall waive any right to have its application reviewed.

(d) The state agency shall review any application for which a stipulation has been filed pursuant to subparagraph (c).

(e) An applicant may withdraw an application at any time thereby terminating the review process.

VI. (a) Within 10 business days of completion of the completeness review under paragraph V of this section, the board shall mail, to any qualified applicant, a notice that formal review of the application has begun and shall publish the notice in other than the legal notice section of one or more newspapers of general circulation in the state and in one or more newspapers of general circulation in the service area of the facility to be reviewed. The board shall provide all affected persons, as defined in subparagraph (b), with written notification of the beginning of a review. The notice shall include a statement that review has begun and the proposed schedule for review by the board. (Amended 6/29/88 Chapter 275:12)

(b) For purposes of this paragraph, "affected persons" include health systems agencies for contiguous health service areas, all health care facilities and health maintenance organizations included on the comprehensive mailing list developed and maintained pursuant to RSA 151-C:5, I(a), the New Hampshire Hospital Association, the New Hampshire Medical Society, the New Hampshire Health Care Association, the Community Health Care Association, the New Hampshire Association of Counties, third-party payors licensed and doing business in this state, and members of the public who are to be served by the proposed project. For purposes of this paragraph, notification of all qualified applicants in which the proposed project is to be offered or developed shall be by certified mail. Notification to all affected persons, except members of the public, shall be by mail. Notification to members of the public shall be by the publication required in this paragraph. Notification to third-party payors licensed and doing business in the state shall be to those third-party payors who have complied with an annual notification as of the effective date of this provision informing them that if they wish to be inclu ed on a certificate of need mailing list, they shall submit a written request to the board within 30 days. (Amended 6/29/88 Chapter 275:12)

VII. The date on which notification is sent to qualified applicants or the date on which notification to the members of the public first appears in a newspaper published in the state, whichever occurs later, shall be the date of notification and shall be the beginning date of the review cycle of the board.

VIII. The board shall establish review schedules which provide that no review by the board shall, to the extent possible, take longer than 90 calendar days from the beginning of the review cycle to the date of a final decision by the board. In accordance with the requirements of RSA 151-C:11, the board shall adopt exception criteria for determining when it would not be practicable to complete a review

within 90 calendar days. If an application clearly meets such exception criteria, the agency may provide for a single extension of the review period for a total of 30 calendar days beyond the initial 90 day period. The total review period for certificate of need shall not extend beyond 120 days from the beginning of review.

IX. Upon request, the board shall provide for access by the general public to all applications reviewed by the board and to all other written materials pertinent to board review.

X. The board shall provide in its review procedures for a public hearing. The board shall, prior to such hearing, provide notice of such hearing in accordance with the notification provisions in paragraph VI of this section. The procedures for a public hearing shall include an opportunity for any person to present testimony regarding the proposed project, the right of any persons testifying to be accompanied and advised by legal counsel, the right of any qualified applicant to cross-examine witnesses, and the establishment of a formal record of the hearing. The board shall not impose any fee for such a public hearing. (Amended 6/29/88 Chapter 275:13)

XI. During the course of review of any application for a certificate of need, the board shall take reasonable measures to prohibit and prevent all ex parte communication relating to the merits of such application.

XII. (a) After an application has been filed with the board, the applicant may request to amend the application only during the 45 days after the date of notification of the beginning of review. Upon written request to the board by the applicant, this period may be extended by the board in accordance with the provision of paragraph VIII. (Amended 6/29/88 Chapter 275:14)

(b) When an application is filed with the board, an applicant shall be required by the board to file an amendment of the application when any supporting documentation or other material submitted to the board by the applicant indicates that:

(1) The nature, scope, or location of the project will differ substantially from those described in the application.

(2) The method of financing will differ substantially from that described in the application in that the estimated capital expenditure will exceed that proposed in the application by 15 percent plus the inflation factor, as specified in RSA 151-C:12, IV.

(3) The identity of the applicant has changed.

(4) The board may waive the requirements of subparagraph (b)(1), (2) or (3) if it is determined that the proposed amendment of the application is technical or otherwise insignificant.

(c) If an amendment is filed in accordance with (a) or (b), the application shall return to the point in the review process defined in paragraph VI relative to the notification to the applicant that review of the application has begun.

XIII. Any action by the board or by an applicant pursuant to this section which results in a delay of the review process shall affect all applicants which filed under the same request for application and are considered by the board to be competing.

151-C:9 Decision Regarding Certificate of Need; Issuance of Certificate of Need; Reconsideration.

I. Upon completion of the review, the board, by majority vote of eligible board members, shall render a decision on the applicant or applicants which filed a response to a request for application. Any board member who has a personal or business conflict with any application shall not vote on such application. The decision shall be in the form of an approval, denial, or an approval with conditions. An approval of a certificate of need shall be in conformance with the standard used as the basis for request for application. (Amended 6/29/88 Chapter 275:15)

II. The board shall consider competing applicants in relationship to each other. The decision shall be based on the applicant who demonstrates superiority in cost effectiveness, quality, and affordability and who will best meet the specifications and criteria outlined in the standard.

III. Once a final decision is rendered, a copy of the decision shall be given to all third party payors who are in compliance with the provisions of this chapter. If the board failed to issue a final decision within the time period specified for the review, a certificate of need shall be denied. The applicant may either request a reconsideration hearing under paragraph IV, or, within a reasonable time following the expiration of that period, petition the supreme court to require the board to render a final decision on the application.

IV. (a) Any person, for good cause shown, may request in writing a public hearing for purposes of reconsideration of a final decision of the board. The board shall adopt appropriate procedures for such a hearing. No fee may be imposed for the hearing. For purposes of this paragraph, a request for a reconsideration hearing, other than by an applicant denied a certificate of need, shall be good cause if it:

(1) Presents significant, relevant information not previously considered by the board;

(2) Demonstrates that there have been significant changes in factors or circumstances relied upon by the board in reaching its decision;

(3) Demonstrates that the board has materially failed to follow its adopted procedures in reaching its decision; or

(4) Provides such other basis for a public hearing as the board determines constitutes good cause.

(b) To be effective, a request for a reconsideration hearing shall be received by the board within 20 business days following the date of the board's decision. If granted, the hearing shall commence within 30 calendar days of receipt of the request. The applicant may waive the 30 day requirement. At least

14 calendar days prior to the reconsideration hearing, notification of the hearing shall be sent to the person requesting the hearing and to the persons proposing the new institutional health service and to others upon request. Within 25 business days after the conclusion of the hearing, the board shall make written findings which state the basis for its decision. The decision shall be considered the final decision of the board.

151-C:10 Appeals to the Supreme Court.

I. Any person submitting an application for a certificate of need, if aggrieved or dissatisfied with the decision of the board, shall have the right, upon a petition which provides a detailed statement of the grounds upon which the decision of the board is claimed to be erroneous and contrary to the facts and the law, to appeal from the decision to the supreme court pursuant to RSA 541.

II. The provisions of RSA 541 shall govern all appeals under this section.

III. The court shall affirm the decision of the board unless it finds it to be arbitrary or capricious or not made in compliance with applicable law.

151-C:11 Additional Rules.

I. The board shall adopt rules governing review of certificate of need applications consistent with and necessary to the proper administration of this chapter. All rules shall be adopted pursuant to RSA 541-A and as described in this section; except that, in the case of an irreconcilable conflict between the provisions of RSA 541-A and the provisions of this section, the provisions of this section shall control. In addition, before adopting proposed rules:

(a) The board shall distribute copies of its proposed rules to:

(1) Statewide health agencies and organizations;

(2) All health care facilities, health maintenance organizations, and other persons on the board's comprehensive mailing list; and

(b) At least 45 days prior to adopting any rule, the board shall send by mail to all persons included on the comprehensive mailing list and shall publish, in at least one newspaper of statewide circulation, a notice stating that rules for the review of certificate of need applications or any revisions thereof have been proposed for adoption and are available at specified addresses for inspection and copying by interested persons. Such notice shall appear in other than the legal notices section of such newspapers; in addition, notice may be given through other public information channels.

II. The board shall distribute copies of its adopted rules to the persons required to be given notice in subparagraph I(b) and to the Secretary of Health and Human Services and shall provide such copies to other persons upon request.

151-C:12 Validity of Certificate of Need; Compliance; Sanctions.

I. A certificate of need issued pursuant to this chapter shall expire upon failure to commence or complete the project authorized thereby within the time period specified in this section. The board's approval shall be terminated upon the expiration of such period, and the person proposing to offer or develop the new institutional health service shall be required to resubmit an application for certificate of need under RSA 151-C:8. In the event that only part of a project to offer or develop the new institutional health service has been commenced or completed within such period, the board's approval shall be terminated upon the expiration of such period solely with respect to the parts of the project which have not been commenced or completed. Project completion date requirements are as follows:

(a) Projects which solely involve the acquisition and installation of equipment must be completed within 2 years from the date of issuance of a certificate of need or certificate of exemption.

(b) In the case of construction projects, the following time periods apply:

(1) If the total estimated cost of the project is less than $1,000,000, the project must be commenced within one year of, and completed within 3 years of, the date of issuance of a certificate of need.

(2) If the total estimated cost of the project is greater than $1,000,000, then the project must be commenced within 18 months of, and completed within 5 years of, the date of issuance of a certificate of need.

(c) In the case of any plan for capital expenditures proposed by or on behalf of a health care facility, health maintenance organization, or health care provider under which a series of obligations for capital expenditures for discrete components of the plan is to be incurred over a period longer than one year, the board may allow up to 3 years following the date of approval for incurring such capital expenditures.

II Pursuant to a showing of good cause by the person proposing the project, the board shall extend by 6 months the period for commencement. A maximum of 2 such extensions shall be allowed. Upon a showing of substantial, diligent progress and good cause by the person proposing the project, the board shall grant up to a maximum of 2 extensions of 6 months each for completion of the project. For purposes of this paragraph, "good cause" includes delay resulting from unpreventable or unexpected occurrences, such as emergency, strike, disaster, unforeseen shortage of materials or other reasonably unforeseeable event. (Amended 6/29/88 Chapter 275:16)

III. For the purposes of this chapter, a project shall be commenced if:

(a) The applicant has submitted to the board a certified copy of a written agreement executed between the applicant and a registered general contractor to construct and complete the project within a designated time schedule in accordance with final architectural plans and specifications; or (Amended 6/29/88 Chapter 275:17)

(b) The applicant has submitted evidence to the board that there has been construction work on the project to justify and require a progress payment by the applicant to the general contractor under the terms of the construction agreement, or, if the construction agreement does not require progress payments, then construction has progressed to the state at which an initial progress payment would otherwise be required in accordance with the usual and customary practices of the building industry. (Amended 6/29/88 Chapter 275.17)

IV. For purposes of this chapter, completion shall means when the approved proposed project is sufficiently complete so that it becomes operational for the purpose for which the certificate of need was issued. A certificate of need shall be valid only for the designated scope of the project and for the premises and geographical area name in the application. A certificate of need granted for a project which is in excess of the sum of: (a) the anticipated cost designated in the application; (b) an additional 15 percent of the total cost; and (c) cost increases clearly attributable to inflation. (Amended 6/29/88 Chapter 275:18)

IV-a. (a) Prior to completion of the proposed project, the board may require any applicant to file a change of scope when any documentation or other material submitted to the board indicates that: (Added 6/29/88 Chapter 275:19)

(1) The nature, scope, or location of the project will differ substantially in the opinion of the board from those described in the application. (Added 6/29/88 Chapter 275:19)

(2) The method of financing will differ substantially because the estimated capital expenditure will exceed that proposed in the application by 15 percent plus the inflation factor, as specified in RSA 151-C:12, IV. (Added 6/29/88 Chapter 275:19)

(3) The identity of the applicant has changed. (Added 6/29/88 Chapter 275:19)

(b) The board may waive the requirements of subparagraph (a)(1), (2) or (3), if it is determined that the proposed change in scope of the project is technical or otherwise insignificant. (Added 6/29/88 Chapter 275:19)

V. All applicants receiving a certificate of need or a certificate of need with conditions shall file, at least semi-annually during the development stage and annually once the project is commenced, a report indicating that the project is in compliance with information provided in the application, and with the conditions outlined in the certificate of need. A report shall only be necessary for the first 5 years after completion of the project.

VI. Any applicant found not to be in reasonable compliance with any statement in their certificate of need application or with the conditions of the certificate of need shall be fined not more than 1/2 of one percent of the previous year's revenue minus contractual allowances or, in the case of a new facility, not more than 1/2 of one percent of the projected first year revenue minus contractual allowances.

VII. Funds collected under the provisions of this chapter shall be deposited in the general fund.

151-C:13 Exemptions.

I. The following are excluded from this chapter:

(a) Private offices or private clinics of physicians, dentists, or other practitioners of the healing arts, meaning the physical places which are occupied by such providers on a regular basis in which such providers perform the range of diagnostic and treatment services usually performed by such providers on an outpatient basis;

(b) Dispensaries and first-aid stations, located within business or industrial establishments, maintained solely for the use of employees, provided that such a facility does not contain inpatient or resident beds for patients or employees who generally remain in the facility for more than 24 hours;

(c) Infirmaries owned and operated by education institutions;

(d) Institutions or homes which provide remedial care or treatment only to residents or patients who rely solely upon treatment by prayer or spiritual means in accordance with the creed or attendance of any recognized church or religious denomination;

(e) The increase or conversion of 9 beds or fewer or less than 10 percent of the bed complement, whichever is less;

(f) Facilities and services which are intended to serve only outpatients and which do not require construction of greater than $1,000,000 or new equipment costing more than $400,000. (Added 6/29/88 Chapter 275:20)

II. The above exclusions shall not include any diagnostic or therapeutic equipment located or used therein, or by any other facility covered by this chapter.

III. The board shall adopt rules under RSA 541-A governing procedures for the expeditious processing of emergency applications and of applications for projects which are solely for the purpose of complying with the requirements of law or rules, including projects necessary for compliance with life and health safety code standards. Emergency applications include applications regarding expenditures for replacement, repair, rebuilding, or re-equipping of any part of a health care facility or health maintenance organization destroyed or damaged as the result of fire, storm, flood, act of God, or civil disturbance, or any other circumstances in which the board finds that the circumstances require action by the board in less time than normally required for review.

151-C:14 Enforcement.

I. Any person who offers or develops any new institutional health service within the meaning of this chapter without first obtaining a certificate of need as required in this chapter, or who otherwise violates any of the provisions of this chapter, shall be subject to the following sanctions:

(a) The state shall not issue a license to any health care facility or health maintenance organization to operate, offer, or develop any new institutional health service in violation of this chapter and without a certificate of need issued pursuant to this chapter. The provisions of RSA 151 notwithstanding, in the case of an increase in actual bed capacity in contravention of the requirements of this chapter, any license for such beds shall be deemed to be revoked.

