FIRST REGULAR SESSION

ONE HUNDRED AND ELEVENTH LEGISLATURE

Legislative Document No. 1353

S.P. 446 In Senate, March 29, 1983

Submitted by the Department of Human Services pursuant to Joint Rule 24.

Referred to the Committee on Health and Institutional Services. Sent down for concurrence and 2500 ordered printed.

JOY J. O'BRIEN, Secretary of the Senate

Presented by Senator Najarian of Cumberland.

Cosponsors: Representative Brannigan of Portland, Representative Hall of Sangerville and Representative Gwadosky of Fairfield.

STATE OF MAINE

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

AN ACT to Limit Future Increases in the Cost of Hospital Care in Maine.

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

Sec. 1. 2 MRSA §6-B is enacted to read:

§6-B. Salaries of certain employees of the Maine Health Care Finance Commission

Notwithstanding any other provision of law, the salaries of certain employees of the Maine Health Care Finance Commission shall be as follows.

1. Executive director. The salary of the executive director shall be within salary range 91.

2. Deputy director. The salary of the deputy director shall be within salary range 89.

3. General counsel. The salary of the general counsel shall be within salary range 88.

Sec. 2. 3 MRSA §507, sub-§10, ¶B, as repealed and replaced by PL 1979, c. 654, §3, is amended to read:

B. Unless continued or modified by law, the following Group E-2 independent agencies shall terminate, not including the grace period, no later than June 30, 1989:

(1) Board of Trustees Group Accident and Sickness or Health Insurance;

(2) Maine Vocational Development Commission;

(3) Post-secondary Education Commission of Maine;

(4) Advisory Committee on Maine Public Broadcasting;

(5) State Government Internship Program Advisory Committee;

(6) State Historian;

(7) Historic Preservation Commission;

(8) Maine State Commission on the Arts and the Humanities;

(9) Maine Occupational Information Coordinating Committee; and

(10) Maine Historical Society; and

(11) Maine Health Care Finance Commission.

Sec. 3. 5 MRSA §711, sub-§1, ¶H, as repealed and replaced by PL 1977, c. 674, §6, is amended to read:

H. Officers and employees of the unorganized territory school system and the teachers and principals of the school systems in state vocational schools and state institutions; and

Sec. 4. 5 MRSA §711, sub-§1, ¶I, as amended by PL 1979, c. 537, is further amended to read:

I. Deputies, assistants, staff attorneys, research assistants, business manager and the secretary to the Attorney General of the Attorney General's Department; and

Sec. 5. 5 MRSA §711, sub-§1, ¶J is enacted to read:

J. The executive director, deputy director, general counsel and staff attorneys of the Maine Health Care Finance Commission.

Sec. 6. 22 MRSA §303, sub-§3-A is enacted to read:

3-A. Commission. "Commission" means the Maine Health Care Finance Commission established pursuant to chapter 107.

Sec. 7. 22 MRSA §303, sub-§17, as enacted by PL 1977, c. 687, §1, is repealed and the following enacted in its place:

17. Project. "Project" means any acquisition, capital expenditure, new health service, termination or change in a health service, predevelopment activity or other activity which requires a certificate of need under section 304-A.

Sec. 8. 22 MRSA §303, sub-§17-B is enacted to read:

17-B. Regional hospital corporation. "Regional hospital corporation" means a nonprofit corporation established pursuant to section 396-M.

Sec. 9. 22 MRSA §304-A, sub-§9, ¶B, as enacted by PL 1981, c. 705, Pt. V, §16, is amended to read:

B. If a person adds a health service not subject to review under subsection 4, paragraph A or C and which was not deemed subject to review under subsection 4, paragraph B at the time it was established and which was not reviewed and

approved prior to establishment at the request of the applicant, and its actual 3rd fiscal year operating cost, as adjusted with an appropriate inflation deflator promulgated by the ~~Health Facilities Cost Review Board pursuant to sections 360 and 366~~ department, after consultation with the commission, exceeds the expenditure minimum for annual operating cost in the 3rd fiscal year of operation following addition of these services.

Sec. 10. 22 MRSA §309, sub-§2, ¶A, as amended by PL 1981, c. 705, Pt. V, §32, is further amended to read:

A. The relationship of the health services being reviewed to the ~~annual implementation plan, the health systems plan and the~~ state health plan and to any applicable regional plan developed by a regional hospital corporation;

Sec. 11. 22 MRSA §309, sub-§6 is enacted to read:

6. Hospital projects. The following conditions apply to hospital projects.

A. In the determination to issue or deny a certificate of need for a project which is subject to review by a regional hospital corporation pursuant to chapter 107, the department shall consider the findings and recommendations of the regional hospital corporation.

B. Notwithstanding subsections 1, 4 and 5, the department may not issue a certificate of need for a project which is subject to approval by the commission pursuant to chapter 107, if the associated required incremental revenue would exceed the amounts specified in section 396-L, subsection 2, paragraph B, or section 396-M, subsection 5, paragraph D.

Sec. 12. 22 MRSA c. 107 is enacted to read:

CHAPTER 107

MAINE HEALTH CARE FINANCE COMMISSION

SUBCHAPTER I

GENERAL PROVISIONS

§381. Findings and declaration of purpose

1. Findings. The Legislature makes the following findings.

A. The cost of hospital care in Maine has been increasing much more rapidly than the ability of its citizens to support these increases. This disparity is detrimental to the public interest. It diminishes the accessibility of hospital services to the people of the State and materially compromises their ability to address other equally compelling needs.

B. The current system of financing hospital care is seriously deficient, has directly contributed to the rapid rise in costs and is in need of reform in that:

(1) The current system of financing hospital care fails to assure that hospitals will charge those they serve no more than is needed to meet their reasonable financial requirements;

(2) The current system of financing hospital care fails to assure or reward efficiency and restraint in hospital spending;

(3) The current system of financing hospital care is inequitable in that it permits hospitals to respond to the legitimate cost containment efforts of the Federal Government and the State by increasing their charges to other patients; and

(4) The current system of financing hospital care threatens the ability of some Maine hospitals to generate sufficient revenues to meet their reasonable financial requirements and, consequently, will inevitably have an

adverse impact on the accessibility and the quality of the care available to those whom they serve.

C. The informed development of public policy regarding hospital and other necessary health services requires that the State regularly assemble and analyze information pertaining to the use and cost of these services.

2. Purposes. The purposes of this chapter are as follows.

A. It is the intent of the Legislature to protect the public health and promote the public interest by establishing a hospital financing system which:

(1) Appropriately limits the rate of increase in the cost of hospital care from year to year;

(2) Protects the quality and the accessibility of the hospital care available to the people of the State by assuring the financial viability of an efficient and effective state hospital system;

(3) Affords those who pay hospitals a greater role in determining their reasonable financial requirements without unduly compromising the ability of those who govern and manage hospitals to decide how the resources made available to them are to be used;

(4) Encourages hospitals to make the most efficient use of the resources made available to them in the provision of quality care to those whom they serve and the training and continuing education of physicians and other health professionals;

(5) Provides predictability in payment amounts for payors, providers and patients; and

(6) Assures greater equity among purchasers, classes of purchasers and payors.

B. It is further the intent of the Legislature that uniform systems of reporting health care information shall be established; that all health care facilities shall be required to file reports in a manner consistent with these systems; and that, using the least restrictive means practicable for the protection of privileged medical information, public access to those reports shall be assured.

§382. Definitions

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

1. Board. "Board" means the Health Facilities Cost Review Board established pursuant to Public Law 1977, chapter 691, section 1.

2. Bureau. "Bureau" means the Bureau of Health Planning and Development within the Department of Human Services.

3. Commission. "Commission" means the Maine Health Care Finance Commission established by this chapter.

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

5. Direct provider of health care. "Direct provider of health care" means an individual whose primary current activity is the provision of health care to other individuals or the administrator of a facility in which that care is provided.

6. Health care facility. Except as provided in subsection 14, "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.

7. Hospital. "Hospital" means any acute care institution required to be licensed pursuant to chapter 405 or its successor, with the exception of the Cutler Health Center and the Dudley Coe Infirmary.

8. Independent data organization. Except as provided in section 394, subsection 4, "independent data organization" means an organization of data users, a majority of whose members are not direct providers of health care services and whose purposes are the cooperative collection, storage and retrieval of health care information.