(b) The state shall not furnish from any reimbursement program administered by the state, nor shall any entity chartered under the laws of New Hampshire or any person licensed and doing business in the state, provide reimbursement for any new institutional health service offered or developed in contravention of the requirements of this chapter.

(c) Any person who violates this chapter shall be fined no more than 1/2 of one percent of the total operating budget of the previous year, or, in the case of a new facility, not more than 1/2 of one percent of the projected annual operating budget for the first year of operation.

(d) In addition to all other sanctions, if any person offers or develops any new institutional health service without first having been issued a certificate of need, or violates any other provision of this chapter, or any lawful rule adopted under this chapter, upon the posting of a bond or security, the board or health care facilities, health maintenance organizations, and health care providers located in the state shall have standing to maintain a civil action in the superior court of the county in which such alleged violation has occurred, or in which such person may be found, to enjoin, restrain, or prevent such violation. Upon written request by the board, it shall be the duty of the attorney general of the state to furnish such legal services as may be appropriate and to prosecute such action for injunctive relief to an appropriate conclusion.

151-C:15 Fees.

I. In addition to any other fees required of it, each acute care hospital, specialty hospital, and nursing home licensed under RSA 151 shall pay an annual administrative fee of up to 1/10 of one percent of their previous year's revenue minus contractual allowances or, if a new facility, up to 1/10 of one percent of their project first year rev nue minus contractual allowances. The total amount collected shall not exceed $400,000 per year, to be prorated at the end of each fiscal year among all acute care hospitals, specialty hospitals, and nursing homes licensed under RSA 151.

II. All persons filing an application in response to a request for applications shall pay a fee of 1/4 of one percent of the total capital cost of the project with a minimum fee of $500, and a maximum of $12,000. This paragraph shall not apply to any facility which is included under RSA 151-C:15, I.

III. Persons requesting a standard development or standard review as outlined in RSA 151-C:6 shall pay a fee of $1,000 if the health services planning and review board determines that a standard review or a standard development process shall occur.

IV. Funds collected under this section shall be deposited in the general fund.

378:7 Health Services Planning and Review Board. The 7 members of the existing certificate of need review board shall be transferred to serve on the health services planning and review board established by RSA 151-C:3. Other members of the health planning and review board shall consist of the commissioner of health and human services or his designee and the commissioner of administrative services or his designee. The first vacancy on the board shall then be filled by the commissioner of insurance or his designee.

378:8 Transfers to Health Services Planning and Review Board. All functions, powers, duties, records, property, and funds of the division of public health services, department of health and human services, relative to the certificate of need program established by RSA 151-C are hereby transferred to the health services planning and review board established by RSA 151-C:3.

378:9 Federal Statutes and Regulations. Any federal statute or regulation taking effect subsequent to the effective date of this act which is more restrictive or inclusive than this act shall supersede this act. All applicants under RSA 151-C shall refer to the provisions contained in this act and the certificate of need rules as adopted by the health services planning and review board.

378:10 Exemption. All state facilities covered by this act are exempt from the fees stipulated in RSA 151-C:15.

378:11 Date for Standard of Need. Within 180 days of the passage of this act, the health services planning and review board shall review all standards currently in existence in the state health plan (department consolidated plan) and make a determination on which of the existing standards shall be carried forward under RSA 151-C and which shall undergo a standard development process pursuant to RSA 151-C:5.

378:12 Appropriation. There is hereby appropriated to the division of public health services the sum of $400,000 for the fiscal year ending June 30, 1986, and the sum of $400,000 for the fiscal year ending June 30, 1987, for the purpose of carrying out this act. The governor is authorized to draw his warrant for said sums out of any money in the treasury not otherwise appropriated.

378:13 Effective date. This act shall take effect July 1, 1985.

Source: 1985, 378. 1988: 275, eff. June 29, 1988.

Chapter He-Hea 800

Acute Psychiatric Inpatient Services

Part 801 Purpose and Definitions.

§ 801.01 Purpose:

This chapter implements an institutional health service standard for acute psychiatric inpatient beds that is intended to meet the needs of the people in the state. The implementation of such a standard is mandated in RSA 151-C:5.

§ 801.02 Definitions:

(a) "Acute psychiatric inpatient beds" means those hospital beds dedicated to providing treatment for mental illness and in which the expected length of stay in the facility or in the psychiatric unit of the facility is less than 30 days.

Part 802 Program Goal:

Acute psychiatric inpatient bed needs should be integrated with the Division of Mental Health and Developmental Services' proposed development of an integrated and comprehensive system of care as defined by their state plan.

Part 803 Standard for Determining the Number of Acute Psychiatric Inpatient Beds Needed by the State.

§ 803:01 (a) No application for additional acute psychiatric inpatient beds, whether for new beds or for the conversion of beds in an existing facility, shall be considered by the Health Services Planning and Review Board unless the applicant has a letter from the Division of Mental Health and Developmental Services informing the board that these beds are necessary for their mental health system as defined in "Planning For Progress: Restructuring The Mental Health/Developmental Services System" which is the plan supported by Chapter 407 which mandates restructuring of the state mental health system.

(b) Any proposals for construction or development of inpatient beds for mental health services that are not covered by "Planning For Progress: Restructuring The Mental Health/Developmental Services System" shall not be submitted to the Health Services Planning and Review Board unless the applicant has a letter from the Division of Mental Health and Developmental Services informing the board that this service is a necessary addition to the state mental health system as outlined in "Planning For Progress: Restructuring The Mental Health/Developmental Services System".

Part 804 Facilities Standards.

§ 804.01 Performance Standards: All applicants for acute psychiatric inpatient services shall document performance standards for the Certificate of Need review which shall be consistent with programmatic standards contained in facility licensure requirements as found in He-P 807, Residential Treatment and Rehabilitation Facilities licensing rules.

§ 804.02 Other Criteria: Any applicant shall demonstrate that they meet the requirement described in RSA 151-C:7.

§ 804.03 Accreditation: All applicants shall demonstrate that they will meet the standards to be accredited by the Joint Commission on Accreditation of Hospitals (JCAH).

§ 804.04 Admission: No patient meeting the admission criterion shall be denied admittance to the program.

§ 804.05 Payment: No patient shall be denied emergency treatment at any facility because of inability to pay. All patients admitted on an emergency basis shall be referred by the facility to the community mental health system when the patient is stabilized. The facility shall make contact with the mental health system and ensure that the patient receives a referral to the most appropriate treatment.

CHAPTER He-Hea 500 FEES

PART 501 CALCULATION OF FEES

He-Hea 501.01 Fees

(a) The administrative fees described in RSA 151-C:15, I shall be determined based on the gross revenue minus contractual allowances for acute care hospitals, nursing homes and specialty hospitals.

(b) The percentage of the total gross revenue minus contractual allowances generated by each classification, i.e. acute hospitals, nursing homes and specialty hospitals, shall be determined.

(c) Fees shall be calculated by multiplying the percentage figure generated in 501.01 (b) times the budget of the office of health services planning and review. The figure generated by this shall be divided by the total number of beds in each group (acute care hospitals, nursing homes, specialty hospitals). This will yield a per bed assessment for each group. Each facility shall be assessed the per bed assessment times the number of beds in the facility licensed under RSA 151.

(d) The total amount collected shall not exceed $400,000.

Source. #4135, eff 9-29-86

He-Hea 501.02 Time. The assessment of fees under this rule shall be on January 1, and be based on the fiscal year ending on the previous June 30, to be paid in full lump sum on March 31.

Source. #4135, eff 9-29-86

(b) Filing Requirements: Request for standards of need shall be received and accepted on January 1, May 1 and September 1.

(c) Notice: The board shall notify an applicant submitting a request for standard review that the request shall be received and accepted for filing effective on the next succeeding date set forth in section He-Hea 401.02(b).

(d) Standard: The board shall develop a standard pursuant to RSA 541-A:3.

Source. #4135, eff 9-29-86

PART He-Hea 402 REQUIREMENTS FOR STANDARD OF NEED

He-Hea 402.01 Standards of Need. A standard of need promulgated by the board shall include:

(a) A definition of the service under review;

(b) Identification of any formal or statistical model to determine need;

(c) Identification of any exceptional issues that go beyond any model used;

(d) Identification of any condition placed on the service under review, including but not limited to, reimbursement, occupancy and the rates of other facilities;

(e) Identification of criteria under which the applicant will be reviewed, pursuant to RSA 151-C:7.

Source. #4135, eff 9-29-86

PART He-Hea 403 PUBLICATION OF REQUEST FOR PROPOSAL

He-Hea 403.01 Publication Requirements. The request for a proposal developed pursuant to a standard of need shall be published no later than 20 business days after the adoption of the standard of need, and in other than the legal notices section of a newspaper of statewide distribution and in at least one newspaper in every county.

Source. #4135, eff 9-29-86

He-Hea 306.03 Filing Requirements. Reports shall be filed according to the following schedule:

(a) During the development stage, each report shall be filed within 30 calendar days following the end of the first 6 month period from date certificate of need was granted and every 6 months thereafter until completion;

(b) After commencement, each report shall be filed within the 30 days following the end of each 12 month reporting period.

Source. #4135, eff 9-29-86

He-Hea 306.04 Submission. The original and 20 copies of each completed report shall be sent to the board.

Source. #4135, eff 9-29-86

He-Hea 306.05 Reconsideration. Applicants which are deemed to be in noncompliance with their certificate of need approval may appeal that decision to the board. If necessary the board shall hold a hearing and make a decision according to the procedures of Part He-Hea 203.

Source. #4135, eff 9-29-86

CHAPTER He-Hea 400 DEVELOPMENT OF STANDARD OF NEED

PART He-Hea 401 DEVELOPING PROPOSED STANDARDS OF NEED

He-Hea 401.01 Procedure for Proposed Standards of Need. The procedure in Part 401 shall precede the procedure for adoption of rules as required by RSA 541-A:3.

Source. #4135, eff 9-29-86

He-Hea 401.02 interrelationship with Certificate of Need Process. The board shall develop standards of need for proposed projects before accepting applications for certificate of need. Standards of need shall be set according to the following procedure, consistent with RSA 151-C:5 and RSA 151-C:6.

(a) Request for Standard: The board may initiate review of an existing standard or a service without an existing standard. A party may request standard review for an existing standard, or a service without an existing standard.

PART He-Hea 306 IMPLEMENTATION REPORTS

He-Hea 306.01 Requirement. All parties who receive approval of their applications shall submit implementation reports.

Source. #4135, eff 9-29-86

He-Hea 306.02 Form. Implementation forms shall be submitted in a form to be provided by the board which shall include any or all of the following information;

(a) Fees associated with project including legal, consultant and application fees;

(b) The method of compliance with any conditions required in the board's approval;

(c) Projected or actual date of substantial completion;

(d) Projected or actual date of licensure, certification or accreditation;

(e) Name and title of person completing implementation report;

(f) Construction costs including labor, materials, fixed equipment, demolition, interest during construction, contingency funds, and insurance during construction;

(g)Construction related costs including real estate acquisition, soil survey or evaluation fee, site preparation, engineering or architect evaluation and design fees, and temporary relocation fees;

(h) For inpatient service information including applicable degree of compliance with applicable standard of need, charge for services, level of use, level of indigent care provided and operation cost;

(i) For purchase of equipment, information including name of manufacturer of equipment, description of equipment, cost, specifications, set-up cost, date equipment is operational or certified, level of use of equipment, cost per procedure, level of use by indigent persons, operational cost, service contract cost;

(j) For transfer of ownership, information including purchase price, amount of debt, amount to be refinanced, cost of services before and after acquisition, and operating cost before and after acquisition.

Source. #4135, eff 9-29-86

(1) All provisions contained in RSA 151-C:8, VI pertaining to a public hearing shall not apply,

(2) In place of the public hearing the notification shall include a 14 day period from the date of notification as established in RSA 151-C:8, VII, within which persons directly affected by review may submit written comment to the board;

(h) Time Limit. The board may conduct a review in accordance with RSA 151-C: 8, VIII;

(i) Reconsideration. The board may conduct a reconsideration hearing in accordance with RSA 151-C:9,IV;

(j) Issuance. The board shall issue a certificate of need for a proposed project if it meets the requirements for law and rule review.

Source. #4135, eff 9-29-86

PART He-Hea 305 ISSUANCE OF CERTIFICATE OF NEED

He-Hea 305.01 Decision. A certificate of need may only be issued, denied or withdrawn by the board, and shall, except in emergency circumstances which pose a threat to public health, be consistent with the State Health Plan in effect at the date the application is filed with the board.

Source. #4135, eff 9-29-86

He-Hea 305.02 Contents. A certificate of need shall at a minimum include the following information:

(a) Date of issue;

(b) Name of applicant;

(c) The proposed Project;

(d) Date of board approval;

(e) Conditions of approval;

(f) Approved cost; and

(g) Certificate number.

Source. #4135, eff 9-29-86

(b) Application: The applicant shall submit a petition for emergency review and the appropriate fee in accordance with RSA 151-C:15 to the board;

(c) Determination of Status: The board shall act on the application within 5 business days of receipt;

(d) The board's decision shall be final;

(e) The board shall notify the applicant of its decision immediately by mail; and

(f) The board may conduct a reconsideration hearing in accordance with RSA-C:9,IV and Part He-Hea 205.

Source. #4135, eff 9-29-86

He-Hea 304.03 Law and Rule Application Procedure.

(a) Preliminary Statement. The applicant shall submit a preliminary statement of notification of existing or potential noncompliance with local, state or federal law to the board;

(b) Review of Preliminary Statement. The board shall review the preliminary statement within 5 business days of receipt.

(c) Qualification. If the proposed project meets the criteria for law and rule application review in He-Hea 101.08 and the minimum thresholds of RSA 151-C:5,II, the board shall ask the applicant to complete an application to be developed by the board. If the proposed project does not meet the criteria for law and rule review, the board shall so notify the applicant;

(d) Assistance. The board shall provide assistance to the applicant, upon request, to prepare the application.

(e) Application. The applicant, as soon as possible, shall submit 20 copies of the application with the appropriate fee to the board.

(f) Completeness. The board shall within 10 business days determine if the application is complete and so notify the applicant; if the application is deemed incomplete the provisions of RSA 151-C:8,V and RSA 151-C:8,VII shall apply.

(g) Review Process. When the application is deemed complete, or otherwise for review, the provisions of RSA 151-C:8,VI and RSA 151-C:8,VII shall apply except that:

He-Hea 303.04 Board Decision.

(a) The final decision of the board shall be based solely on established criteria in the standard as introduced into the record and/or facts which have been officially noticed. The board shall send its decision to the applicant, all other applicants and others upon request.

(b) "Evidence which has been introduced into the record" shall include:

(1) The completed application filed by the applicant;

(2) The record made at any public hearing and all written evidence or arguments presented at the hearing;

(3) The analysis of the staff to the board; and

(4) Any additional oral or written information submitted by the applicant or by any interested person.

(c) "Facts which have been officially noted" shall mean evidence or information within the specialized knowledge and expertise of the board, including information and evidence which the board is obligated to gather in order to meet its burden with respect to the criteria contained in the standard. Whenever notice is taken of a fact which may be disputable, the fact and its source shall be stated by the board at the earliest practicable time before ordering a public hearing. Notification of such public hearing shall be given by written notice to all persons listed in the subparagraph concerning additional evidence, or in the final decision. Any person shall, on timely request, be given a chance to dispute the fact of its materiality through a written submission of evidence or argument. The board may in its discretion, determine that fairness requires that the parties be afforded an opportunity to contest officially noticed facts at a public hearing for this purpose.

Source. #4135, eff 9-29-86

PART He-Hea 304 EXPEDITED REVIEW

He-Hea 304.02 Emergency Review.

(a) Qualification: If the proposed capital expenditure meets the definition of emergency review as defined in Section He-Hea 101.06, the application shall be considered as a certificate of need emergency application;

(e) The extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved and the extent to which medically underserved populations are expected to use the proposed services if approved;

(f) The performance of the applicant in meeting its obligation, if any, under applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance (including the existence of any civil rights access complaints against the applicant);

(g) The extent to which Medicare, Medicaid and medically indigent patients are served by the applicant;

(h) The extent to which the applicant offers a range of means by which a person will have access to its services (i.e., outpatient services, admission by house staff, admission by personal physician);

(i) The degree of support expressed by other health care providers, third party payers and interested persons within the service area;

(j) The effect of the project on alternative delivery systems such as, but not limited to, health maintenance organizations, preferred provider organizations, and independent practice organizations;

(k) The effect of the proposed project on the clinical needs of health professional training programs in the geographical area; and

(l) The extent to which health professional schools will have access to the services for training purposes.

Source. #4135, eff 9-29-86

PART He-Hea 303 REVIEW PROCESS

He-Hea 303.01 Procedure. RESERVED

He-Hea 303.02 Public Access. Applications shall not be available for public inspection until review begins pursuant to RSA 151-C:8,VI (a).

Source. #4135, eff 9-29-86

He-Hea 303.03 Deadline for Submitting Information. After the start of formal review, no further information shall be accepted by the board until the public hearing.

Source. #4135, eff 9-29-86

application with all parts submitted but the board needs clarification of information provided to complete its review. Whenever an application is determined to be incomplete, the board or its staff shall notify the applicant by certified mail within 15 business days and include a full statement of the reasons for incompleteness. If no request for additional information is made, the application shall be considered complete.

(b) An applicant whose application is incomplete shall have opportunity to provide additional information pursuant to RSA 151-C:8,V(b) and RSA 151-C:8,V(c).

Source. #4135, eff 9-29-86

He-Hea 301.07 Amendments. Amendments to applications shall be made in accordance with RSA 151-C:8,XII. All request for amendments shall be approved by the board within 2 weeks of the request.

Source. #4135, eff 9-29-86

PART He-Hea 302 CRITERIA FOR CERTIFICATE OF NEED

He-Hea 302.01 Criteria. Criteria for certificates of need shall include those identified in RSA 151-C:5,II, those identified in the standard and may include any of the following:

(a) The relationship of the proposed project to the existing health care system of the state;

(b) The integration of the project into the existing facility and its relationship to other ancillary or support services;

(c) The impact on entities such as medical and other health professional schools, multi-disciplinary clinics, and specialty centers, for which 10% or more people using their services live outside New Hampshire;

(d) In the case of construction projects:

1. The costs and methods of the proposed construction, including the costs and methods of energy provision; and

2. That alternatives to new construction, such as modernization or sharing arrangements, have been considered and implemented as much as is practicable;

(o) The relationship of the proposed project to the applicant's internal long-range development plan;

(p) The relationship of the proposed project to the population to be served including definition of the service area, the population's need for the proposed project, the accessibility and availability of the proposed project, the estimated use of the project;

(q) The integration of the proposed project into the existing health care delivery system;

(r) The operating plan for the proposed project and the resources available to accomplish it, including staffing requirements, integration of a new service into the existing facility, a quality assurance program, methods of any proposed construction and energy efficiency of the facility; and

(s) Financial feasibility of the proposed project including project costs, project financing, level of proposed debt and projected annual financial statements.

Source. #4135, eff 9-29-86

He-Hea 301.05 Filing Requirements.

(a) The applicant shall submit 20 copies of the application along with the appropriate fee, if applicable, to the board.

(b) Any additional submitted information shall be typed single spaced on 8 1/2" x 11" plain white paper and shall be identified by number and item.

(c) Exhibits shall be titled and included as continuing pages at the end of the information items and responses. When an exhibit is referenced in a response, the title and page number shall be footnoted.

(d) All pages of the application shall be numbered sequentially.

Source. #4135, eff 9-29-86

He-Hea 301.06 Completeness Requirement.

(a) All portions of the certificate of need application shall be complete before it shall be accepted by the board. "Incomplete" as used in reference to the certificate of need application in RSA 151-C:8 shall mean an

He-Hea 301.03 Submission of Applications. Applications shall not be required to be submitted less than 40 days after the date of the technical assistance meeting.

Source. #4135, eff 9-29-86

He-Hea 301.04 Application Form. Applicants shall fill out a form to be provided by the board which shall require the following information if applicable:

(a) A brief description of the project;

(b) The name and legal structure of the entity submitting the application;

(c) The names of the members of the governing body of the entity submitting the application;

(d) The names of the owners of record of the entity submitting the application;

(e) The name, title, address and telephone number of a contact person responsible for the contents of the application;

(f) Type of review sought;

(g) Type of project; (including both type of facility and type of service)

(h) Total cost of the project;

(i) Estimated date that preliminary plans will be complete;

(j) Estimated date that a binding commitment of financing will be secured;

(k) Estimated date that finalized plans and specifications for project will be submitted;

(l) Estimated date that construction will begin;

(m) Estimated date that the project will be substantially completed;

(n) The relationship of the proposed project to required criteria as specified in the applicable standard of need, RSA 151-C and Part He-Hea 302;

PART He-Hea 102 BOARD ORGANIZATION

He-Hea 102.01 Scope and Purpose. The health services planning and review board shall conduct business as authorized by RSA 151-C.

Source. #4135, eff 9-29-86

He-Hea 102.02 Communications. All communications to the board shall be directed to the board's office:

Director, Office of Health Services
Planning and Review
Division of Public Health Services
6 Hazen Drive
Concord, New Hampshire 03301-6527

Source. #4135, eff 9-29-86

CHAPTER 300 CERTIFICATE OF NEED

PART He-Hea 301 APPLICATION FOR CERTIFICATE OF NEED

He-Hea 301.01 Application Procedure. Applicants for certificates of need shall follow the following procedures: the request for applications notice published pursuant to RSA 151-C:8,I, shall include a proposed date for a technical assistance meeting between applicants and the board, or the office of health services planning and review staff to be held within 20 days of the publication.

Source. #4135, eff 9-29-86

He-Hea 301.02 Pre-application Meeting. Applicants shall meet with the board on the designated date, or at another date mutually agreed upon by the board and the applicant, and receive the following:

(a) Copies of the application format;

(b) The minimum criteria and specifications by which the board will judge the merits of each application; and

(c) Any other technical assistance which is required to help the applicant with its application.

Source. #4135, eff 9-29-86

He-Hea 101.08 "Law and rule application review" means review of applications, filed pursuant to RSA 151-C:13,III, regarding expenditures solely for the purpose of complying with legal and regulatory requirements for provisions for the handicapped, energy grants or energy conservation or both, to eliminate or prevent imminent safety code violations, to comply with state licensure standards or to comply with accreditation standards in order to receive reimbursement under Title XVIII of the Social Security Act or payments under a state plan for medical assistance approved under Title XIX of such act.

Source. #4135, eff 9-29-86

He-Hea 101.09 "Long-term care" means care provided in a licensed nursing home or an extended care unit.

Source. #4135, eff 9-29-86

He-Hea 101.10 "Medically underserved" or "medically underserviced" persons means members of groups who experience difficulty in obtaining access to health services such as, but not limited to, low income persons, racial and ethnic minorities, women, handicapped persons and elderly persons.

Source. #4135, eff 9-29-86

He-Hea 101.11 "Project" or "proposed project" means a new institutional health service as outlined in RSA 151-C:5,II.

Source. #4135, eff 9-29-86

He-Hea 101.12 "Publication" means publication in a daily statewide newspaper.

Source. #4135, eff 9-29-86

He-Hea 101.13 "Request for proposal" means publication of notice that the board will be accepting applications pursuant to a standard of need developed pursuant to RSA 151-C:5 and Chapter He-Hea 400.

Source. #4135, eff 9-29-86

He-Hea 101.14 "Service area" means the geographic area from which the majority of patients at a facility are from, unless otherwise specified in another part of these rules.

Source. #4135, eff 9-29-86

He-Hea 101.15 "Special hospital" or "specialty hospital" means a facility which is designed and used for special health care purposes to include, but not be limited to: psychiatric hospitals, substance abuse facilities, and rehabilitation facilities.

Source. #4135, eff 9-29-86

He-Hea 101.16 "State Health Plan" means the compilation of the standards developed through the standard review process and standard development process outlined in RSA 151-C:5 and RSA 151-C:6.

Source. #4135, eff 9-29-86

He-Hea 101.17 "Substance abuse facility" means an inpatient unit which provides physiological detoxication or rehabilitative services or both to patients affected by a alcohol or drug addiction or abuse.

Source. #4135, eff 9-29-86

He-Hea 101.18 "Substantial completion" means a project is operational for the purpose for which the certificate of need was issued.

Source. #4135, eff 9-29-86

He-Hea 101.19 "Technical assistance" means advice given by the board to applicants to help ensure the applicants submit all the necessary information on their certificate of need applications.

Source. #4135, eff 9-29-86

He-Hea 101.20 "Therapeutic equipment" means any equipment used in the treatment of disease.

Source. #4135, eff 9-29-86

He-Hea 101.21 "Total new institutional health service cost" means the total of all costs related to the new institutional health service to be capitalized in accordance with generally accepted accounting principles and includes, but is not limited to, legal fees, feasibility studies, land acquisition, site development, soil survey and investigation, consulting fees, interest during construction, temporary relocation, architect and engineering fees, construction/renovation or alteration, contingency, labor, materials and equipment.

Source. #4135, eff 9-29-86

CHAPTER He-Hea 100 DEFINITIONS AND GENERAL INFORMATION

PART He-Hea DEFINITIONS

He-Hea 101.01 "Acute care" means services provided for episodic hospital treatment of short-term disease with an average length of stay of less than 30 days.

Source. #4135, eff 9-29-86

He-Hea 101.02 "Acute care or short-term care bed" means a bed for an admission for an average length of stay of less than 30 days.

Source. #4135, eff 9-29-86

He-Hea 101.03 "Agency" means the health services planning and review board

Source. #4135, eff 9-29-86

He-Hea 101.04 "Board" means the health services planning and review board and all parties delegated authority by the board pursuant to RSA 151-C.

Source. #4135, eff 9-29-86

He-Hea 101.05 "Diagnostic equipment" means any equipment used in the identification of disease.

Source. #4135, eff 9-29-86

He-Hea 101.06 "Emergency Review" means review of applications regarding emergency expenditures pursuant to RSA 151-C:13,III, and RSA 151-C:5,II, which include expenditures for replacement, repair, rebuilding or re-equipping of any part of a health care facility or health maintenance organization destroyed or damaged as a result of fire, storm, flood, act of nature, or civil disturbance in which the board finds that the circumstances require action by the board in less time than normally required for review.

Source. #4135, eff 9-29-86

He-Hea 101.07 "Extended care" means a section of an acute care hospital licensed to provide long-term care.

Source. #4135, eff 9-29-86

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STATUTORY AUTHORITY: RSA 151-C

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Department of Health And Human Services
6 Hazen Drive
Concord, NH 03301

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CHAPTER He-Hea 600 MAGNETIC RESONANCE IMAGING SCANNERS

PART He-Hea 601 PURPOSE AND DEFINITION

He-Hea 601.01 Purpose. This chapter implements an institutional health service standard for magnetic resonance imaging scanners that is intended to lower entry barriers to and promote reasonable competition among qualified venders of such services. Certificates of need shall be issued to qualified applicants who demonstrate compliance with the applicable requirements of this chapter. Because a competitive environment will best promote the state's health care interests during the early development phase of magnetic resonance imaging technology ("MRI"), applications for MRI scanners shall not be subject to the procedures of RSA 151-C:8.

Source. #4057, eff 5-28-86

He-Hea 601.02 Definitions.

(a) "Magnetic Resonance Imaging Scanner" means a diagnostic tool using a combination of magnetic fields and radio frequency waves known as "magnetic resonance imaging" or "MRI" to provide images of internal parts of the human body.

(b) "Fixed unit" means a magnetic resonance imaging scanner which is physically fixed at a single operational location and is not moved from site to site.

(c) "Mobile unit" means a magnetic resonance imaging scanner which is housed in a tractor trailer or otherwise freely transported from site to site.

(d) "Tertiary care facility" means an acute care hospital which is affiliated with a medical school, has resident physicians and which is the site for research and education.

(e) "Vendor" means a person holding a certificate of need to provide magnetic resonance imaging services or a person applying to the board for such a certificate.

Source. #4057, eff 5-28-86

PART He-Hea 602 STANDARDS FOR MOBILE UNIT SERVICES.

He-Hea 602.01 Limitation on Vendors. No hospital shall be certified as a vendor of mobile unit services. A vendor may, however, be a corporate subsidiary of a hospital.

Source. #4057, eff 5-28-86

He-Hea 602.02 Limitations on Use. Mobile unit services shall only be sold to or contracted for by acute care hospitals. Vendors may contract with as many hospitals as they wish. They shall not, however, participate in a contract which requires any given hospital to use a vendor's services exclusively or prohibits the vendor from serving other hospitals.

Source. #4057, eff 5-28-86

He-Hea 602.03 Limitations on Service Locations. Mobile unit services shall only be operated on the premises of an acute care hospital.

Source. #4057, eff 5-28-86

He-Hea 602.04 Financial Qualifications. A vendor shall demonstrate the availability of sufficient liquid assets in excess of current liabilities to purchase a mobile unit approved for mobile use by the Federal Food and Drug Administration or a unit which is approved for fixed use and which is currently undergoing pre-market review for approval for mobile use.

He-Hea 602.05 Staffing Plan. A vendor shall demonstrate a staffing plan, and the financial and managerial resources to implement this plan, which is sufficient to provide the personnel necessary to transport the unit and make it operational at its service areas.