9. Major 3rd-party payor. "Major 3rd-party payor" means a 3rd-party payor, as defined in subsection 21, which, with respect to an individual hospital:

A. Is responsible for payment to the hospital of amounts equal to or greater than 2 1/2% of all payments to the hospital, as this amount is determined by the commission; and

B. Maintains a participating agreement with the hospital.

Notwithstanding paragraphs A and B, the department shall be deemed a major 3rd-party payor with respect to any hospital participating in the Medicaid program. In addition, any payor responsible for payment under the Medicare program shall be deemed a major 3rd-party payor with respect to any hospital participating in that program, provided that a payor which acts as a fiscal intermediary for the Medicare program shall not be considered a major 3rd-party payor with respect to payments it makes other than as a Medicare fiscal intermediary, unless it also meets the provisions of paragraphs A and B with respect to these payments.

10. New and expanded services. "New and expanded services" include:

A. The addition, enhancement or expansion of a health service which results in incremental noncapital costs to a health care facility;

B. The addition or replacement of fixed equipment or facilities to the extent of costs in excess of the replacement value established pursuant to section 396-A, subsection 3, and section 396-D, subsection 3; and

C. The addition or replacement of movable equipment to the extent of costs in excess of the depreciable basis established pursuant to section 396-A, subsection 2.

11. Participating agreement. "Participating agreement" means a written agreement between a hospital and a 3rd-party payor under which the payor is obligated to pay the hospital directly on behalf of its beneficiaries and under which the hospital is obligated to meet participation requirements which may include, but are not limited to, such areas as submission of claims information, utilization review programs and record keeping.

12. Payor. "Payor" means a 3rd-party payor.

13. Person. "Person" means an individual, trust or estate, partnership, corporation, including associations, joint stock companies and insurance companies, the State or a political subdivision or instrumentality, including a municipal corporation of the State, or any other legal entity recognized by state law.

14. Provider of health care. "Provider of health care" means:

A. A direct provider of health care;

B. A health care facility, as defined in section 303, subsection 7; or

C. A health product manufacturer.

15. Purchaser. "Purchaser" means a natural person responsible for full or partial payment for health care services rendered by a hospital.

16. Regional hospital corporation. "Regional hospital corporation" means a nonprofit corporation

established by all the hospitals in a regional hospital group for the purpose of conducting regional planning and administering regional development funds.

17. Regional hospital group. "Regional hospital group" means a grouping of hospitals on the basis of their geographic location and their ability to coordinate and share, as appropriate, services.

18. Revenue center. "Revenue center" means a functioning unit of a hospital which provides identifiable services to patients for a charge.

19. Secretary. "Secretary" means the Secretary of the United States Department of Health and Human Services.

20. Small hospital. "Small hospital" means a hospital having 50 or fewer licensed beds.

21. Third-party payor. "Third-party payor" means any entity, other than a purchaser, which is responsible for payment, either to the purchaser or the hospital, for health care services rendered by a hospital. It includes, but is not limited to, federal governmental units responsible for the administration of the Medicare program, the department, insurance companies, health maintenance organizations and nonprofit hospital and medical service corporations; provided that it shall not be construed to include any state agency or subunit of a federal agency other than those directly administering programs under which payment is made to hospitals for health care services rendered to program beneficiaries.

§383. Maine Health Care Finance Commission

1. Establishment. The Maine Health Care Finance Commission shall be established as follows.

A. There is established the Maine Health Care Finance Commission, which shall function as an independent executive agency.

B. The commission shall be composed of 5 members, who shall be appointed by the Governor,

subject to review by the joint standing committee of the Legislature having jurisdiction over health and institutional services and confirmation by the Legislature.

The appointees shall be persons conversant with the organization, delivery or financing of health care. No person may be eligible for appointment to, or to serve on, the commission if he is affiliated with or employed by any 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, nor enrollment in a health maintenance organization, nor membership as a policyholder in a mutual insurer or coverage under such a policy, nor the purchase of nor coverage under a policy issued by a stock insurer, nor service on a governmental advisory committee, nor employment by, or affiliation with, a municipality, may disqualify a person from serving as a member of the commission.

C. The terms of the initial appointees shall be staggered. Two shall be appointed for terms of 4 years, 2 for terms of 3 years and one for a term of 2 years. Thereafter, all appointments shall be for a term of 4 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. No member may be appointed to more than 2 consecutive 4-year terms.

D. The Governor may remove any member who would no longer be eligible to serve on the commission by virtue of the requirements of paragraph B or who becomes disqualified for neglect of any duty required by law.

E. The Governor shall appoint a chairman and a vice-chairman, who shall serve in these capacities at his pleasure.

2. Meetings. The commission shall meet as follows.

A. The commission shall meet from time to time as required to fulfill its responsibilities. Meetings shall be called by the chairman or by any 3 members. Meetings shall be announced in advance and open to the public, as required by Title 1, chapter 13, subchapter I.

B. Three members of the commission shall constitute a quorum. No action of the commission may be effective without the concurrence of at least 3 members.

3. Compensation. Each member of the commission shall receive a per diem allowance of $150 for each day he is actively engaged in performing the work of the commission and each member shall be reimbursed for the actual necessary and proper expenses incurred in the performance of his duties.

§384. Executive director and staff

The commission shall appoint an executive director, who shall perform the duties delegated to him by the commission. The executive director shall serve at the pleasure of the commission and his salary shall be set by the commission within the range established by Title 2, section 6-B. The executive director shall appoint a deputy director, who shall perform the duties delegated to him by the executive director. The deputy director shall serve at the pleasure of the executive director and his salary shall be set by the executive director within the range established by Title 2, section 6-B. The commission may employ such other staff as it deems necessary. The appointment and compensation of such other staff shall be subject to the Personnel Law.

§385. Legal counsel

The commission shall appoint, with the approval of the Attorney General, a general counsel and such other staff attorneys as it deems necessary. The general counsel shall serve at the pleasure of the commission and his salary shall be set by the commis-

sion within the range established by Title 2, section 6-B. Other staff attorneys shall serve at the pleasure of the commission and their salaries shall be set by the commission. The general counsel and any other staff attorneys may represent the commission or its staff in any proceeding, investigation or trial. Private counsel may be employed, from time to time, with the approval of the Attorney General.

§386. Powers of commission generally

In addition to the powers granted to the commission elsewhere in this chapter, the commission is granted the following powers.

1. Rulemaking. The commission may adopt, amend and repeal such rules as may be necessary for the proper administration and enforcement of this chapter, subject to Title 5, chapter 375.

2. Committees. In addition to the committees required to be established under section 396-Q, the commission may create committees from its membership and appoint advisory committees consisting of members, other individuals and representatives of interested public and private groups and organizations.

3. Receipt of grants, gifts and payments. The commission may solicit, receive and accept grants, gifts, payments and other funds and advances from any person, other than a provider of health care, as defined in section 382, subsection 14, or a 3rd-party payor, as defined in section 382, subsection 21, and enter into agreements with respect to those grants, payments, funds and advances, including agreements that involve the undertaking of studies, plans, demonstrations or projects. The commission may only accept funds from providers of health care or from 3rd-party payors in accordance with subsection 9 and section 392.

4. Studies and analyses. The commission may conduct studies and analyses relating to health care costs, the financial status of any facility subject to this chapter and any other related matters it deems appropriate.

5. Grants. The commission may make grants to support research or other activities undertaken in furtherance of the purposes of this chapter.

6. Contract for services. The commission may contract with anyone other than commission members for any services necessary to carry out the activities of the commission. Any party entering into a contract with the commission shall be prohibited from releasing, publishing or otherwise using any information made available to it under its contracted responsibilities without the specific written authorization of the commission.

7. Audits. The commission may, during normal business hours and upon reasonable notification, audit, examine and inspect any records of any health care facility to the extent that the activities are necessary to carry out its responsibilities. To the extent feasible, the commission shall avoid duplication of audit activities regularly performed by major 3rd-party payors.

8. Public hearings. The commission may conduct any public hearings deemed necessary to carry out its responsibilities.

9. Fees. The commission may charge and retain fees to recover the reasonable costs incurred both in reproducing and distributing reports, studies and other publications and in responding to requests for information filed with the commission.

§387. Public information

Any information, except confidential commercial information obtained from a payor or privileged medical information, and any studies or analyses which are filed with, or otherwise provided to, the commission under this chapter shall be made available to any person upon request, provided that individual patients or health care practitioners are not directly identified. The commission shall adopt rules governing public access in the least restrictive means possible to information which may indirectly identify a particular patient or health care practitioner.