Source. #4057, eff 5-28-86

He-Hea 602.06 Reporting Requirements.

(a) Certificated vendors shall record and maintain the following data request:

(1) volume at each site.

(2) patient origin of each patient at each site.

(3) patient demograph including age, sex, and payment source.

(4) DRG for inpatients.

(5) major symptoms for outpatients.

(6) cost per scan.

(b) This information shall be forwarded to the board on a quarterly basis or upon request. Regular quarterly reports shall be submitted by January 31, April 30, July 31, and October 31, of each year.

Source. #4057, eff 5-28-86

PART He-Hea 603 STANDARDS FOR FIXED UNIT SERVICES.

He-Hea 603.01 Limitations on Vendors. No hospital shall be certified as a vendor of fixed unit services. A vendor may, however, be a corporate subsidiary of a hospital.

Source. #4057, eff 5-28-86

He-Hea 603.02 Limitations on Vendors. Fixed Unit services shall be provided only at tertiary care facilities which maintain a program to provide accredited educational programs to all interested New Hampshire physicians and medical students.

Source. #4057, eff 5-28-86

He-Hea 603.03 Reporting Requirements.

(a) Certificated vendors shall record and maintain the following data request:

(1) volume at each site.

(2) patient origin of each patient at each site.

(3) patient demographic data.

(4) DRG for inpatients.

(5) major symptoms for outpatients.

(6) cost per scan.

(b) This information shall be forwarded to the board on a quarterly basis or upon request. Regular quarterly reports shall be submitted by January 31, April 30, July 31, and October 31, of each year.

Source. #4057, eff 5-28-86

PART He-Hea 604 APPLICATION PROCEDURES.

He-Hea 604.01 Exemption From RSA 151-C:8. Applications are not subject to the requirements of RSA 151-C:8. They shall be processed and evaluated pursuant to this part.

Source. #4057, eff 5-28-86

He-Hea 604.02 Format. Applications shall be in letter form and attested to in their entirety by the vendor's chief executive officer. Unsigned applications shall not be accepted for filing. Applications shall clearly and thoroughly describe how the vendor shall comply with each requirement of Part

He-Hea 602 or Part He-Hea 603 (as the case may be) and shall include such supporting documentation (e.g., financial statement, balance sheet, hospital user contract, staffing plan) as may be deemed necessary by the board for purposes of insuring that the vendor is in compliance with this chapter.

Source. #4057, eff 5-28-86

He-Hea 604.03 Board Action.

(a) The board shall review and evaluate applications within 30 days following acceptance for filing.

(b) If an application demonstrates full compliance with this chapter, a certificate of need shall be issued to the vendor. Notice of the board's action shall be given pursuant to RSA 151-C:9, III.

(c) If the application does not demonstrate full compliance with this chapter, the board shall issue an order of conditional disapproval in which it sets forth the deficiencies in the application and affords the vendor an opportunity to correct the deficiencies or to request a hearing prior to a specified date. If the vendor fails to avail itself of either option, the application shall be denied.

(d) Possible competitive impact upon existing vendors or other proposed vendors shall not be a basis for denying an application. The effects of competition among MRI vendors shall not be a basis for denying an application. The effects of competition among MRI vendors shall be raised only in the form of a petition to revise the basic pro-competitive standard established by this chapter.

Source. #4057, eff 5-28-86

PART He-Hea 605 WAIVER FROM HE-HEA 602.02 AND HE-HEA 602.03.

He-Hea 605.01 Petition for Waiver from He-Hea 602.02 and He-Hea 602.03. A vendor may petition the board for a waiver from the requirements of He-Hea 602.02 and He-Hea 602.03 if they wish to provide services at other than an acute care hospital. Such a petition shall include:

(a) A description of the type of site/facility at which the services will be provided.

(b) A description of the contract arrangement between the vendor and the facility.

(c) A projection of the number of patients to be served annually at the site.

(d) Assessment of the impact of this site on acute care sites in the region.

Source. #4057, eff 5-28-86

He-Hea 605.02 Criteria for Evaluation of Petition for Waiver. The board shall consider the following criteria in determining whether to grant a waiver:

(a) The fiscal and organizational relationship between the vendor and facility.

(b) The presence of a special population of patients with special needs for MRI services who would experience accessibility problems if an MRI were not located at that site.

(c) The impact on patient volume at acute care hospitals in the region.

(d) The exempted site shall have medical backup including Basic Life Support equipment.

(e) The proposed charges at the site subject to waiver shall not exceed the charges at acute care hospital sites.

Source. #4057, eff 5-28-86

He-Hea 605.03 Decision on Waiver Petition. The board shall review the petition for waiver from He-Hea 602.02 and He-Hea 602.03 and shall issue written findings of its decision within 45 days of filing.

Source. #4057, eff 5-28-86

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CHAPTER He-Hea 700 PHYSICAL REHABILITATION BEDS

PART He-Hea 701 PURPOSE AND DEFINITION

He-Hea 701.01 Purpose. This chapter implements an institutional health service standard for physical rehabilitation beds that is intended to provide adequate services to meet the needs of the people in the state. The implementation of such a standard is mandated in RSA 151-C:5.

Source. #4136, eff 9-29-86

He-Hea 701.02 Definitions.

(a) "Comprehensive inpatient rehabilitation facilities" means facilities or units within facilities comprised of designated physical rehabilitation beds.

(b) "Physical disability" means an impairment caused by illness or injury, exclusive of substance abuse, that restricts those who have the impairment from performing adequately in any social role or roles that are expected, either at home, at work, or in the community.

(c) "Physical rehabilitation beds" means those hospital beds dedicated to providing medical, psychosocial, educational, vocational, and independent living services for people who have one or more physical disabilities in order that these people can attain the highest level of physical, social, psychological, and vocational functioning as possible.

Source. #4136, eff 9-29-86

PART He-Hea 702 STANDARDS FOR DETERMINING THE NUMBER OF PHYSICAL REHABILITATION BEDS NEEDED BY THE STATE

He-Hea 702.01 Standard. The number of additional beds needed for physical rehabilitation shall be determined by applying the Orange County, California needs formula to the 1990 New Hampshire population estimate of 1,138,800 people as provided by the United States Census Bureau. The application of this formula results in a 1990 need for 134 beds statewide. The current 266 bed inventory exceeds the 1990 estimate. Therefore, no additional certificates of need for physical rehabilitation beds shall be granted to any new or existing facility.

Source. #4136, eff 9-29-86

He-Hea 702.02 Exception. Consideration shall be given to the establishment of physical rehabilitation beds beyond those allowed by the standard in He-Hea 702.01 if all facilities with certificates of need have experienced at least 1 year of operation at or above optimum capacity, which shall be 90% occupancy, for the full year prior to any request for this exception.

Source. #4136, eff 9-29-86

He-Hea 702.03 Expiration. If there has been no need to review standards due to the occupancy levels described in He-Hea 702.02, then at the end of 2 years this standard shall be reviewed as to its current applicability.

Source. #4136, eff 9-29-86

PART He-Hea 703 FACILITIES STANDARDS

He-Hea 703.01 Performance Standards. All applicants for comprehensive inpatient rehabilitation services shall document for the certificate of need review that they will meet programmatic standards as contained in facility licensure requirements as found in He-P 807, Residential Treatment and Rehabilitation Facilities licensing rules.

Source. #4136, eff 9-29-86

He-Hea 703.02 Other Criteria. Applicants shall demonstrate that they meet the requirement described in RSA 151-C:7.

Source. #4136, eff 9-29-86

He-Hea 703.03 Involvement With Other State Agencies. All state agencies involved with the rehabilitation reimbursement or program shall be consulted as to whether the proposed services are consistent with their programs' plan for a comprehensive continuum of care.

Source. #4136, eff 9-29-86

He-Hea 703.04 Accreditation. All applicants shall demonstrate that they will meet the 1986 requirements for accreditation by the Joint Commission on Accreditation of Hospitals and the Commission on Accreditation of Rehabilitation Facilities.

He-Hea 703.05 Reporting Requirements. All comprehensive inpatient rehabilitation facilities shall collect data as established in the specialty hospital data set as defined in He-C 1500, as well as diagnostic data.

Source. #4136, eff 9-29-86

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CHAPTER He-Hea 1200 TRANSFERS OF OWNERSHIP OF NONTITLE XVIII AND XIX SPECIALTY HOSPITALS

PART 1201 PURPOSE AND DEFINITION.

He-Hea 1201.01 Purpose. This chapter implements an institutional health standard relative to the transfer of ownership of nontitle XVIII and XIX specialty hospitals.

Source. #4111, eff 8-20-86

He-Hea 1201.02 Definitions.

(a) "Acquisition" means a transfer of ownership interest, in whole or in part, from 1 person to another by way of purchase, donation, lease, transfer or comparable arrangement.

(b) "Applicant" means a person applying to the board for a certificate of need.

(c) "Board" means the health services planning and review board as defined in RSA 151-C: 2 (IV).

(d) "Title XVIII" means the health insurance program of the Social Security Act, Medicare, which provides health insurance benefits primarily to persons over the age of 65 and other persons eligible for Social Security benefits.

(e) "Title XIX" means the health insurance program of the Social Security Act, Medicaid, which provides health insurance benefits to indigent and medically indigent persons. This program is funded on a formula of federal-state cost sharing, and is administered by the individual states.

Source. #4111, eff 8-20-86

PART 1202 STANDARDS OF TRANSFERS OF OWNERSHIP OF NONTITLE XVIII OR XIX SPECIALTY HOSPITALS

He-Hea 1202.01 Acquisitions.

(a) No health care facility licensed by the bureau of health facilities administration (BHFA) which does not receive reimbursement from Title XVIII or Title XIX of the Social Security Act shall transfer greater than 50% of their total assets without obtaining a certificate of need.

(b) All nontitle XVIII and XIX specialty hospitals shall file an application for a certificate of need by addressing the following criteria.

(1) Documented evidence of financial ability to acquire and operate the proposed facility.

(2) Documented evidence of the impact on total patient charges resulting from a transfer of ownership.

(3) Documented evidence of changes in the operation of the facility resulting from a transfer of ownership.

(4) A description of the charity care program including the percent of total revenues which will be uncompensated.

Source. #4111, eff 8-20-86

PART 1203 APPLICATION PROCEDURES

He-Hea 1203.01 Submittal of Applications. Applications filed under this rule shall be submitted the first business day of any month.

Source. #4111, eff 8-20-86

He-Hea 1203.02 Format. Applications shall be in letter form and attested to in their entirety by the applicant's chief executive officer. Unsigned applications shall not be accepted for filing. Applications shall clearly and thoroughly describe how the applicant shall comply with each requirement of He-Hea 1202.01 (b)(1), (2), (3) and (4) and shall include the following supporting documentation.

(a) Three (3) years audited financial statements from the facility and the new owner.

(b) Staffing plan of the new owner.

(c) Charity care plan of the new owner.

(d) Charity care plan of any other facilities owned by the new owner.

(e) A rate schedule of patient charges under the old owner and the new owner.

He-Hea 1203.03 Board Action. The board shall consider the applications filed under He-Hea 1203.02 at the first regularly scheduled meeting following date of notification that the application is deemed complete pursuant to RSA 151-C:8(V). The board shall issue a final decision pursuant to RSA 151-C:9

Source. #4111, eff 8-20-86

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CHAPTER He-Hea 1100 CARDIAC SERVICES STANDARDS

PART He-Hea 1101 PURPOSE AND DEFINITION

He-Hea 1101.01 Purpose. This chapter implements an institutional health service standard for proposed providers of inpatient cardiology services and for proposed providers of cardiac surgery. The standard is intended to promote reasonable distribution of inpatient cardiology services and cardiac surgery services and to stimulate competition between qualified providers. All inpatient cardiac procedures which do not involve insertion of a catheter into the left heart chamber or coronary arteries, except cardiac surgery, are allowed without regulation under RSA 151-C. (Amended 7/25/88)

He-Hea 1101.02 Definitions:

(a) "Adult Cardiac Surgery" means procedures which use a heart-lung bypass machine to perform the function of circulation during surgery, including all pump-assisted procedures on the heart and great vessels.

(b) "Adult Cardiology Services" means inpatient heart catheterization and coronary angiography performed on adults.

(c) "Coronary Angiography" means the placement of a catheter into the coronary arteries for the purpose of injecting angiographic dye or performing coronary angioplasty.

(d) "Coronary Angioplasty" means the placement of a device into a coronary artery for the purposes of dilation of a narrow portion of the artery.

(e) "Left Heart Catheterization" means the placement of a catheter into the left ventricular heart chamber or central aortic chamber to measure pressures or to inject angiographic dye.

(f) "Quality Assurance Plan" means a continuous plan of collection, screening and evaluation of information concerning patient care, placement and clinical performance leading to methods of resolving and/or eliminating problems as identified by professional and administrative staffs, patients and their families and other professionals involved in the delivery of health care services.

PART He-Hea 1102 STANDARDS FOR ADULT CARDIOLOGY SERVICES PROVIDERS

He-Hea 1102.01 Quality Assurance Plan. Any applicant for adult cardiology services shall submit a quality assurance plan with the application.

He-Hea 1102.02 Service Areas:

(a) The applicant shall submit a description of its proposed service area and provide market share population data for that service area with the application. The applicant shall justify the proposed service area based on historical and/or projected utilization of adult cardiology services and/or referral patterns of physicians who will use or refer to the proposed service.

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(b) The applicant shall include a projected market share analysis of the proposed service area in the application. The market share analysis will be based on the following formula:

Town Population X Market % = Market Population

The market population for each town, whether located in New Hampshire or other states, shall be totaled to calculate the total population base for the service area. The Board shall not approve a new adult cardiology service unless the total population base for the proposed service is at least 110,000 persons.

He-Hea 1102.03 Need for Cardiology Services:

(a) Any person proposing to establish a new adult cardiology service shall demonstrate there exists a need for the proposed service. Need shall be demonstrated in any one of the following three ways:

(1) The applicant or its medical staff currently refer at least 300 adults annually for left heart catheterizations or coronary angiograms; or currently perform, annually on an outpatient basis, a minimum of 300 adult left heart catheterizations or coronary angiograms. The applicant shall submit, with the application, historical utilization of outpatient procedures at the proposed site and/or letters from referring physicians indicating their historical referral patterns and their intent to refer to the proposed site should approval be granted. Letters from referring physicians shall include an estimate of the number of projected referrals to the proposed site; or

(2) A minimum of 300 adults are currently referred to other sites for adult cardiology services and the applicant can demonstrate that it is likely to capture those referrals should a new service be established. The applicant shall provide letters of commitment from referring physicians stating their intent to refer patients currently going to other sites for services and identifying the projected number of referrals to the new site and letters from the original referral sites verifying the number of annual referrals from those referring physicians; or

(3) Changes have occurred in medical practice patterns which will result in increased utilization of adult cardiology services sufficient to generate 300 additional cardiac catheterizations or coronary angiography procedures annually within three years of the establishment of the program. Applicants shall include in the application a full description of the new medical practices and supporting evidence from national organizations such as the American College of Cardiology or the American Heart Association or from medical literature that the new practices are efficacious and will result in increased utilization of existing cardiology services.