§388. Reports

1. Annual reports. Annually, prior to January 1st, the commission shall prepare and transmit to the Governor and to the Legislature a report of its operations and activities during the previous year. This report shall include such facts, suggestions and policy recommendations as the commission considers necessary.

2. Consumer reports. The commission shall, from time to time as it deems appropriate, publish and disseminate any information that would be useful to consumers in making informed choices in obtaining health care, including the results of any studies or analyses undertaken by the commission.

§389. State antitrust exemption

Any regional hospital corporation established pursuant to section 396-M and any hospital cooperating with such a corporation shall be exempt from Title 5, sections 207 to 214, and Title 10, chapter 201, for activities required to be conducted pursuant to section 396-M. It is the intent of the Legislature to displace competition and antitrust laws with respect to such activities.

§390. Penalties

Any person who violates any provision of this chapter or any valid order or rule made or promulgated pursuant to this chapter, or who willfully fails, neglects or refuses to perform any of the duties imposed upon him under this chapter, shall be deemed to have committed a civil violation for which a forfeiture of not more than $1,000 a day may be adjudged, unless specific penalties are provided for elsewhere.

§391. Enforcement

Upon application of the commission or the Attorney General, the Superior Court shall have full jurisdiction to enforce all orders of the commission and the performance by health care facilities of all duties imposed upon them by this chapter and any

valid regulations adopted pursuant to this chapter.

§392. Funding of the commission

1. Assessments. Every hospital subject to regulation under this chapter shall be subject to an assessment of not more than .15% of its gross patient service revenues. For the period of January 1, 1984, to September 30, 1984, each hospital shall pay an assessment equal to 75% of the total annual dues and fees for which it was liable to a voluntary budget review organization during its most recent fiscal year which ended prior to July 1, 1983. Each hospital shall pay this assessment in 3 equal installments, with payments due on or before January 1st, April 1st and July 1st of 1984. Thereafter, the commission shall determine the assessments annually prior to October 1st and shall assess each hospital for its pro rata share. Each hospital shall pay the assessment charged to it on a quarterly basis, with payments due on or before October 1st, January 1st, April 1st and July 1st of each fiscal year. The first annual assessment shall be for the fiscal year commencing October 1, 1984.

2. Legislative approval of the budget. The assessments and expenditures provided in this section shall be subject to legislative approval in the same manner as the budget of the commission is approved. The commission shall report annually, before February 1st, to the joint standing committee of the Legislature having jurisdiction over health and institutional sevices on its planned expenditures for the year and on its use of funds in the previous year.

3. Deposit of funds. All revenues derived from assessments levied against the hospitals described in this section shall be deposited with the Treasurer of State in a separate account to be known as the Health Care Finance Commission Fund.

4. Use of funds. The commission may use the revenues provided in this section to defray the costs incurred by the commission pursuant to this chapter, including salaries, administrative expenses, data system expenses, consulting fees and any other reasonable costs incurred to administer this chapter.

5. Unexpended funds. Except as specified in this section, any amount of the funds that is not expended at the end of a fiscal year shall not lapse, but shall be carried forward to be expended for the purposes specified in this section in succeeding fiscal years. Any unexpended funds in excess of 7% of the total annual assessment authorized in subsection 1 shall, at the option of the commission, either be presented to the Legislature in accordance with subsection 2 for reallocation and expenditure for commission purposes or used to reduce the hospital assessment in the following fiscal year.

§393. Program audit and evaluation

1. Sunset provisions. The commission shall be subject to review and termination or continuation by the Legislature in accordance with Title 3, chapter 23.

2. Evaluation. In addition to the requirements as to contents of justification reports under Title 3, section 504, the commission shall include in its report an evaluation of the impact of the hospital financing system established under this chapter on the quality of hospital care, access to such care and the financial stability of hospitals in the State.

SUBCHAPTER II

HEALTH FACILITIES INFORMATION DISCLOSURE

§394. Uniform systems of reporting generally

1. Establishment. The commission shall establish, after consultation with appropriate advisory committees and after holding public hearings, uniform systems of reporting financial and health care information as required under this chapter.

2. Information required. In addition to any other requirements applicable to specific categories of health care facilities, as set forth in section 395, and in subchapters III and IV and pursuant to rules adopted by the commission for form, medium, content and time for filing, each health care facility shall file with the commission the following information:

A. Financial information, including costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges, units of services, wage and salary data and such other financial information as the commission deems necessary for the performance of its duties;

B. Scope of service information, including bed capacity, by service provided, special services, ancillary services, physician profiles in the aggregate by clinical specialties, nursing services and such other scope of service information as the commission deems necessary for the performance of its duties; and

C. A completed uniform hospital discharge data set, or comparable information, for each patient discharged from the facility after June 30, 1983.

3. Previously filed discharge data. The commission may direct the transfer to its possession and contol of all discharge data required to have been filed with an independent data organization pursuant to the Health Facilities Information Disclosure Act prior to July 1, 1983. In the event that any such discharge data have not been filed with an independent data organization as of the effective date of this chapter, the commission shall direct such discharge data to be filed with the commission.

4. Storage of discharge data. The commission may, subject to section 386, subsection 6, contract with any entity, including an independent data organization, to store discharge data filed with the commission. For purposes of this subsection, "independent data organization" means an organization of data users, a majority of whose members are neither providers of health care, organizations representing providers of health care, nor individuals affiliated with those providers or organizations, and whose purposes are the cooperative collection, storage and retrieval of health care information.

5. Previously filed financial data. The commission may direct the transfer to its possession and control of all financial reports and data required to have been filed with the Health Facilities Cost

Review Board or with a voluntary budget review organization pursuant to the Health Facilities Information Disclosure Act prior to the effective date of this chapter. In the event that any such reports or data have not been filed as of the effective date of this chapter, the commission shall direct such reports or data to be filed with the commission. The commission may require the filing of financial reports and data which, during the period from July 1, 1983, to the effective date of this chapter, would have been required to be filed pursuant to the board's regulations in effect on June 30, 1983, had the Health Facilities Information Disclosure Act not been repealed effective July 1, 1983.

6. Consideration of other systems. To the extent feasible, the commission in establishing uniform systems shall take into account the data requirements of relevant programs and the reporting systems previously established by the Health Facilities Cost Review Board.

7. More than one licensed health facility operated. Where more than one licensed health facility is operated by the reporting organization, the information required by this chapter shall be reported for each health facility separately.

8. Certification required. The commission may require certification of such financial reports as it may specify and may require attestation as to these statements from responsible officials of the facility that these reports have to the best of their knowledge and belief been prepared in accordance with the requirements of the commission.

9. Verification. If a further investigation is considered necessary or desirable to verify the accuracy of information in reports made by health care facilities under this chapter, the commission may examine further any records and accounts as the commission may by regulation provide. As part of the examination, the commission may conduct a full or partial audit of all such records and accounts.

10. Filing schedules. The information and data required pursuant to this chapter shall be filed on

an annual basis or more frequently as specified by the commission. The commission shall establish the effective date for compliance with the required uniform systems.

§395. Hospital reporting; additional requirements

1. Fiscal year. The commission shall require all hospitals subject to this chapter to adopt a uniform fiscal year beginning on October 1st of each year. The first uniform fiscal year shall be the fiscal year beginning October 1, 1984.

2. Hospital reporting. The commission shall, after consultation with appropriate advisory committees and after public hearing, direct hospitals to use a uniform system of financial reporting. This system shall include such cost allocation and revenue allocation methods as the commission may prescribe for use in reporting revenues, expenses, other income and other outlays, assets, liabilities and units of service.

3. Modification of systems. The commission may modify the financial and clinical reporting systems to allow for differences in the scope or type of services and in financial structure among the various sizes, categories or types of hospitals subject to this chapter.

4. Medical record abstract data. In addition to the information required to be filed under section 394 and pursuant to rules adopted by the commission for form, medium, content and time of filing, each hospital shall file with the commission such medical record abstract data as the commission may prescribe.

5. Merged data. The commission may require the discharge data submitted pursuant to section 394, subsection 2, and any medical record abstract data required pursuant to subsection 4, to be merged with associated billing data.

6. Authority to obtain information. Nothing in this subchapter may be construed to limit the commission's authority to obtain information from hospitals which it deems necessary to carry out its duties under subchapter III.

SUBCHAPTER III

HOSPITAL CARE FINANCING SYSTEM

§396. Establishment of revenue limits and apportionment methods

1. Authority. The commission may establish and approve revenue limits and apportionment methods for individual hospitals.