(b) Any applicant proposing to establish a new adult cardiology service shall demonstrate that establishment of the new cardiology service shall not result in cardiology services at an existing provider dropping below 300 adult cardiac catheterizations and coronary angiograms. The applicant shall include in its application a calculation of the impact on existing New Hampshire providers of adult cardiology services based on historical and projected utilization of existing providers and an estimate of the number of referrals which normally would have gone to existing providers, but which would go to the proposed site should that service be approved.

He-Hea 1102.04 Staffing Requirements:

(a) For applicants proposing to establish adult cardiology services, the applicant shall demonstrate that it has on staff a board-certified cardiologist with training and experience in adult cardiac catheterization techniques who will be directing the program.

(b) All applicants shall demonstrate the availability of nursing and support staff trained and experienced in the care and treatment of patients to be served by the proposed program.

He-Hea 1102.05 Other Review Criteria:

(a) For applicants proposing to establish an adult catheterization service, the applicant shall identify the acute care facility in which the service will be located.

(b) All applicants shall also meet all other applicable review criteria in RSA 151-C:7 and He-Hea 302.01.

PART He-Hea 1103 APPLICATION PROCEDURES

He-Hea 1103.01 Request for Projects (RFP):

(a) In accordance with RSA 151-C:8, the Board shall request applications for the establishment of a new inpatient cardiology service on the first day of the month following the effective date of these rules and annually thereafter.

(b) Applications in response to an RFP shall be submitted within 90 days of the issuance of the RFP.

PART He-Hea 1104 STANDARDS FOR CARDIAC SURGERY

He-Hea 1104.01 Service Areas:

(a) The applicant shall include as part of the application a detailed description of its proposed service area and provide market share population data for that service area. The applicant shall justify the proposed service area based on historical utilization of cardiac services and/or historical referral patterns of physicians who intend to use or refer to the proposed service.

(b) The applicant shall include as part of the application a market share analysis of the proposed service area. The market share analysis shall be based on the following formula:

Town Population X Market % = Market Population

The market populations for each city or town, whether located in New Hampshire or other states, shall be totaled to calculate the total population base for the service area. The applicant shall, using historical and projected utilization rates for cardiac surgery, demonstrate that a minimum of 200 cardiac surgeries can be performed in the service area.

Effective 7/25/88

He-Hea 1104.02 Need for Adult Cardiac Surgery Services:

(a) Any applicant proposing to establish a new adult cardiac surgery service shall demonstrate as a part of the application that its acute care facility shall perform a minimum of 200 adult cardiac surgeries annually within two years of commencement of operations. The applicant shall demonstrate this by the following method:

(1) That, on an annual basis, the applicant or its medical staff currently refers 200 cases elsewhere for adult cardiac surgery, or that other physicians in the applicant's service area, on an annual basis, currently refer 200 persons elsewhere for adult cardiac surgery. The applicant shall submit with the application letters from referring physicians indicating their intent to refer to the proposed site and identifying the projected number of referrals to the new site and letters from original referral site verifying the annual number of referrals from those referring physicians.

(b) The Board shall condition any approval of a new program with the requirement that if the program performs less than 200 annual procedures by the second year of operation, the Board shall revoke the approval unless the certificate holder can demonstrate that actual utilization is a result of circumstances beyond its control and that utilization will meet the 200 threshold within the next 18 months. Circumstances beyond a certificate holder's control shall include either a loss of a primary referring physician or facility relocation or departmental relocation, renovation or expansion, but shall not include decreased market share or inability to obtain sufficient referrals. All certificate holders shall provide documentation concerning utilization and shall provide justification if utilization does not meet the 200 annual surgery level within two years of commencement and operations.

(c) The applicant shall demonstrate that the project shall not adversely impact existing cardiac surgery programs by including as a part of the application a calculation of the impact on existing New Hampshire providers of cardiac surgery based on historical and projected utilization of

existing providers and an estimate of the number of referrals which normally would have gone to existing providers but which would go to the proposed site should that service be approved.

(d) The Board shall take the following actions in reviewing impact of a new program:

(1) The Board shall not approve a project if that approval would cause the number of annual procedures performed by an existing provider to fall below 200 annual procedures.

(2) If an applicant demonstrates that the approval of a new program would not cause an existing provider to perform fewer than 350 annual procedures, the Board shall determine that the proposed project has no adverse impact.

(3) For any project, the approval of which would cause the number of annual procedures performed by an existing provider to decline to between 200 and 349 procedures, the Board shall determine if the impact is significant enough to justify disapproval. In making this determination, the Board shall take into account the impact of the project on costs at other existing programs and the extent to which the proposed project would duplicate existing programs. The Board shall give special consideration to projects which increase access to cardiac surgery by underserved population groups or market areas.

Effective 7/25/88

He-Hea 1104.03 Staffing Requirements:

(a) An applicant proposing to provide adult cardiac surgery services shall assure availability prior to initiation of the proposed service of the following qualified staff:

(1) at least two cardiac surgeons, one of which shall be board-certified and the other, at a minimum, eligible for board certification;

(2) at least one board-certified anesthesiologist with special training, through residency or continuing education credits, in the management of cardiac surgery patients;

(3) 24-hour availability of a nephrologist, cardiologist and a specialist in infectious disease;

(4) a surgical and intensive care nursing staff with experience or educational certification in, and fully dedicated to, the care of cardiac patients; and

(5) at least one certified cardio-pulmonary bypass perfusionist.

(b) Documentation of staff availability shall be in the form of a staffing plan submitted as part of the application. The staffing plan shall identify all required staffing and provide a detailed description of how staffing needs shall be met either in-house, through recruitment or through contractual arrangements. Copies of applicable contracts shall be included with the application.

Effective 7/25/88

He-Hea 1104.04 Required Support Services:

(a) All applicants proposing to establish adult cardiac surgery services shall submit with the application a detailed description of the availability on-site of the following support services:

(1) A minimum of 4 fully dedicated and segregated cardiac care unit (CCU) beds staffed in accordance with the most currently published Joint Commission on Accreditation of Health Care Organizations standards;

(2) a telemetry unit proximate to the CCU;

(3) an acute renal dialysis service;

(4) a family-centered rehabilitation service;

(5) a minimum of 2 operating rooms available as needed for cardiac surgery patients;

(6) a state approved in-house cardiac catheterization service; and

(7) either in-house supply of, or rapid access to, all blood types as well as to platelets through an affiliation with an established blood bank network.

(b) The applicant shall submit as part of the application a statement that the proposed adult cardiac surgery service shall be available 24 hours a day, seven days a week, for emergency coverage.

Effective 7/25/88

He-Hea 1104.05 Other Review Criteria. All applicants proposing to establish an adult cardiac surgery service shall also meet all other applicable review criteria in He-Hea 302.01 and RSA 151-C:7.

Effective 7/25/88

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PART He-Hea 1105 APPLICATION PROCEDURES

He-Hea 1105.01 Request for Projects (RFP):

(a) In accordance with RSA 151-C:8, the Board shall annually request applications for the establishment of new adult cardiac surgery services on June 1 of each year. Each RFP shall state that publication of the RFP does not necessarily constitute a finding of need by the Board for additional cardiac surgery services and that the Board may approve no applications submitted pursuant to an RFP.

(b) Applications in response to an RFP shall be submitted within 90 days of the issuance of the RFP.

Effective 7/25/88

POSITION PAPER
CARDIAC SURGERY UTILIZATION

Rationale for Position Paper:

This paper presents the rationale for development of cardiac surgery standards in New Hampshire and for the form which those standards have taken. It is the intent of the Health Services Planning and Review Board that this paper be attached to the rules and included with them as an addendum.

Minimum Utilization Level:

The Health Services Planning and Review Board, in developing this standard, analyzed certificate of need standards developed by other states for review of cardiac surgery proposals. Of the states surveyed, 200 procedures appeared to be a minimum threshold for the development of a new program. The 200 figure generally was held to be the minimum needed to maintain efficiency of operation and to assure adequate quality of service. In addition, a number of states required all existing programs to be operating a minimum of 350 annual procedures before a new program could be approved.

In addition, the American College of Surgeons developed guidelines in 1984 which established 150 procedures as the minimum volume necessary to assure surgical team proficiency. Their guidelines were directed solely at quality issues and did not address need for additional programs.

The Board recognizes that a cardiac surgery program requires both capital and sufficient revenues to commence and maintain operations. Therefore, it has determined that a minimum volume level needs to exist in order to assure a cost-effective and quality program.

According to hospital sources, 376 surgeries were performed at Catholic Medical Center (CMC) in 1987. This means that the programs at CMC and Mary Hitchcock Memorial Hospital (MHMH) both performed over 350 annual procedures in the most recent calendar years. CMC initiated its program in March of 1986 and exceeded the 350 level in its second year of operation.

The Board also notes that, in FY 1985, 454 persons from N.H. went to Massachusetts hospitals for cardiac surgery. Most of these patients came from the southern half of N.H. Research is currently being conducted to determine how implementation of a program at CMC has affected these referral patterns.

Maine and Vermont data is currently being analyzed and will be provided as soon as possible. Based on data provided by the hospital for 1986, MHMH draws approximately 40% of its cardiac surgery caseload from Vermont. Preliminary data from Maine indicates that only 95 N.H. residents went to Maine hospitals for cardiac surgery.

Based on the above data and the recommendations of other states, the Board has developed a standard which requires a proposed program to demonstrate that it will be able to perform 200 annual procedures within 2 years of commencement of operation. To assure that this level is met, the Board will condition approvals on re-review of the program 2 years following implementation. The Board will revoke the approval if the program fails to achieve the 200 minimum utilization level or to meet other conditions imposed by the Board.

Furthermore, the Board will review any proposal with respect to its potential impact on existing programs. Special scrutiny will be given to new programs, the approval of which would cause an existing program's utilization to decline to an annual level of between 200-349 procedures.

Geographic Distribution of Programs:

N.H. currently has one program in Hanover and one in Manchester. As FY 1986 market area data indicates, the two programs overlap only in Concord and the Lakes Region. CMC's program in Manchester competes primarily with Boston hospitals but tends to draw very few patients from Massachusetts. There are also programs in Portland, Maine, and Burlington, Vermont, which serve the Seacoast and the far north respectively.

In developing these standards, the Board has determined that competition between cardiac surgery programs is not in the public interest if it would cause utilization of existing programs to fall below a level which assures both quality and economy of operation. While no mileage or geographic boundary standards are included in in the rule, the Board clearly feels that programs should be distributed in a manner which best assures access to all citizens of the state. As such, priority for any new programs should be given to those which best meet a documented unmet need in the state.

Staffing and Facilities:

Facility and staffing standards for cardiac surgery programs have been developed by a number of professional organizations and other agencies and these standards are will accepted by the medical and hospital professions. The Board, therefore, has included only those requirements which it feels are essential for the operation of a quality cardiac surgery program. It is not the intention of the Board to dictate the structure and nature of each program in the state. The rule leaves these details to the expertise of the medical staffs of the affected hospitals.

Conclusion:

The Board feels that these standards represent the best possible balance between competition and regulation of cardiac surgery programs in the state. The rules are not so inflexible as to pre-

clude future development of any new cardiac surgery programs. However, they recognize that cardiac surgery is an expensive technology and that unhampered competition can have adverse effects on quality of care and on costs to residents of New Hampshire. For this reason, the Board has chosen to require clear demonstration of need for new programs before approval can be granted and to review that need in terms of the potential impact on existing cardiac surgery programs.

NEW HAMPSHIRE CODE OF ADMINISTRATIVE RULES

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CHAPTER He-Hea 1000 ACUTE CARE FACILITIES

PART 1001 PURPOSE AND DEFINITION

He-Hea 1001.01 Purpose. This chapter implements an institutional health standard relative to the activities of acute care facilities that is intended to define the financial, accessibility and availability criteria which shall be met in order for an acute care facility to obtain a Certificate of Need pursuant to RSA 151-C:5(a) and (c).

Source. #4097, eff 7-22-86

He-Hea 1001.02 Definitions

(a) "Acute Care Facility" means a hospital which provides at a minimum general medical and surgical services, which houses patients overnight and which has an average length of stay of less than 30 days.

(b) "Average Daily Census (ADC)" means the average number of beds filled in the hospital on any given day.

(c) "Admission Rate" means the number of admissions to an acute care facility per 1,000 residents in a service area.

(d) "Capital Expenditure" means an expenditure which, under generally accepted accounting principles consistently applied, is not properly chargeable as an expense of operation or maintenance and includes acquisition by purchase, by transfer or by lease or comparable arrangement or through donation if the expenditure would have been considered a capital expenditure if the acquisition had been by purchase.

(e) "Cash Flow" means total revenue minus total expenses plus depreciation and interest payment.

(f) "Current Assets" means the economic resources of a facility which are likely to be converted to cash in one year.

(g) "Current Liabilities" means debt of a facility which shall be paid within one year.

(h) "Depreciation" means the portion of the total cost of a fixed asset amortized during one year.

(i) "Expansion Project" means a capital expenditure project designed to increase the overall square footage of a facility.

(j) "Fund Balance" means the excess of assets over liabilities.

(k) "Interest Expense" means the yearly cost of borrowed funds.

(l) "Length of Stay" means the number of days a patient stays in a facility.

(m) "Longterm Liability" means a debt with maturity of more than one year after the date of issuance.

(n) "Market Share" means the percent of patients in a given area using a specific facility.

(o) "Operating Expense" means the annual costs involved in the daytoday provision of patient care services.

(p) "Operating Revenue" means the revenue collected from the provision of patient care services.

(q) "Patient Charges" means the aggregate price charged for patient care services at a facility.

(r) "Principal Payment" means the amount of a loan due during one year which is attributable to the principal portion of the debt and does include interest costs.

(s) "Renovation" means a captial expenditure which repairs, remodels and/or reconfigures existing space.

(t) "Replacement" means a capital expenditure which rebuilds in whole or in part an acute care facilty on a new or the original site.