2. Criteria. Subject to more specific provisions contained in this subchapter, the revenue limits and apportionment methods established by the commission shall assure that:

A. The financial requirements of a hospital are reasonably related to its total services;

B. A hospital's patient service revenues are reasonably related to its financial requirements; and

C. Rates are set equitably among all payors, purchasers or classes of purchasers of health care services without undue discrimination or preference.

In addition, the commission shall establish revenue limits that will permit the institution to render effective and efficient service in the public interest.

3. Excess charges prohibited. No hospital may charge for services at rates other than those required to achieve the equitable apportionment of the gross patient service revenue limit approved by the commission under this subchapter.

§396-A. Definition of base year financial requirements

The commisison shall define by regulation the elements of base year financial requirements of hospitals. These elements shall include the following components.

1. Patient care related costs exclusive of capital costs. These costs shall include salaries and wages, fringe benefits, contracted services, supplies and other noncapital expenses. These costs shall be defined in accordance with the Medicare program established pursuant to the United States Social Security Act, Title XVIII, and shall be offset by operating revenues as prescribed by Medicare regulations. In addition, compensation paid to physicians for professional services shall be included to the extent that it is included on a hospital's trial balance of expenses as reported in its Medicare cost report.

2. Movable equipment. An allowance for depreciation of movable equipment shall be calculated on the basis of historical cost, in accordance with regulations promulgated under the Medicare program. Funding of this depreciation may be required as specified by the commission.

3. Facilities and fixed equipment. An allowance for the costs of facilities, fixed equipment and debt shall include:

A. Debt service requirements associated with the hospital's facilities and fixed equipment; and

B. Annual contributions to a sinking fund sufficient to provide a down payment on replacement facilities and fixed equipment. The sinking fund shall be required to be maintained by each hospital and the commission may include in it price level depreciation on fixed equipment or a portion of price level depreciation on facilities.

§396-B. Computation of base year financial requirements

1. Base year. The commission shall determine the appropriate fiscal period to be designated the base year for purposes of computing base year financial requirements for each hospital. That period may be any consecutive 12-month period commencing on or after January 1, 1982.

2. Computation. The commission shall compute base year financial requirements, as defined pursuant to section 396-A, for each hospital subject to this chapter which was in operation on December 31, 1982, and shall make appropriate adjustments thereto to reflect increases or decreases in financial requirements occurring between the base year and September 30, 1984, provided that any rate of increase from the base year to September 30, 1984, shall not exceed the rate of increase for inpatient hospital costs allowed under the Tax Equity and Fiscal Responsibility Act of 1982.

3. New hospitals. The commission shall establish, by regulation, a methodology for computing base year financial requirements for hospitals subject to this chapter which commence operations on or after January 1, 1983. This methodology may include reasonable limits based on the costs approved pursuant to the Maine Certificate of Need Act.

§396-C. Computation of payment year financial requirements

The commission shall determine the payment year financial requirements of each hospital as follows.

1. Payment years. Payment years shall coincide with the uniform fiscal year established pursuant to section 395. The first payment year shall be the uniform fiscal year commencing October 1, 1984.

2. First year. The payment year financial requirements for each hospital for the first payment year shall be the base year financial requirements computed in accordance with section 396-B and adjusted by the commission in accordance with section 396-D.

3. Subsequent years. The payment year financial requirements for each hospital for the 2nd payment year and each subsequent payment year shall be the payment year financial requirements determined for the immediately preceding payment year adjusted by the commission in accordance with section 396-D.

§396-D. Adjustments to financial requirements

In determining payment year financial requirements of each hospital, the commission shall provide for adjustments based on factors affecting hospital financial requirements in accordance with this section.

1. Economic trend factor. In determining payment year financial requirements for each fiscal year, the commission shall include an adjustment for the projected impact of inflation on the prices paid by hospitals for the goods and services required to provide patient care. In order to measure and project the impact of inflation, the commission shall establish and use the following data:

A. Homogeneous classifications of hospital costs for goods and services and of capital costs, which shall be called "cost components;"

B. Estimates or determinations of the proportion of hospital costs in each cost component; and

C. Identification or development of proxies which measure the reasonable increase in prices, by cost component, which the hospitals would be expected to pay for goods and services.

It may also consider the discrepancies, if any, between the projected and actual inflation experience of noncompensation proxies in preceding payment years.

The commission may, from time to time during the course of a payment year, in accordance with duly promulgated regulations, make further adjustments in the event it obtains substantial evidence that its initial projections for the current payment year will be in error.

2. Case mix. Adjustments may be made for changes in case mix as follows.

A. In determining payment year financial requirements for each fiscal year, the commission shall include an adjustment for the projected impact on the hospital's financial requirements of changes in the acuity of illness of the hospital's patients.

In order to measure and project the impact of changes in acuity, the commission shall establish and use the following data:

(1) Classifications of hospital patient admissions, called "patient classification," which are medically meaningful and which have relatively similar resource requirements for their treatment;

(2) Estimates or determinations of the average patient care costs of treating patients, including nursing costs, in each patient classification, which costs shall not include any costs which are fixed or largely independent of the volume of services provided; and

(3) Measurements of the reasonable impact on each hospital's costs of changes in the distribution of the hospital's patients over the patient classifications.

It may also consider discrepancies, if any, between the projected and actual changes in case mix in the preceding payment years.

B. The commission may from time to time during the course of a payment year, in accordance with duly promulgated regulations, make further adjustments, on an interim or final basis, in the event of discrepancies, if any, between projected and actual case mix changes in the preceding payment years or in the event it obtains substantial evidence that its initial projections for the current payment year will be in error.

3. Replacement of facilities and fixed equipment. In determining payment year financial requirements for each fiscal year, the commision shall include an adjustment to reflect any net increase in capital costs resulting from the replacement of facilities and fixed equipment. An adjustment under this subsection shall not be effective prior to the date on which the facilities or fixed equipment have been replaced and the associated expenses would be eligible for reimbursement under the Medicare program. The

amount determined under this subsection shall be consistent with section 396-A, subsection 3.

4. Volume. Changes in a hospital's volume of services shall be considered as follows.

A. In determining payment year financial requirements for each fiscal year, the commission shall consider the reasonable expected impact on the hospital's financial requirements of changes in the volume of services required to be provided by hospitals resulting from:

(1) Changes in the characteristics, including age, of the population served by the hospital;

(2) Changes in the level of hospital services per capita; and

(3) The introduction of new physicians in medically under-served areas.

Subject to the requirements of paragraph D, the commission shall establish for each regional hospital group a maximum amount available for volume adjustments which shall be allocated to individual hospitals in accordance with paragraph B. In establishing these limits, the commission may consider the reasonableness of the historical level of volume of services.

B. The commission shall distribute the regional volume adjustment to the hospitals in a regional hospital group in accordance with the schedules developed pursuant to paragraph C. In the event that actual changes in volume, as calculated after the close of a payment year, exceed the regional limit, the commission shall make a pro rata reduction in the adjustments allocated to each hospital.

C. In order to measure the impact of changes in the volume of service on hospital's costs, the commission shall establish schedules which shall be completed and submitted by each hospital and which shall include:

(1) Classifications of the services which shall be used to measure volume changes;

(2) Statistical units of measure for each service classification; and

(3) Specified percentages of the variable costs of each center to be added or subtracted from the approved revenues of the center as a result of specified changes in volume.

These schedules may vary according to the regional hospital group to which they apply. They shall be developed in such a manner as to introduce financial incentives for the efficient and effective delivery of services.

D. For the first 3 payment years, the limits on volume adjustments shall be as follows.

(1) For the first payment year, the interim volume adjustment for each hospital shall be 1% of base year financial requirements and the sum of the adjustments computed subsequent to the close of the first payment year for all hospitals in each regional hospital group may not exceed 1% of the sum of the base year financial requirements for all hospitals in the group.

(2) For the 2nd and 3rd payment years, the aggregate volume adjustment shall not exceed 1% of the sum of the payment year financial requirements determined for all hospitals in the preceding year.

E. The commission shall establish by regulation the methodology by which the volume adjustments calculated subsequent to the close of a payment year are to be included in the payment obligations of payors and purchasers.

F. The commission may, from time to time during the course of a payment year, in accordance with duly promulgated regulations, make such further adjustments as may be necessary in the event of

discrepancies, if any, between projected and actual volume changes in preceding payment years or in the event it obtains substantial evidence that its initial projections for the current payment year will be in error.

5. New and expanded services. Adjustments to financial requirements for the impact on hospital's costs of new and expanded services shall be determined as follows.