(u) "Service Area" means the list of towns and cities listed below:

	TOWN	TOWN	TOWN
SMALL AREA:			
MARY HITCHCOCK MEMORIAL HOSPITAL AND ALICE PECK DAY			
	1. Canaan	4. Grafton	7. Lyme
	2. Cornish	5. Hanover	8. Orange
	3. Enfield	6. Lebanon	9. Orford
			10. Plainfield
CONCORD			
	1. Allenstown	9. Dunbarton	17. Pittsfield
	2. Barnstead	10. Epsom	18. Salisbury
	3. Boscawen	11. Henniker	19. Warner
	4. Bow	12. Hillsborough	20. Washington
	5. Canterbury	13. Hopkinton	21. Weare
	6. Chichester	14. Loudon	22. Webster
	7. Concord	15. Northwood	23. Windsor
	8. Deering		

SMALL AREA:	TOWN	TOWN	TOWN
ELLIOT AND CATHOLIC MEDICAL CENTER			
	1. Auburn	4. Chester	7. Manchester
	2. Bedford	5. Goffstown	
	3. Candia	6. Hooksett	
NASHUA MEMORIAL AND ST. JOSEPH			
	1. Amherst	5. Litchfield	9. Mont Vernon
	2. Brookline	6. Lyndeborough	10. Nashua
	3. Hollis	7. Merrimack	11. Wilton
	4. Hudson	8. Milford	
LAKES REGION GENERAL HOSPITAL			
	1. Belmont	5. Laconia	9. Northfield
	2. Center Harbor	6. Meredith	10. Sanbornton
	3. Gilmanton	7. Moultonborough	11. Sandwich
	4. Gilford	8. New Hampton	12. Tilton
WENTWORTH-DOUGLASS HOSPITAL			
	1. Dover	3. Madbury	5. Somersworth
	2. Durham	4. Rollinsford	
CHESHIRE HOSPITAL			
	1. Fitzwilliam	6. Marlow	11. Sullivan
	2. Gilsum	7. Nelson	12. Surry
	3. Harrisville	8. Richmond	13. Swanzey
	4. Keene	9. Roxbury	14. Troy
	5. Marlborough	10. Stoddard	15. Winchester
EXETER			
	1. Brentwood	6. Hampton	11. Newmarket
	2. East Kingston	7. Hampton Falls	12. North Hampton
	3. Epping	8. Kensington	13. Nottingham
	4. Exeter	9. Lee	14. Raymond
	5. Fremont	10. Newfields	15. Stratham
PORTSMOUTH			
	1. Greenland	3. Newington	5. Rye
	2. New Castle	4. Portsmouth	
FRISBIE			
	1. Farmington	3. New Durham	
	2. Milton	4. Rochester	
VALLEY REGIONAL			
	1. Charlestown	2. Claremont	3. Unity

SMALL AREA:		TOWN		TOWN		TOWN
ANDROSCOGGIN VALLEY						
	1.	Berlin	5.	Gorham	8.	Randolph
	2.	Cambridge	6.	Milan	9.	Shelburne
	3.	Dummer	7.	Millsfield	10.	Success Township
	4.	Errol				
MONADNOCK GENERAL						
	1.	Antrim	5.	Greenfield	9.	Sharon
	2.	Bennington	6.	Hancock	10.	Temple
	3.	Dublin	7.	Jaffrey		
	4.	Francestown	8.	Peterborough		
LITTLETON						
	1.	Bethlehem	6.	Landaff	11.	Sugar Hill
	2.	Carroll	7.	Lincoln	12.	Whitefield
	3.	Dalton	8.	Lisbon	13.	Woodstock
	4.	Easton	9.	Littleton		
	5.	Franconia	10.	Lyman		
HUGGINS						
	1.	Effingham	3.	Ossipee	5.	Wolfeboro
	2.	Freedom	4.	Tuftonboro		
PARKLAND						
	1.	Derry				
LANCASTER						
	1.	Jefferson	3.	Northumberland	5.	Stark
	2.	Lancaster	4.	Odell	6.	Thompson & Mes
FRANKLIN REGIONAL						
	1.	Franklin	2.	Hill		
SCEVA SPEARE						
	1.	Campton	4.	Groton	7.	Rumney
	2.	Dorchester	5.	Hebron	8.	Thornton
	3.	Ellsworth	6.	Plymouth	9.	Waterville Valley
NEW LONDON						
	1.	Andover	4.	Newbury	7.	Wilmont
	2.	Danbury	5.	Springfield		
	3.	New London	6.	Sutton		
MEMORIAL						
	1.	Albany	4.	Eaton	7.	Madison
	2.	Bartlett	5.	Harts Location		
	3.	Conway	6.	Livermore		

SMALL AREA:

	TOWN	TOWN	TOWN
COTTAGE			
1.	Benton	2. Haverhill	3. Monroe

UPPER CONNECTICUT VALLEY

1.	Atkinson and Gil	4. Columbia	7. Stewartstown
2.	Clarksville	5. Dixville	
3.	Colebrook	6. Pittsburg	

NEWPORT

1.	Croydon	2. Newport

NO DISCHARGES

1.	Bean's Grant	7.	Green's Grant	12.	Martin's Location
2.	Chandler's Purchase	8.	Hadley's Purchase	13.	Pinkham's Grant
3.	Cutt's Grant	9.	Hale's Location	14.	Second College Grant
4.	Crawford's Purchase	10.	Kilkenny Township	15.	Sergent's Purchase
5.	Dixs Grant	11.	Low and Burbanks		
6.	Erving's Locatio..				

BORDER (20% or more Birth or Death occurred out-of-state)

1.	Alstead	10.	Kingston	19.	Salem
2.	Atkinson	11.	Langdon	20.	Sandown
3.	Chatham	12.	Londonderry	21.	Seabrook
4.	Chesterfield	13.	Mason	22.	South Hampton
5.	Danville	14.	New Ipswich	23.	Walpole
6.	Greenville	15.	Newton	24.	Westmoreland
7.	Hampstead	16.	Pelham	25.	Windham
8.	Hinsdale	17.	Plaistow		
9.	Jackson	18.	Rindge		

CONTESTED (No one hospital received 50% or more of the patients)

1.	Ackworth	10.	Bristol	19.	Piermont
2.	Alexandria	11.	Brookfield	20.	Strafford
3.	Alton	12.	Deerfield	21.	Stratford
4.	Ashland	13.	Goshen	22.	Sunapee
5.	Barrington	14.	Grantham	23.	Tamworth
6.	Bath	15.	Holderness	24.	Wakefield
7.	Bean's Purchase	16.	Lempster	25.	Warren
8.	Bradford	17.	Middleton	26.	Wentworth Location
9.	Bridgewater	18.	New Boston	27.	Wentworth Town

(v) "Total Expense" means all operating expenses plus all other expenses including but not limited to those associated with cafeteria, schools of nursing and home health care programs.

(w) "Total Patient Days" means the sum of the number of days patients stay at a facility.

(x) "Total Revenue" means all operating revenue plus revenue generated from other sources including but not limited to investments, donations and cafeteria.

Source. #4097, eff 7-22-86

PART He-Hea 1002 STANDARDS FOR EXPANSION, RENOVATION AND REPLACEMENT OF ACUTE CARE FACILITIES

He-Hea 1002.01 Space Requirements. All applicants for a Certificate of Need shall demonstrate need for additional or renovated space by at least one of the following methods:

(a) Documented increases in volume.

(b) Documented new acquisition of equipment which require additional space.

(c) Deficiencies in the structure or layout of the space as documented by a licensing or accrediting body.

(d) Documentation that operating costs as a result of either staff inefficiency or increased maintenance costs have resulted from functional spatial inefficiencies.

Source. #4097, eff 7-22-86

He-Hea 1002.02 Documentation of Space Needs: All applicants shall document the sources and or methodologies used to determine space needs. If written source material was used, the applicant shall provide the Board with copies of these.

Source. #4097, eff 7-22-86

He-Hea 1002.03 Financial Feasibility Requirements: In addition to all other information required in Part 300 of these rules, each applicant shall provide the following financial ratios using their project's financial figure if the project were implemented.

(a) Operating Ratio calculated as:

$$\frac{\text{Total Operating Revenue - Operating Expenses}}{\text{Total Operating Revenue}}$$

Amended 7/88

(b) Debt Services coverage calculated as:

$$\frac{\text{Cash Flow + Interest}}{\text{Principal Payment + Interest Expense}}$$

(c) Debt to Equity calculated as:

$$\frac{\text{Long-Term Liabilities}}{\text{Fund Balance}}$$

(d) Current Ratio calculated as:

$$\frac{\text{Current Assets}}{\text{Current Liabilities}}$$

(e) Bottom/Bottom Line calculated as:

$$\frac{\text{Total Revenues}}{\text{Total Expenses}}$$

Source. #4097, eff 7-22-86

He-Hea 1002.04 Assumptions for Financial Ratio Analysis: All applicants shall demonstrate the assumptions used to project financial position with the new project and thus calculated ratios. These assumptions shall include:

(a) Population growth: Applicants shall document the source of population projections.

(b) Changes in market share: Applicants shall document changes in market conditions which will result in changes in market share.

(c) Changes in length of stay: Applicants shall document the causes of any projected change in overall length of stay.

(d) Changes in admission rates: Applicants shall document the cause of any projected changes in admission rates.

(e) Changes in patient charges: Applicants shall outline their patient charges.

Source. #4097, eff 7-22-86

He-Hea 1002.05 Industry Averages:

(a) The Board shall review all ratios in light of the industry averages as outlined in the most recently published edition of Hospital Industry Analysis Report of the Health Care Financial Management Association. (Amended 7/88)

(b) Ratios shall be compared to the state average using the data collected pursuant to RSA 126:25, I(b). Calculations of the state averages shall be available through the Office of Health Services Planning and Review.

Source. #4097, eff 7-22-86

PART He-Hea 1003 FILING DATES FOR EXPANSION, REBUILDING OR RENOVATION OF ACUTE CARE FACILITIES

He-Hea 1003.01 Requests for Applications: The Board shall issue a request for applications pursuant to RSA 151-C:8 I on August 1 of each year.

Source. #4097, eff 7-22-86

He-Hea 1003.02 Submission of Applications: Applications shall be submitted to the Board within 90 days of Request for Application.

Source. #4097, eff 7-22-86

PART He-Hea 1004 REQUESTS FOR ACUTE CARE BEDS

He-Hea 1004.01 Number of Acute Care Beds: No request for additional acute care beds shall cause the total number of beds statewide to exceed 3.2 beds for each 1,000 persons living in New Hampshire.

He-Hea 1004.02 Statewide Use Rate. All requests for additional acute care beds shall be developed employing a use rate which does not exceed the most currently available statewide use rate of patient days per 1,000 persons residing in New Hampshire. The most currently available use rate shall be provided by the Office of Health Services Planning and Review at the time of the formal request for projects described in He-Hea 1003.01. Applicants may employ a use rate which resembles the historical use rate at their facility provided the use rate is less than the statewide use rate. Amended 7/88.

He-Hea 1004.03 Service Area: Each applicant's service area shall be as defined in He-Hea 1001.02 (u). Applicants may petition for a change in service area by documenting in their applications:

(a) Changes in market share.
(b) New services with a different market.
(c) Specialized services with a different market.
(d) Any other such cause as deemed appropriate by the applicant.

He-Hea 1004.04 Reasonable Occupancy: Reasonable occupancy shall be determined separately for each acute care bed unit by using the Normile Formula which is as follows:

NORMILE FORMULA

Bed Need = ADC + fp/ADC

ADC = Average Daily Census = $\frac{\text{Patient Days}}{365}$

fp = Availability Factor
95/100 = 1.65 - M/S, Pedi and Others
99/100 = 2.33 - ICU, CCU, and OB

fp/$\overline{ADC}$ is the number of additional beds, over the number occupied on an average day, needed to insure bed availability on busy days.

$$\text{Reasonable Occ.} = \frac{\text{total patient days}}{\text{total calculated bed need} \times 365}$$

Source. #4097, eff 7-22-86

He-Hea 1004.05 Service Area Population. Service area population shall be determined by the population projections provided by the Office of State Planning and shall be available through the Office of Health Services Planning and Review.

Source. #4097, eff 7-22-86

He-Hea 1004.06 Market Share. Market share shall be determined by using the patient origin data from the Uniform Hospital Discharge Data Set (UHDDS). This data shall be available from the Office of Health Services Planning and Review.

Source. #4097, eff 7-22-86

He-Hea 1004.07 Market Share Population. Market share population shall be determined by the following formula:

Town Population x Market % = Market Population

Source. #4097, eff 7-22-86

He-Hea 1004.08 Future Patient Days. Future patient days shall be calculated as follows:

Use Rate x Future Market Population + patient days generated by persons living outside the service area.

He-Hea 1004.09 Bed Need Calculations: Bed need shall be calculated separately for each acute care bed unit as follows:

$$\frac{\text{Future Patient Days}}{(\text{Reasonable Occupancy})\ 365}$$

The number of beds yielded from this formula shall be considered the optimum number of beds for the facility.

He-Hea 1004.10 Impact on Existing Facilities. The applicant shall include as part of the application a detailed analysis of the impact of the proposed expansion, renovation or replacement of the current facility on each existing acute care facility currently serving residents of the applicant's proposed service area, both in New Hampshire and in adjoining states. The analysis shall include consideration of the following:

(a) impact on utilization;
(b) impact on charges;
(c) impact on service areas and market shares;
(d) impact on physician referral patterns; and
(e) impact on the supply of nurses and other health care professionals. (effective 7/88.)

PART He-Hea 1005 STANDARDS FOR CONSTRUCTION OF A NEW ACUTE CARE FACILITY

He-Hea 1005.01 Description of Service Area.

(a) The applicant for a certificate of need to construct a new acute care facility shall include as part of the application a detailed description of the proposed service area. This description shall include the following:

(1) geographic boundaries of the proposed service area;
(2) demographic characteristics of the service area, including age and sex composition;
(3) income characteristics of the population; and
(4) anticipated insurance characteristics of the population, including the percentage covered by Medicare, Medicaid, private insurance, self-pay, and health maintenance organizations.

(b) The applicant shall include as part of the application a calculation of the proposed market share from each town and city in the proposed service area using the following formula:

City or Town Population X Market % = Market Share Population

The calculations for all towns and cities in the proposed service area shall be summed to determine the total projected service area population.

Effective 7/25/88

He-Hea 1005.02 Documentation of Unmet Need.

(a) The applicant shall include in the application a detailed description of where persons in the proposed service area currently receive inpatient services which would be offered by the proposed new acute care facility. This description shall include the following information for both the primary and secondary market areas of the proposed hospital:

(1) types of services to be offered by the new facility; and
(2) the number of persons annually going to each existing site for services by each major category of service.

(b) The applicant shall include in the application a description of the number of persons who are currently underserved by existing facilities in terms of availability, accessibility, quality of care and cost of health care services and who would be served by the proposed facility. The applicant shall also include a description of the characteristics of that underserved population. This description shall include a discussion of the factors causing this population to be underserved and how this project addresses those factors. The applicant shall include in that description a discussion of the following issues:

(1) travel times/distances to existing facilities, especially those in excess of 30 minutes or 15 miles;
(2) geographic barriers such as mountains or inaccesible river crossings;
(3) problems in physicians obtaining admitting privileges at existing hospitals;
(4) specialized services which are unavailable in the service area;
(5) inadequate number of beds for the current population;
(6) cost or reimbursement problems which have hampered access to care; and
(7) other problems documented by the applicant.