A. In determining payment year financial requirements for each fiscal year, the commission shall include a positive adjustment to reflect the impact on the hospital's costs of new and expanded services approved in accordance with section 396-L, subsection 2, or 396-M, subsection 5. These adjustments may be made subsequent to the commencement of a fiscal year and except as provided in section 396-M, subsection 6, shall take effect on the date the expenses associated with the new or expanded services would be eligible for reimbursement under the Medicare program.

B. In determining payment year financial requirements for each fiscal year, the commission shall include a positive adjustment to reflect the impact on the hospital's costs of projects approved by the department pursuant to the Maine Certificate of Need Act prior to the effective date of this chapter, but not reflected in the base year financial requirements; provided that any approved costs shall be adjusted to be consistent with the definition of those costs established under section 396-A. An adjustment under this paragraph shall not be effective prior to the date on which the expenses associated with the approved project would be eligible for reimbursement under the Medicare program.

6. Productivity. In determining payment year financial requirements for each fiscal year commencing on or after October 1, 1987, the commission shall consider, and may include, an offsetting adjustment in the event a hospital is not operating as efficiently as possible.

7. Working capital. In determining payment year financial requirements, the commisison shall include an adjustment to provide for financing reasonable increases in the hospital's accounts receivable, net of accounts payable and whatever additional working capital provisions the commission deems appropriate. The commission may, from time to time during the course of a payment year, make such further adjustments with respect to working capital as may be necessary.

8. Change in services. In determining payment year financial requirements for each fiscal year, the commission may include an offsetting adjustment to reflect the impact on the hospital's financial requirements of:

A. The termination or significant reduction of health services provided by the hospital;

B. A merger or consolidation with another hospital; or

C. A reorganization, as defined pursuant to section 396-O.

Any adjustment under this subsection should be calculated in such a manner as not to unreasonably discourage more efficient and effective delivery of services.

9. Other adjustments. Other adjustments are determined as follows.

A. In determining payment year financial requirements, the commission may include a positive adjustment for the support of improvements in medical care management and information systems.

B. In determining payment year financial requirements, the commission may include a positive adjustment for the reasonable impact on a hospital's costs of events which could not be reasonably foreseen by the hospital and which were beyond the control of the hospital. This adjustment may be made subsequent to the commencement of a fiscal year.

C. New regulatory costs are determined as follows.

(1) In determining payment year financial requirements for each fiscal year, the commission shall include an adjustment to reflect the difference between the assessment for the fiscal year imposed pursuant to section 392 and the total amount of dues and fees paid to a voluntary budget review organization in the hospital's base year.

(2) In determining financial requirements for the first payment year, the commission shall include a positive adjustment to reflect the reasonable impact, if any, on a hospital's costs which is proven to have resulted from a hospital's conversion to a uniform fiscal year pursuant to section 395.

10. General considerations. General considerations shall be determined as follows.

A. In its consideration of the factors enumerated in this section, the commission shall take into account the special needs and circumstances of small hospitals.

B. In its consideration of the factors enumerated in this section, the commission shall direct its professional staff to develop a data base and a series of analytical techniques to facilitate this consideration and to enhance the predictability and financial stability of hospital financing in the State.

11. Nature and effect of adjustments. The nature and effect of adjustments shall be determined as follows.

A. Unless otherwise specified, adjustments may be positive or negative adjustments.

B. Adjustments made for a fiscal year for working capital, management support and new regulatory costs shall not be considered part of base year or payment year financial requirements for

purposes of computing payment year financial requirements pursuant to section 396-C for a subsequent payment year. The commission may determine from the nature of the unforeseen circumstances whether that adjustment is to be included in payment year financial requirements for purposes of computing financial requirements for a subsequent payment year.

§396-E. Application of available resources

The commission shall establish criteria governing the application of a hospital's available financial resources to satisfy its financial requirements consistent with the following provisions.

1. Donor restricted funds. Available financial resources shall not be defined to include donor restricted funds, except to the extent these funds are applied to the use for which they were donated.

2. Replacement of capital. Funds which are not donor restricted may be designated by a hospital's governing board as a portion or all of the sinking fund for replacement of facilities and fixed equipment to be established pursuant to section 396-A or as a portion or all of the funded depreciation for movable equipment required pursuant to section 396-A.

3. Gradual application. Available financial resources which are neither donor restricted funds nor designated for replacement of facilities and equipment in accordance with subsection 2 shall be applied to offset financial requirements in accordance with a schedule determined by the commission.

4. Affiliated interests. Financial resources of affiliated interests, as defined in section 396-O, shall be considered as resources available to a hospital.

5. Savings. If a hospital's actual expenses for a payment year are less than its approved financial requirements, 50% of the difference shall be excluded from available resources for purposes of computing its gross patient service revenue limit in subsequent years.

§396-F. Revenue deductions

In establishing revenue limits for individual hospitals for each fiscal year commencing on and after October 1, 1984, the commission shall make provision for revenue deductions in the following categories.

1. Charity care. After review of applicable policies of the hospital, the commission shall determine a reasonable amount of revenue deduction attributable to charity care. For purposes of this section, the amount of revenue deduction attributable to charity care shall be defined as the amount of revenue, net of recoveries, which is expected to be written off as a result of a determination, made pursuant to a policy adopted by the hospital, that the patient is unable to pay for the hospital services provided.

2. Bad debts. After review of applicable policies of the hospital, the commission shall determine a reasonable amount of revenue deduction attributable to bad debts. For purposes of this section, bad debts shall be defined as the amount of revenue deduction, net of recoveries, which is expected to be attributable to patients who, after reasonable collection efforts made pursuant to a policy adopted by the hospital, are determined to have uncollectable accounts.

3. Differentials. The commission shall provide for revenue deductions which reflect differentials established and approved pursuant to section 396-G.

§396-G. Differentials

1. Interim differentials. For the fiscal year commencing October 1, 1984, differentials may only be approved as follows.

A. Any nonprofit hospital and medical service corporation receiving a differential from hospital charges as of the effective date of this chapter shall be entitled to a statewide differential equal to 9%.

B. The department shall be entitled to a statewide differential equal to 75% of the audited average differential in effect on July 1, 1982, with respect to payments under the United States Social Security Act, Titles V and XIX, unless a greater differential is necessary for the department to remain in compliance with the requirements of the United States Social Security Act.

C. Any other 3rd-party payors or purchasers who make prompt payments, as defined by the commission by regulation, shall be entitled to a differential of 2%.

2. Establishment of methodology. The factors and methodology for determining differentials for fiscal years commencing on and after October 1, 1985, shall be established by the commission as follows.

A. After review and consideration of studies conducted or submitted pursuant to paragraph B, the commission shall establish by regulation factors and methods to be used in computing a statewide differential no later than April 1, 1985. The differential shall be allowed for only those activities and programs provided or conducted by payors which result in quantifiable savings to the hospitals or reductions in the payments of other payors. This differential shall reflect only the cost savings to hospitals, rather than the cost to the payors of implementing these activities and programs. Each component utilized in determining the differential shall be individually quantified so that the differential shall equal the total of the values assigned to each component.

B. In establishing the factors and methods for determining the differential, the commission may conduct its own study or rely upon studies conducted by other persons as provided in this section.

(1) The commission may institute a study of objective methods of computing a statewide differential, including a review and determination of the relevant and justifiable

economic factors which can be considered in setting a differential. All hospitals and all payors shall cooperate fully with the commission in the conduct of the study and shall provide any data or other information which the commission may reasonably request. In the event that the commission requires the disclosure by a payor of privileged or confidential commercial or financial information, this information shall be exempt from public disclosure.

(2) The nonprofit hospital and medical service corporations and the companies authorized to sell accident and health insurance under Title 24-A shall each, collectively, have the option of conducting a study of the differential issue or of contracting with a person or entity to conduct such a study. All such studies shall be completed by November 1, 1984. During the course of these studies, each hospital subject to this chapter shall cooperate fully with the persons or entities conducting these studies in providing any data or other information these persons or entities may reasonably request.

C. The commission shall review and modify, as appropriate, the working capital component of the differential on an annual basis and all other components on at least a triennial basis.

3. Approval of differentials. For fiscal years commencing on and after October 1, 1985, any 3rd-party payor or purchaser may apply to the commission for a reduction in the payments it would otherwise be required to make and the commission shall grant a reduction in payments commensurate with one or more components of the differential on a prospective basis if it finds:

A. That the applicant has implemented activities or programs which, pursuant to the commission's rules, qualify for a reduction; or

B. That the applicant is willing and able to implement activities or programs which, pursuant

to the commission's rules, qualify for a reduction, but which a hospital will not permit to be implemented.