Effective 7/25/88

He-Hea 1005.03 Number of New Acute Care Beds. No request for a new hospital shall cause the total number of acute care beds statewide to exceed 3.2 beds for every 1000 persons living in New Hampshire.

Effective 7/25/88

He-Hea 1005.04 Reasonable Occupancy. Reasonable occupancy shall be calculated separately for each acute care bed unit using the Normile formula described in He-Hea 1004.04.

Effective 7/25/88

He-Hea 1005.05 Use Rates. All requests for a new acute care facility shall be developed employing a use rate which does not exceed the most currently available statewide use rate of patient days per 1000 persons residing in New Hampshire. The most currently available use rate shall be provided by the Office of Health Services Planning and Review at the time of the formal request for applications described in He-Hea 1006.01. Applicants shall include in the application a justification for employing the chosen use rate applied in calculating need for the

new hospital. That use rate shall be comparable to historical and projected use rates for hospitals of similar size and intensity levels as the proposed hospital and to other hospitals currently serving persons located in the proposed service area.

Effective 7/25/88

He-Hea 1005.06 Projected Patient Days. Projected patient days shall be calculated by multiplying the chosen use rate times the projected population determined in He-Hea 1005.01(b).

Effective 7/25/88

He-Hea 1005.07 Bed Need Calculation.

(a) Bed need shall be calculated in the manner described in He-Hea 1004.09.

(b) The applicant shall provide a detailed justification of why all or part of the projected bed need cannot be met by existing acute care facilities and why the proposed number of beds is required to meet need which cannot be met by existing providers.

Effective 7/25/88

He-Hea 1005.08 Impact on Existing Facilities. The applicant shall include as part of the application a detailed analysis of the impact of the proposed new facility on each existing acute care facility currently serving residents of the proposed service area, both in New Hampshire and in adjoining states. The analysis shall include consideration of the following:

(a) impact on utilization;
(b) impact on charges;
(c) impact on service areas and market shares;
(d) impact on physician referral patterns; and
(e) impact on the supply of nurses and other health care personnel.

Effective 7/25/88

He-Hea 1005.09 Documentation of Space Needs. All applicants shall document the sources and/or methodologies used to determine space needs. If written source material was used, the applicant shall provide the Board with copies of these.

Effective 7/25/88

He-Hea 1005.10 Financial Feasibility Requirements. In addition to all other information required in Part 300 of these rules, each applicant

shall provide the following financial ratios using its project's financial figures if the project were implemented.

(a) Operating Ratio calculated as:

$$\frac{\text{Total Operating Revenue - Operating Expense}}{\text{Total Operating Revenue}}$$

(b) Debt Service Coverage calculated as:

$$\frac{\text{Cash Flow + Interest}}{\text{Principal Payment + Interest Expense}}$$

(c) Debt to Equity calculated as:

$$\frac{\text{Long Term Liabilities}}{\text{Fund Balance}}$$

(d) Current Ratio calculated as:

$$\frac{\text{Current Assets}}{\text{Current Liabilities}}$$

(e) Bottom/Bottom Line calculated as:

$$\frac{\text{Total Revenues}}{\text{Total Expenses}}$$

Effective 7/25/88

He-Hea 1005.11 Assumptions for Financial Ratio Analysis.

(a) All applicants shall include as part of the application the assumptions used to project the financial ratios calculated in He-Hea 1005.02 and the resulting financial psoition of the propose facility. These assumptions shall include at least the following:

(1) utilization trends;
(2) changes in average length of stay; and
(3) changes in market share.

(b) Patient charges. Applicants shall include in the application a list of proposed patient charges.

Effective 7/25/88

He-Hea 1005.12 Industry Averages.

(a) The Board shall review all ratios in light of the industry averages as outlined in the most recently published edition of Hospital Industry Analysis Report of the Health Care Financial Management Association.

(b) Ratios shall be compared to the state average using the data collected pursuant to RSA 126:25,I(b). Calculation of the state average shall be available through the Office of Health Services Planning and Review.

Effective 7/25/88

He-Hea 1005.13 Other Review Criteria. The applicant shall also meet all other applicable review criteria in RSA 151-C:7 and He-Hea 302.01.

Effective 7/25/88

PART He-Hea 1006 FILING DATES FOR NEW ACUTE CARE FACILITIES

He-Hea 1006.01 Requests for Projects (RFP). The Board shall issue a request for projects pursuant to RSA 151-C:8, I, on August 1 of each year. Each RFP shall state that the publication of the RFP does not necessarily constitute a finding of need by the Board for a new acute care hospital and the Board may approve no applications submitted pursuant to the RFP. Each RFP shall also state the most currently available statewide use rate as described in He-Hea 1005.05.

Effective 7/25/88

He-Hea 1006.02 Submissions of Applications. Applications shall be submitted to the Board within 90 days of the RFP.

Effective 7/25/88

POSITION PAPER
NEW HOSPITAL STANDARDS

Introduction:

These standards have been developed by the Health Services Planning and Review Board as an amendment to the current acute care hospital standards, He-Hea 1000. While the Board is concerned about all increases in acute care bed capacity, these standards deal specifically with the development and construction of new hospitals in the state of New Hampshire. Current standards already address the expansion, renovation or replacement of existing hospitals.

Need for New Hospitals:

It is the Board's position that new hospitals should be constructed only if there is a clearly demonstrated need which cannot be met by existing acute care facilities. The addition of a new hospital in the state represents a major expenditure of capital which can have a significant impact on the pattern and cost of health care. Unnecessary duplication of health care facilities can adversely affect utilization of existing facilities, quality of care and health care costs. For this reason, the Board feels that the strict regulation and a conservative approach to need determination is justified.

Furthermore, the Board holds that the primary reason for approving a new hospital would be to meet a documented unmet need in the state. Unmet need is defined in terms of substantial documented problems in accessibility to, availability of, quality of or cost of health care services. The applicant is required to describe and document in detail the problems currently being experienced by residents of the proposed service area. These may include, but are not necessarily limited to, problems of physicians in receiving admitting privileges at area hospitals, unavailability of specialized services which would be offered by the new hospital, inadequacy of bed supply to serve the population in question or cost and reimbursement problems which tend to restrict access.

The Board has placed the burden of proof on the applicant to demonstrate that persons residing in a proposed hospital's service area are not adequately served by existing facilities. The Board feels that state boundaries should not be viewed in and of themselves as barriers to the provision of health care. As such, residents of border towns may be adequately and appropriately served by hospitals located in Massachusetts, Maine or Vermont.

Impact on Existing Facilities:

As stated earlier, the Board recognizes that the addition of a new hospital in the state can potentially have a major impact on the operations, utilization, staffing and costs of care at existing hospitals. The impact of a new hospital can take many forms. For example, a new hospital could increase competition for nurses and other health care professionals which are already in limited supply

in this state. In addition, a new hospital could shift referral patterns sufficiently to decrease utilization and thereby increase the cost of care at an existing health care facility.

For these reasons, the Board has required anyone who proposes to construct a new hospital to determine and describe in detail the anticipated impact of the proposal. The applicant is expected to take into account the impact on hospitals both in New Hampshire and, where applicable, in other states. This does not preclude the Board from approving a new hospital, but rather focuses the discussion on the broader health care issues involved.

Conclusion:

The proposed standards update the current standards and provide the Board with guidance for the review of new hospitals. The rules are restrictive, but would permit the Board to approve a new hospital if need can be demonstrated and if impact on patients served is not adverse. This represents a clear balance between competitive and regulatory forces while protecting the people of New Hampshire from unnecessary health care expenditures and costs.

NEW HAMPSHIRE CODE OF ADMINISTRATIVE RULES

HEALTH SERVICES PLANNING AND REVIEW BOARD

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CHAPTER He-Hea 900 LONG-TERM CARE FACILITIES

PART 901 PURPOSE AND DEFINITION

He-Hea 901.01 Purpose. This chapter implements an institutional health service standard for providers of long-term care services (LTC) that is intended to promote reasonable distribution of these services and stimulate competition among qualified providers.

Source. #4096, eff 7-22-86

He-Hea 901.02 Definitions.

(a) "Board" means the health services planning and review board.

(b) "Continuing care contract" means, for purposes of this rule, a contractual arrangement between the operation and resident of a CCRC which is in force for not less than one year, which details the rights and obligations of each party to the contract and which guarantees the resident nursing home care and other services for the duration of resident nursing home care and other services for the duration of residence in the CCRC in exchange for an entrance or other fee.

(c) "Continuing care retirement community" or "CCRC" means, for purposes of this rule, a residential complex which:

(1) operates a residential retirement complex and a nursing home under a single independent corporate structure; and

(2) operates a residential unit and nursing home on a single campus or, if not on the same campus, operates the nursing home within 1 mile of the residential complex; and

(3) documents the existence of one of the following:

a. a continuing care contract with the residents of the CCRC that offers health care and support services to all residents of the CCRC, including but not limited to independent living, dietary services, medical services, housekeeping and nursing home services in exchange for an entrance or other fee; or

b. in lieu of a continuing care contract, a prominently and publicly displayed posted continuing care policy, copies of which are available upon request to all prospective residents and to the board.

(d) "Continuum of care" means a comprehensive system of services having diagnostic, preventative, therapeutic, rehabilitative, supportive and maintenance services in institutional and non-institutional settings which include but are not limited to medical care, mental health services, primary health care, nursing care, therapy (all kinds), nutrition services, home health care, pharmaceutical services, personal care services (bathing, dressing, toileting, etc.), domestic services (homemaker, meal preparation, laundry, home maintenance chores, etc.) full range of living arrangements (single family, apartment, shared housing, etc.) legal services, transportation, information and referral respite care and financial assistance.

(e) "Entrance fee" means an initial or deferred payment of a sum of money made as full or partial payment to assure the resident of a place in the CCRC. An accommodation fee, admission fee or other similar fee is an entrance fee for the purpose of this rule.

(f) "Intermediate care facility (ICF) means a nursing home which is intended to provide health care and service (on a regular basis) to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide (i.e. acute care or skilled nursing care) but who, because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

(g) "Long-term care" (LTC) means medical and support services provided to individuals who are frail and dependent due to chronic physical or mental impairments in order to assist them in attaining an optimal level of physical, social and psychological functioning.

(h) "Posted continuing care policy" means a written description of the obligations, rights and privileges of and the services available to all residents of the CCRC including but not limited to a guarantee of residence in the CCRC for not less than one year, a guarantee of nursing home care for the full duration of residence in the CCRC and a statement that the posted rights, obligations and privileges and available services constitute an enforceable contract with all residents of the CCRC.

(i) "Provider" means a person or entity holding a certificate of need and licensed to do business in the state providing long-term care services in an institutional setting.

(j) "Quality assurance plan" means a continuous plan of collection, screening and evaluation of information concerning patient care, placement and clinical performance leading to the methods of resolving and/or eliminating problems as identified by professional and administrative staffs, patients and their familiies, and other professionals in the delivery of health care services.

(k) "Region" means the service areas as defined in He-Hea 902.02 of this chapter.

(l) "Resident" means the purchaser of a continuing care contract who physically resides in the residential unit of a CCRC or a person who physically resides in the residential unit of the CCRC which has a posted continuing care policy.

(m) "Residential unit" means an apartment, sheltered care facility or other independent living arrangement which does not require licensure as a nursing home under He-P 803.

(n) "Skilled nursing facility" (SNF) means a nursing home which is intended to provide health care services on a daily basis pursuant to physician orders which;

1) require the skills of technical or professional personnel, e.g. registered nurse, licensed practical nurse, physical therapist, occupational therapist, audiologist, and;

(2) are provided directly by or under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to assure the safety of the patient and achieve the medically desired result.

Source. #4096, eff 7-22-86; ss by #4325, eff 10-21-87

PART 902 STANDARD FOR LONG-TERM CARE FACILITIES

He-Hea 902.01 Quality Assurance Plan. Any applicant for long-term care facilities shall demonstrate the availability of a quality assurance plan to objectively and systematically monitor patient placement and care on a continuous basis. Such plan shall be submitted with an application.

He-Hea 902.02 Service Area.

(a) The service area for new long-term care facilities shall include those towns and cities within a 15 mile radius or 30 to 45 minutes driving time of the proposed facility.

(b) The service area for new long-term care facilities owned by county government shall be the county which owns the facility.

Source. #4096, eff 7-22-86

He-Hea 902.03 Access to Public Transportation. Where possible, long-term care facilities shall be located where access is easily gained by low-cost public transportation.

Source. #4096, eff 7-22-86

He-Hea 902.04 Physical Environment. Where possible, the siting of new long-term care facilities shall allow for future expansion, provide ample staff and visitor parking, and conform to local zoning and building requirements.

Source. #4096, eff 7-22-86

He-Hea 902.05 Safe Environment. Where possible the siting of new long-term care facilities shall be free of hazardous environmental conditions, high noise levels, offensive odors and unsightly physical surroundings.

Source. #4096, eff 7-22-86

PART He-Hea 903 CRITERIA FOR EVALUATING LONG-TERM CARE FACILITY APPLICATIONS

He-Hea 903.01 Granting a Certificate of Need. In addition to the criteria included in RSA 151-C:7 and Chapter He-Hea 300 of these rules the board shall consider the following criteria in determining to grant a certificate of need.

(a) Applicants shall demonstrate that resources are available to fund the proposed capital and operating costs. Demonstration shall include 3 years historical financial statements if available and 5 years projected financial statements.

(b) Applicants shall demonstrate that the proposed project shall be financed at the most favorable rate of interest and term of debt currently available. Demonstration shall include a letter from the lendor stating interest and term of debt.

(c) Applicants shall demonstrate that resources are available to maintain operations in the event of interruptions to cash flow. Demonstration shall be through projected financial statements.

(d) Applicants shall demonstrate that resources are available to provide a reasonable percentage of total services to Medicaid patients. Applicants must state the number of Medicaid patients and indicate the projected charge per day for these patients.

(e) Applicants shall demonstrate the integration of the proposed project(s) into the continuum of care system of the area in which the new facility will be located. Applicants shall show letters from other agencies dealing with elderly or produce a plan which demonstrates how they will provide services in the continuum of care.

(f) Applicants shall certify that no revocation, noncertification action, or Medicare or Medicaid fraud proceedings exist or are pending against the applicant or an affiliated organizational entity.

(g) Applicants shall provide preliminary construction drawings showing space allocations by department, expressed in the number of square feet.

(h) Applicants shall provide staffing projections and projected average salaries for the proposed project.

(i) Applicants shall demonstrate the anticipated energy consumption by providing an MBTU (thousand british termal units) usage per square foot.