Nothing in this section may be construed to prohibit the commission from granting, on its own initiative, a reduction in payments for all 3rd-party payors and purchasers who make prompt payments as defined by the commission.

4. Differentials established. Notwithstanding any other provisions of this section, the commission shall establish such differentials for payments under the United States Social Security Act, Title XVIII, as may be required pursuant to contractual limitations imposed on these payments. The differential established for payments by the department under the United States Social Security Act, Titles V and XIX, shall be the greater of the differential approved in accordance with subsection 3 or such amount as may be required for the department to remain in compliance with the requirements of the United States Social Security Act, Titles V and XIX.

§396-H. Establishment of gross patient service revenue limits

In accordance with the procedures under section 398, the commission shall establish a gross patient service revenue limit for each hospital for each fiscal year commencing on and after October 1, 1984. This limit shall be established by adding:

A. The payment year financial requirements of the hospital, offset by the hospital's available resources in accordance with section 396-E; and

B. The revenue deductions determined pursuant to section 396-F.

§396-I. Payments to hospitals

1. Components of revenue limits. The commission shall, for each fiscal year, apportion each hospital's approved gross patient service revenue limit into the following components, as applicable.

A. One component shall be designated "management fund revenue" and shall be equal to the adjustment, if any, for management support services determined under section 396-D, subsection 9, paragraph A.

B. One component shall be designated "hospital retained revenue" and shall be equal to the approved gross patient service revenue limit less the "management fund revenue."

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

A. Major 3rd-party payors, each of whom shall be a separate category; and

B. All purchasers and payors, other than major 3rd-party payors, which shall together constitute one category.

3. Payments by payors and purchasers. Payments by payors and purchasers shall be determined as follows.

A. Payments made by major 3rd-party payors shall be made in accordance with the following procedures.

(1) The commission shall require major 3rd-party payors to make biweekly periodic interim payments to hospitals, provided that any such payor may, on its own initiative, make more frequent payments. Payments to hospitals shall be calculated by applying any approved differential for a payor to the gross patient service revenue apportioned to the payor and dividing the amount by 26.

(2) After the close of each fiscal year, the commission shall adjust the apportionment of payments among major 3rd-party payors based on actual utilization data for

that year. Final settlement shall be made within 30 days of that determination.

B. Payments made by payors, other than major 3rd-party payors, and by purchasers, shall be made in accordance with the following procedures.

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

(2) Subsequent to the close of a fiscal year, the commission shall determine the amount of overcharges, if any, made to payors, other than major 3rd-party payors, and to purchasers and shall reduce, by the percentage amount of the overcharges, the portion of the succeeding year's gross patient service revenue limit which would otherwise have been allocated to purchasers and payors other than major 3rd-party payors.

C. In addition to any reductions in payments to hospitals under paragraphs A and B, if a hospital exceeds its gross patient service revenue limit by an amount in excess of a margin established by the commission, the commission may impose a penalty equal to 140% of the amount in excess of the margin times the rate of inflation. The amount of any penalty imposed shall be applied prospectively, and in accordance with methods prescribed by the commission, to reduce charges applicable to the class or classes of payors or purchasers which were overcharged.

4. Transmittal of management fund revenue. No later than 30 days after receipt of each payment, each hospital shall transmit to the Management Support Fund, established pursuant to section 396-J, the portion, if any, of the payment which corresponds to the management fund revenue.

§396-J. Establishment and administration of Management Support Fund; disbursements from fund

1. Establishment. There is established a statewide Management Support Fund administered by the commission. The assets of this fund shall be derived from the portion of the approved gross patient service revenue of each hospital, if any, in a fiscal year designated as management fund revenue and transmitted to the Management Support Fund pursuant to section 396-I, subsections 1 and 4.

2. Administration. The Management Support Fund shall be administered as follows.

A. Except as otherwise provided, the Treasurer of State shall be the custodian of the Management Support Fund. Upon receipt of vouchers signed by a person or persons designated by the commission, the State Controller shall draw a warrant on the Treasurer of State of the amount authorized. A duly attested copy of the resolution of the commission designating these persons and bearing on its face specimen signatures of these persons shall be filed with the State Controller as his authority for making payments upon these vouchers.

B. The commission may cause funds to be invested and reinvested subject to its periodic approval of the investment program.

C. The commission shall publish annually, for each fiscal year, a report showing fiscal transactions of funds for the fiscal year and the assets and liabilities of the funds at the end of the fiscal year.

3. Disbursements from fund. One or more hospitals within a regional hospital group may apply to

the commission to receive disbursements from the Management Support Fund. The commission shall establish criteria governing the approval of disbursements from the fund which shall, at a minimum:

A. Require a finding by the commission that the proposed use of funds will result in a significant improvement in medical care management and information systems; and

B. Take into consideration the special needs and circumstances of small hospitals.

Disbursements under this section shall not be offset against payment year financial requirements in computing a hospital's gross patient service revenue limit under section 396-H.

§396-K. Establishment of regional hospital groups

The commission shall, after consultation with the hospitals and with the bureau, group hospitals on the basis of their geographic location. The purpose of this grouping shall be to identify those hospitals which could reasonably be expected to coordinate the development of hospital services and support systems, to consolidate and share services, where the public would be so served, and to arrange for the orderly elimination of excess hospital capacity, where such capacity exists. The hospitals included in any such group established by the commission pursuant to this section shall be called a regional hospital group. There shall be at least 6 regional hospital groups and, except as a result of a merger or consolidation, there shall be at least 4 hospitals in each regional hospital group. Nothing in this section may be construed to empower the commission to mandate the merger or consolidation of any hospitals, the consolidation or sharing of services or the elimination of excess hospital capacity, within a regional hospital group.

§396-L. Establishment and allocation of regional development account

The commission shall establish, for each regional hospital group, a regional development account as follows.

1. Amount established. Subject to the requirements of paragraphs A and B, for each fiscal year, the commission shall consider the need for, and may establish, an amount to support the development of new and expanded services within the regional hospital group. This regional amount shall be established after consideration of any regional plans reviewed and commented upon by the bureau, the State Health Plan, the ability of the citizens of Maine to underwrite the additional costs and the limitations imposed on these payments by the Federal Government pursuant to the United States Social Security Act, Titles XVIII and XIX. For the first 3 payment years, the commission shall establish the regional amounts as follows:

A. For the first payment year, 1% of the base year financial requirements of all hospitals in the regional hospital group; and

B. For the 2nd and 3rd payment years, 1% of the payment year financial requirements determined for all hospitals in the regional hospital group for the preceding year.

2. Review. The commission shall review and approve or disapprove each proposal of a hospital to develop new or expanded services for which the hospital seeks an adjustment to its financial requirements. The commission shall approve such a proposal if:

A. The proposal was subject to review and was approved by the department under the Maine Certificate of Need Act; and

B. The associated required incremental revenue would not exceed the amount which the commission has determined will have been credited to the regional development account by the date of implementation of the project, after accounting for previously approved projects.

In the case of a proposal not subject to review under the Maine Certificate of Need Act, the commission may not approve a proposal unless it meets the requirements of paragraph B and such other criteria as may be established by the commission.

3. Adjustment. A hospital shall be entitled to an adjustment under section 396-D, subsection 5, paragraph A, for a new or expanded service approved in accordance with subsection 2. The amount attributable to this adjustment shall be debited against the regional development account.

§396-M. Regional hospital corporations; approval; duties; special procedures

The hospitals in a regional hospital group may, at their sole discretion, establish a regional hospital corporation, which shall be subject to approval by the commission, in accordance with subsection 1, and which shall perform the duties enumerated in subsection 2. Upon establishment and approval of a regional hospital corporation, the provisions relative to payment procedures and to adjustments to financial requirements, set forth in this section and section 396-N, shall apply.

1. Approval. The commission shall approve a regional hospital corporation which meets the following criteria.

A. The governing body includes an equal number of representatives from each hospital in the regional hospital group. These representatives shall include at least one trustee or director, one member of the administrative staff and one member of the medical staff from each hospital.

B. The procedures of the corporation will permit it to accomplish the functions specified in subsection 2.

C. The procedures of the corporation provide for public meetings of its governing body and for public disclosure of its records.

D. The policies of the corporation require its individual hospital members to participate in joint planning activities.

The commission may withdraw approval from a regional hospital corporation if the composition of the corporation and its procedures and policies no longer satisfy the criteria contained in this subsection.

2. Duties. A regional hospital corporation shall:

A. Develop a regional plan for the efficient and effective delivery of hospital services which shall be subject to review by the bureau;

B. Calculate and distribute volume adjustments for member hospitals in accordance with subsection 3;

C. Administer the regional development fund by receiving, holding, investing and disbursing funds for the development of new and expanded services, subject to the procedures established in subsection 5; and

D. Review and comment on each proposal of a member hospital to develop new or expanded services requiring disbursement of funds from the regional development fund.

3. Calculation and distribution of volume adjustments. Notwithstanding section 396-D, subsection 4, paragraph B, for the 4th and subsequent payment years, an approved regional hospital corporation may distribute the regional volume adjustment established by the commission, provided that this distribution shall be in accordance with criteria which has been reviewed and approved by the commission.

4. Regional Development Fund. A regional hospital corporation shall establish a Regional Development Fund. The assets of the Regional Development Fund shall be derived from the portion of the approved gross patient service revenue of each hospital, if any, in a fiscal year designated as development fund revenue and transmitted to the Regional Development Fund pursuant to section 396-N.

5. Review and approval of disbursements for new services. A hospital in a regional hospital group where a regional hospital corporation has been established and approved shall be entitled to receive monthly disbursements from the Regional Development Fund for the first 12 months of operation of a new or expanded service approved in accordance with this subsection.

A. An approved regional hospital corporation shall review each proposal of a hospital to develop new or expanded services requiring disbursement of funds from a Regional Development Fund and, subject to paragraph D, shall recommend approval or disapproval of the disbursement.

B. A proposal which is subject to review in accordance with the Maine Certificate of Need Act may be submitted to the department subsequent to review by the regional hospital corporation.

C. The commission shall review each proposal of a hospital to develop new or expanded services requiring disbursement of funds from the Regional Development Fund and shall approve or disapprove the disbursement in accordance with the following provisions.

(1) In case of a proposal subject to review under the Maine Certificate of Need Act, the proposal may be submitted to the commission after approval by the department. The commission shall, subject to paragraph D, approve the proposal if the proposal has been approved by the department pursuant to the Maine Certificate of Need Act.

(2) In the case of a proposal not subject to review under the Maine Certificate of Need Act, the proposal may be submitted to the commission after review by the regional hospital corporation.

D. In addition to any other applicable criteria, no person responsible for reviewing a proposal of a hospital to develop new or expanded services requiring disbursement of funds from a Regional Development Fund shall approve, or recommend approval of, the proposal or disbursement if the associated required incremental revenue would exceed the amount of funds in the Regional Development Fund which the commission has determined will have accrued by the date of implementation of the project, after accounting for previously approved projects.

6. Adjustment. A hospital shall be entitled to an adjustment under section 396-D, subsection 5, paragraph A, for a new or expanded service approved in accordance with subsection 5. This adjustment shall take effect 12 months after the date the expenses associated with the new or expanded services would be eligible for reimbursement under the Medicare program.

§396-N. Exceptions to payment procedures

Upon the establishment and approval of a regional hospital corporation, the following provisions shall apply to the hospitals represented by the corporation.

1. Gross patient service revenue limit. Notwithstanding section 396-H, for hospitals in a regional hospital group where an approved regional hospital corporation has been established, the gross patient service revenue limit shall be calculated so as to include the hospital's pro rata share of the regional amount, if any, determined under section 396-L, subsection 1, for the support of the development of new and expanded services.

2. Development fund revenue. Notwithstanding section 396-I, subsection 1, the gross patient service revenue limit shall include a 3rd component designated "development fund revenue" equal to the amount, if any, established under section 396-L, subsection 1.

3. Funds transmitted. In addition to the requirements of section 396-I, subsection 4, no later than 30 days after receipt of each payment, each hospital shall transmit to the Regional Development Fund administered by the regional hospital corporation pursuant to section 396-M, the portion, if any, of the payment which corresponds to the "development fund revenue."

§396-O. Affiliated interests

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Affiliated interest" means:

(1) Any person, or group of persons acting in concert, which exercises or has the potential to exercise, directly or indirectly, significant influence over the policies or actions of a hospital;

(2) Any person over whose policies or activities a hospital exercises, or has the potential to exercise, directly or indirectly, significant influence;

(3) Any person over whose policies or actions an affiliated interest, as defined in subparagraph (1), exercises, or has the potential to exercise, directly or indirectly, significant influence;

(4) Any person of whose activities a hospital is the sole beneficiary, as defined in paragraph D; and

(5) Any person or group of persons acting in concert to which the commission may determine, after investigation and hearing, a hospital has transferred assets for the purpose, but not necessarily the sole purpose, of evading government regulation or otherwise not in the public interest.

B. "Reorganization" means any creation, organization, extension, consolidation, merger, transfer of ownership or control, liquidation, dissolution or termination, direct or indirect, in whole or in part, of an affiliated interest accomplished by the issue, sale, acquisition, lease, exchange, distribution or transfer of control or property. The commission may decide what other hospital actions constitute a reorganization to which the provisions of this section apply.

C. "Significant transaction" means a transaction between a hospital and another person which has an actual or imputed value or worth in excess of $10,000 or more for a fiscal year or if the total

amount of the contract price, consideration and other advances by the institution on account of the transactions is $10,000 or more for the fiscal year.

D. A hospital is a "sole beneficiary" of a person if one or more of the following circumstances exist:

(1) The person has solicited funds in the name of and with expressed or implied approval of the hospital or any of its affiliated interests, and substantially all the funds solicited by the person were intended by the contributor or were otherwise required to be transferred to the hospital or any of its affiliated interests or used at their discretion or direction;

(2) The hospital has transferred some of its resources to the person, substantially all of whose resources are held for the benefit of the hospital or any of its affiliated interests; or

(3) The hospital has assigned certain of its functions to the person who is operating primarily for the benefit of the hospital or any of its affiliated interests.

2. Reporting and consideration of significant transactions. A statement of significant transactions will be submitted as follows.

A. Each hospital shall annually submit to the commission a written statement of significant transactions, as defined in subsection 1, between itself and any person in which an officer, trustee or director of a hospital is an employee, partner, director, officer or beneficial owner of 3% or more of the capital stock, or between itself and any affiliated interest.

B. In determining base year financial requirements pursuant to section 396-B or in establishing adjustments for productivity or other factors pursuant to section 396-D, the commission may

disregard costs under significant transactions between a hospital and the persons specified in paragraph A if such transactions are found not to be in the public interest.

3. Access to accounts and records. The commission may require the production of books, accounts, records, papers and memoranda of an affiliated interest which relate, directly or indirectly, to any of its dealings with a hospital which affect the hospital's costs. The commission may, in determining financial requirements of a hospital, disallow all or a portion of the payments under such dealings, the account of record of which is not made available to the commission.

4. Reorganization. Reorganization shall be subject to commission approval as follows.

A. Unless exempt by rule or order of the commission, no reorganization may take place without the approval of the commission. No reorganization may be approved by the commission unless it is established by the applicant for approval that the reorganization is consistent with the interests of the people of the State. The commission shall rule upon all requests for approval of a reorganization within 60 days of the filing date. The filing date shall be the date when the commission notifies the applicant that the filing is complete. If the commission deems that the necessary investigation cannot be concluded within 60 days after the filing date, the commission may extend the period for a further period of no more than 120 days. In granting its approval, the commission shall impose such terms, considerations or requirements as, in its judgment, are necessary to protect the interests of payors and purchasers. These conditions shall include provisions which assure the following.

(1) The commission has reasonable access to books, records, documents and other information relating to the hospital or any of its affiliates.

(2) The commission has all reasonable powers to detect, identify, review and approve, or disapprove, costs associated with transactions between affiliated interests.

(3) The hospital's ability to attract capital on reasonable terms, including the maintenance of a reasonable capital structure, is not impaired.

(4) The ability of the hospital to provide reasonable and adequate care is not impaired.

(5) The hospital continues to be subject to applicable laws, principles and rules governing the regulation of hospitals.

(6) The hospital's credit is not impaired or adversely affected.

§396-P. Medicare waiver

The commission may seek from the Secretary a waiver of hospital reimbursement requirements under the United States Social Security Act, Title XVIII, as authorized by the United States Social Security amendments of 1967, Section 402, as amended. Notwithstanding any other provisions of this chapter, the commission is further authorized to enter into such agreements with the Secretary as may be required to secure the waiver, provided that nothing in this section may be construed to require that such a waiver be obtained in order for this subchapter to be implemented.