Source. #4096, eff 7-22-86

He-Hea 903.02 Certificate of Need Denial. No person who has had a health facilities license revoked, Medicare or Medicaid certification involuntarily terminated, or been convicted of civil or criminal Medicare or Medicaid fraud or patient abuse shall be granted a certificate of need.

Source. #4096, eff 7-22-86

PART He-Hea 904 METHODOLOGY FOR DETERMINING NEED

He-Hea 904.01 Determination for Additional Long-term Care Facility Beds. The board shall determine the need for additional long-term care facility beds for the year 1990 by applying a bed to population ratio of 50 beds per thousand population aged 65+. The population shall be the population provided by the New Hampshire office of state planning exclusive of persons over age 65 residing in residential units of CCRC's designated under this rule. The bed need formula shall be applied as follows:

$$\text{Beds Required} = \frac{\text{REGION POPULATION AGED 65+} \times 50}{1000}$$

Source. #4096, eff 7-22-86; ss by #4325, eff 10-21-87

He-Hea 904.02 Regional Bed Need Formula. The board shall apply the bed need formula (included in He-Hea 904.01) to the following 11 regions of the state of New Hampshire:

LONG-TERM CARE SERVICE AREA

REGION

(1) Atkinson & Gilm. Grant
Bath
Berlin
Bethlehem
Cambridge
Carroll
Clarksville
Lancaster
Landaff
Lincoln
Lisbon
Littleton
Livermore
Lyman
Warren
Wentworth Loc.
Whitefield
Woodstock

LONG-TERM CARE SERVICE AREA

(1) cont'd

Colebrook
Columbia
Dalton
Dixs Grant
Dixville
Dummer
Easton
Erroll
Ervins Location
Franconia
Gorham
Hart Location
Haverhill
Jefferson
Kilkenney
Milan
Millsfield
Monroe
Northumberland
Odell
Piermont
Pittsburg
Randolph
Second College Grant
Shelburne
Stark
Stewartstown
Stratford
Success
Sugar Hill

(2) Canaan
Dorchester
Enfield
Grafton
Grantham
Hanover
Lebanon
Lyme
Orange
Orford
Plainfield
Wentworth

(3) Andover
Alexandria
Ashland
Belmont
Bridgewater
Bristol
Campton
Center Harbor
Ellsworth
Franklin
Gilford
Gilmanton
Groton
Hebron
Holderness
Hill
Laconia
Meredith
Moultonboro
New Hampton
Northfield
Plymouth
Rumney
Salisbury
Sandbornton
Sandwich
Thornton
Tilton
Waterville Valley

(4) Albany
Bartlett
Chatham
Conway
Eaton
Jackson
Madison
Tamworth

LONG-TERM CARE SERVICE AREA

REGION		
(5)	Alton	Middleton
	Effingham	Tuffonboro
	Freedom	Wakefield
		Wolfeboro
(6)	Acworth	Newbury
	Charlestown	New London
	Cornish	Newport
	Claremont	Springfield
	Craydon	Sunapee
	Danbury	Sutton
	Goshen	Unity
	Langdon	Wilmot
	Lempster	
(7)	Allenstwon	Henniker
	Antrim	Hillsboro
	Boscawen	Hopkinton
	Bow	Loudon
	Bradford	Northwood
	Canterbury	Pembroke
	Chicester	Pittsfield
	Concord	Warner
	Deerfield	Washington
	Deering	Weare
	Dunbarton	Webster
	Epsom	Windsor
(8)	Barnstead	New Durham
	Dover	Newington
	Durham	Rochester
	Farmington	Rollinsford
	Lee	Strafford
	Madbury	Somersworth
	Milton	
(9)	Alstead	Nelson
	Bennington	New Ipswich
	Chesterfield	Peterborough
	Dublin	Richmond
	Fitzwilliam	Rindge
	Francestown	Roxbury
	Gilsum	Sharon
	Greenfield	Sullivan
	Hancock	Surry

LONG-TERM CARE SERVICE AREA

REGION		
(9)	Harrisville	Swanzey
	Hindsdale	Temple
	Jaffrey	Troy
	Keene	Walpole
	Lyndenborough	Westmoreland
	Marborough	Wilton
	Marlow	Winchester
(10)	Amherst	Litchfield
	Auburn	Manchester
	Bedford	Mason
	Brookline	Merrimack
	Candia	Milford
	Goffstown	Mont Vernon
	Hooksett	Nashua
	Hollis	New Boston
	Hudson	Pelham
	Atkinson	Londonderry
	Chester	Plaistow
	Danville	Salem
	Derry	Sandown
	Hampstead	Windham
(11)	Brentwood	New Market
	East Kingston	New Castle
	Epping	North Hampton
	Exeter	Nottingham
	Fremont	Portsmouth
	Greenland	Raymond
	Hampton	Rye
	Hampton Falls	Stratham
	Kensington	Seabrook
	Kingston	South Hampton
	Newfields	

Source. #4096, eff 7-22-86

He-Hea 904.03 Determination of Unmet Need. The board shall subtract the number of long-term beds licensed or approved by certificate of need exclusive of long-term beds licensed or approved and located in a CCRC designated and approved under 908, in each region outlined in He-Hea 904.02 from the calculated need. If the calculated need is greater than the existing bed inventory, then the difference shall be considered unmet need and shall be considered for issuance of an RFP (Request for Proposal).

Source. #4096, eff 7-22-86; ss by #4325, eff 10-21-87

PART He-Hea 905 REQUEST FOR PROPOSAL

He-Hea 905.01 Ranking of Areas With Demonstrated Unmet Need. The board shall rank by priority the areas of unmet need by considering the following criteria:

(a) Ratio of unmet need to total calculated need.

(b) Any evidence provided by persons in the region demonstrating the shortage.

(c) Any other such evidence as presented to the board.

Source. #4096, eff 7-22-86

He-Hea 905.02 Issuance of RFP (Request For Proposal).

(a) RFP's (Request For Proposal) shall be issued for only one region at a time.

(b) In accordance with RSA 151-C:8 (I), RFP's (Requests FOR Proposal) shall be issued twice a year on September 1 and March 1 of each year until no region has an unmet need.

Source. #4096, eff 7-22-86

He-Hea 905.03 Submission of Applications. Applications in response to an RFP (Request For Proposal) shall be submitted within 90 days of the publication of the RFP (Request For Proposal).

Source. #4096, eff 7-22-86

PART He-Hea 906 GRANTING CERTIFICATES OF NEED

He-Hea 906.01 Approval of Application. The board may grant a certificate of need to one or more applicants in one or more locations in the region. The total number of beds approved shall not exceed the unmet need.

Source. #4096, eff 7-22-86

PART He-Hea 907 RENOVATION AND REPLACEMENT OF EXISTING LONG-TERM CARE FACILITIES

He-Hea 907.01 Deficiencies. Any owner of a long-term care facility, which has been deemed to have life safety-code and/or licensing deficiencies under He-P 803 may apply for a certificate of need to replace and/or renovate the existing structure.

Source. #4096, eff 7-22-86

He-Hea 907.02 Noncompetitive. All licensed beds in the facility described in He-Hea 907.01 shall be considered existing beds and may be replaced without using an RFP (Request For Proposal) as outlined in He-Hea 905.

Source. #4096, eff 7-22-86

He-Hea 907.03 Acquisitions. Acquiring a facility with nontransferable life-safety code waivers shall not constitute an emergency or law and regulation review as defined in RSA 151-C: 13 (III). However, this does not preclude emergency or law and regulation reviews that are subject to RSA 151-C: 13 (III).

(a) All applicants shall contact (in writing) the New Hampshire office of health facilities, division of public health prior to acquiring a long-term care facility to determine if, after transfer of ownership, the facility will comply with He-P 803.

Source. #4096, eff 7-22-86

He-Hea 907.04 Criteria For Replacement and/or Renovation. In addition to all other requirements in RSA 151-C:7 and chapter He-HEa 300 of these rules the board shall consider the following criteria in determining to grant a certificate of need.

(a) Documented evidence of either structural safety deficiencies or code violations or both as defined by a state or local licensing or accrediting agency which threaten the safety of residents and employees. This includes deficiencies or violations in a building which cannot be remedied in the existing structure to comply with the provisions of He-P 803.

(b) Documented evidence of additional expenses incurred in housekeeping, maintenance and fire safety operations as a result of inefficiencies in the existing facility.

(c) Documented evidence of structural deficiencies which hamper the safety or convenient use of the facility by handicapped persons.

(d) Documented evidence that the facility may safely continue operation until renovation or replacement of the building is completed.

(e) Documented evidence that the proposed renovations or replacement of the building shall be within the following construction standards:

(1) The construction cost per bed, cost per square foot and square foot per bed shall be within 10% of the current Marshall Valuation Service values provided in section 15 (offices, public buildings and schools) of this guide for the proposed class and type of construction.

(2) The construction costs shall be adjusted to reflect inflation, labor and materials by using the indices provided in sections 98 and 99 (cost indexes and trend multipliers; current and local cost multipliers) of the current Marshall Valuation Service.

(f) Documented evidence of the impact on patient charges resulting from the proposed renovation or replacement of the building.

(g) Five years of projected operating costs shall be submitted.

Source. #4096, eff 7-22-86

PART He-Hea 908 STANDARDS FOR NURSING HOMES WITHIN CCRC's

He-Hea 908.01 Limitation on Nursing Home Beds.

(a) For any facility which meets the definition of a CCRC in section 901.02(c) and which seeks approval for additional beds under this chapter, the board shall approve no more than one nursing home bed for every 4 residential units in the CCRC.

(b) Any CCRC which adds residential units after the effective date of this rule may seek from the board certificate of need approval to add nursing home beds. The board shall not approve any long-term care beds which would cause the total nursing home bed capacity of a CCRC to exceed one bed for every 4 residential units in the CCRC.

Source. #4325, eff 10-21-87

He-Hea 908.02 Limitation on Admissions and Certification. Any CCRC which seeks certificate of need approval to all long-term care beds shall, as a condition of approval, agree to the following restrictions on admissions and certification:

(a) Admissions to the nursing home component of a CCRC shall be limited to persons who have been residents of the CCRC for a period of not less than 180 consecutive days immediately preceding admission into the nursing home. This restriction shall not apply to any medically indicated admission to the nursing home resulting from an illness or accident which occurred subsequent to residence in the CCRC or to an admission by a non-resident by a non-resident spouse of a resident of the CCRC.

(b) A CCRC may obtain medical assistance certification for no more than one bed for every 4 persons residing in federally or state subsidized housing for low-income persons residing in the CCRC, except for those CCRC's which can demonstrate to the board a past and continuing policy of subsidizing through endowments residents of the CCRC who are in need. Documentation shall include the number of patients annually subsidized by endowments by the CCRC and a financial statement of the CCRC's current endowment fund with a

statement of the number of patients from whom the CCRC shall provide subsidized care in the future. No CCRC shall admit to its nursing home any person who qualifies for medical assistance unless that person was a resident of the CCRC's subsidized low-income housing prior to admission to the nursing home.

(c) The applicant shall include with the application a plan for the planned phase-out of all medical assistance patients and beds in the CCRC through attrition, except as permitted under (b), to be effective upon approval of the application by the board.

Source. #4325, eff 10-21-87

He-Hea 908.03 Enforcement. The board shall revoke the certificate of need of any CCRC which fails to comply with the restrictions on admissions and certification described in 908.02(a) - (c) or any other conditions attached to the certificate of need approval by the board.

Source. #4325, eff 10-21-87

He-Hea 908.04 Special Review Criteria.

(a) Any CCRC which seeks a certificate of need to add nursing home beds shall demonstrate the following:

(1) That it meets the definition of a CCRC in 901.02(c). The applicant shall include in the application an itemized and detailed description of how the facility meets the definition of a CCRC.

(2) That the CCRC shall cover the full cost of any resident's required care in the nursing home unit of the CCRC and that it has adequate financial resources to do so without resorting to medical assistance funding, except as allowed under section 908.02(b). The applicant shall submit with the application an independent financial analysis of the CCRC's ability to cover the cost of care for its residents.

(3) That the CCRC shall cover all costs of nursing home care in facilities not owned or operated by the CCRC in the event that nursing home beds are not available in the CCRC an the resident requires nursing home services. The applicant shall submit an independent financial analysis which documents that it has adequate resources to cover such costs. In addition, the applicant shall submit with the application a plan for the coverage of nursing home care when beds are not available at the CCRC. This plan shall include signed written statements from the administrators of nursing homes within a 15 mile radius of the CCRC stating that they agree to admit CCRC residents who need nursing home care until a bed becomes available in the CCRC.

(4) That it agrees to permit relocation of any outplaced nursing home patient back into the CCRC's nursing home as soon as a bed becomes available. The applicant shall include with the application a signed statement attesting to this policy. This requirement shall not apply to any outplaced patient whose medical, personal and psychosocial needs cannot be met by the facility or to any person who is known to have or suspected of having a communicable disease.

(5) That written policies exist, or shall be established upon implementation of the project, which guarantee that a bed in a CCRC's nursing home is available to a nursing home patient for at least 45 consecutive days following admission of that nursing home patient to an acute care hospital for inpatient treatment or care. The applicant shall submit with the application copies of the established or proposed policies.

(6) In the case of a new CCRC, that there is demand for the residential component of the CCRC in the service area. The applicant shall define the service area for the CCRC and provide demographic data and any available market studies justifying the location of the CCRC and the nursing home in that service area. The applicant may do this through submission with the application of evidence of prepaid deposits or of a detailed market study. The nursing home service areas described in 904.02 do not apply to applications by or on behalf of the CCRC's.

(b) The applicant shall comply with all other applicable criteria in RSA 151-C:7 and He-Hea 302.01.

Source. #4325, eff 10-21-87

He-Hea 908.05 Application Process.

(a) Given that promotion and expansion of CCRC's are in the best competitive interest of health care in the state, applications to construct or add nursing home beds in a CCRC shall not be subject to the requirements of RSA 151-C:8. Applications shall be processed and evaluated pursuant to this part.

(b) Applications shall be in letter form and attested to in their entirety by the applicant's chief executive officer. Unsigned applications shall not be accepted for filing. Applications shal clearly and thoroughly describe how the applicant shall comply with each requirement of sections 908.01 - 908.04 and shall include such supporting documentation as may be deemed necessary by the board for purposes of insuring that the applicant is in compliance with this section.

Source. #4325, eff 10-21-87

He-Hea 908.06 Board Action.

(a) The board shall review and evaluate applications within 60 days following the application being declared complete.

(b) If an application demonstrates full compliance with this section, a certificate of need shall be issued to the applicant. Notice of the board's action shall be given pursuant to RSA 151-C:9, III. The certificate of need shall contain the conditions described in He-Hea 908.02 and may contain other conditions which the board finds are necessary to assure compliance with this section.

Source. #4325, eff 10-21-87