§396-Q. Advisory committees

The commission shall establish and, as appropriate, consult with the following advisory committees.

1. Professional Advisory Committee. The commission shall establish a Professional Advisory Committee consisting of 2 allopathic physicians, 2 osteopathic physicians, 2 nurses and one hospital employee, other than a nurse or physician, directly

involved in the provision of patient care. This committee shall be available to provide advice and consultation to the commission and its staff with respect to the effects of the health care financing system established under this subchapter on the quality of care provided by hospitals.

2. Technical Advisory Committee. The commission shall establish a Technical Advisory Committee consisting of one representative of nonprofit hospital and medical service corporations, one representative of commercial insurance companies, one representative of the department, one representative of the Bureau of Insurance and 2 representatives of hospitals. This committee shall be available to provide advice and consultation to the commission and its staff with respect to analytical techniques, data requirements and other technical matters involved in implementing and administering the health care financing system established under this subchapter.

SUBCHAPTER IV

PROCEDURES

§397. Proceedings generally

1. Proceedings. Proceedings before the commission shall be governed by rules that the commission may establish from time to time, not inconsistent with the Maine Administrative Procedure Act, Title 5, chapter 375.

2. Substantial compliance. A substantial compliance with the requirements of this chapter shall be sufficient to give effect to all the rules, orders, acts and regulations of the commission and they shall not be declared inoperative, illegal or void for any omission of a technical and immaterial nature in respect thereto.

3. Burden of proof. In all trials, actions and proceedings arising under this chapter, the burden of proof shall be upon the party seeking to set aside any determination, requirement, direction or order of the commission complained of as unreasonable, unjust or unlawful, as the case may be. In all original pro-

ceedings before the commission where approval of the commission is sought, the burden of proof shall be on the person seeking the approval.

4. Appeals. Any person aggrieved by a final determination of the commission may appeal therefrom to the Superior Court in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter VII.

§398. Procedures for establishment of revenue limits and interim adjustments

In establishing procedures for the determination of revenue limits and interim adjustments, the commission shall provide for the following.

1. Revenue limits. At least 90 days prior to the start of the uniform fiscal year established for hospitals subject to this chapter, the executive director shall propose the gross patient service revenue limits for each hospital and the apportionment thereof for approval by the commission. If no notice of contest is filed, within the period of time specified by the commission, by an affected hospital, regional hospital corporation, 3rd-party payor or group of purchasers, and if the commission does not disapprove or modify the proposed limits or apportionment, the limits and apportionment shall take effect on October 1st of the applicable fiscal year; otherwise, the commission shall, after opportunity for hearing before the commission, an individual member of the commission or a duly appointed and sworn hearing examiner, issue a final order no later than October 1st of the applicable fiscal year, except that, if the proposed limits for the fiscal year beginning October 1, 1984, are timely contested, and the commission, after due diligence, is unable to issue a final order by October 1, 1984, it shall issue a provisional order by that date which shall be superseded by a final order no later than January 1, 1985.

2. Interim adjustments. Upon application by a hospital payor, or group of purchasers, for an interim adjustment to financial requirements permitted under section 396-D, or upon application by a

payor or group of purchasers for a modification of its approved differential or of the apportionment of the gross patient service revenue, a final order shall be promulgated within 120 days from the date a completed application was filed. Any proposed change shall take effect upon the date specified in the order. At any time during the period between the filing date and the commission's final decision on the request, the commission may extend provisional approval to any part of the request. This provisional approval shall be superseded by the commission's final decision on the request. The commission may establish reasonable limits on the frequency of requests filed under this subsection.

3. Commission to make adjustments. Nothing in this section may be construed to limit the authority of the commission to make adjustments during the course of a fiscal year, on its own initiative, as provided in section 396-D, and with appropriate notice to affected persons.

§399. Other powers

In addition to the powers granted to the commission elsewhere in this chapter, the commission may conduct investigations to require the filing of information, and subpoena witnesses, papers, records, documents and all other data sources relevant to the establishment and apportionment of gross patient service revenue limits and compliance therewith, reorganizations and significant transactions, the operation of regional hospital corporations and other matters regulated by the commission pursuant to subchapter III.

Sec. 13. 22 MRSA §2061, sub-§2, as amended by PL 1981, c. 455, is further amended to read:

2. Review. Each project for a hospital or nursing home has been reviewed and approved to the extent required by the agency of the State which serves as the Designated Planning Agency of the State in accordance with the provisions of section 1122 of the ~~Federal~~ United States Social Security Act, as amended, or by the Department of Human Services in accordance with the provisions of the Maine Certificate of Need

Act of 1978, as amended, or, in the case of a project for a hospital, has been reviewed and approved by the Maine Health Care Finance Commission to the extent required by chapter 107;

STATEMENT OF FACT

This bill reforms hospital care financing in Maine in order to contain rising costs, assure the survival of small hospitals serving rural communities and establishes greater equity among those who pay hospital bills.

The current cost-based retrospective payment system provides little or no incentive to reduce costs. Cost containment efforts undertaken by one payor are either nullified by the ability to shift payment responsibility to other payors or, in the absence of parties able to assume the greater responsibility, threaten the financial survival of a hospital.

According to the United States Department of Health and Human Services, during the period of 1975 to 1980, Maine's community hospitals ranked 12th highest of the 50 states in terms of their cumulative and average annual percentage increase in expenses per adjusted admission. All but one of the 8 states with mandatory hospital rate-setting programs were among the 13 states with the lowest rates of increase. All New England states, except Maine, were among the 14 lowest states.

The voluntary budget review effort engaged in by Maine hospitals over the last 4 years has met with only limited success. The reported increases remain excessive, well beyond the rate of inflation and economic growth. The 1982 rate of increase alone amounted to $60,000,000 and, if continued, would more than double the cost of hospital services in Maine by 1988.

This bill establishes a Maine Health Care Finance Commission empowered to implement a mandatory prospective payment system. Specific provisions are as follows.

Sections 1 and 5 establish salary ranges for certain employees of the Maine Health Care Finance Commission and clarify which positions are included within the unclassified service.

Sections 2 and 6 amend the Maine Sunset Act to include the Maine Health Care Finance Commission within its scope.

Sections 7 to 11 amend the Maine Certificate of Need Act to require the coordination of activities and decisions of the Department of Human Services under the certificate of need program with activities and decisions of the Maine Health Care Finance Commission.

Section 12 enacts Title 22, chapter 107, which establishes the Maine Health Care Finance Commission and delineates its powers and duties.

Title 22, chapter 107, subchapter I, sets out its purposes; defines relevant terms; provides for the establishment of the commission whose 5 public members are appointed by the Governor subject to confirmation by the Legislature; enumerates the general powers of the commission, including the authority to promulgate rules, hold hearings, contract for services and conduct audits; establishes public access to information filed with the commission with appropriate protection for privileged medical information, confidential commercial information and information identifying individual patients and practitioners; provides for exemption from state antitrust laws for regional planning activities conducted by hospitals in accordance with this law; establishes penalties and enforcement mechanisms and provides for funding mechanisms and evaluation of the commission's activities.

Title 22, chapter 107, subchapter II, authorizes the commission to continue the data collection activities previously carried out by the Health Facilities Cost Review Board. It provides for the uniform reporting by hospitals and nursing homes of financial and patient service information. In addition, it provides for the establishment of uniform fiscal years for hospitals.

Title 22, chapter 107, subchapter III, sets out the prospective hospital payment system to be implemented by the commission. The commission is not involved in the setting of prices to be charged for particular services. Rather, its principal responsibilities are to determine the actual financial requirements of each hospital in a base year; to measure and project the impact of those factors, such as inflation, changes in volume and replacement of facilities, which cause the financial requirements of Maine hospitals to increase or decrease from year to year; to determine prospectively the maximum amount each hospital may charge overall those it serves during the course of a year; and to assign, on an equitable basis, the responsibility for paying each hospital to the various groups of patients served and those who pay for their care. Appropriate provision is also made for revenue a hospital is not expected to receive as a result of bad debts, charity care or payor discounts. Additional provisions of Title 22, chapter 107, subchapter III, include the study and determination of payor practices which warrant discounts in payments; appropriate linkages with the Maine Certificate of Need Act; facilitation of regional planning through the development of regional hospital corporations; required approval by the commission of hospital reorganization plans in order to assure the objectives of the payment system are not thwarted; authorization for the commission to seek and negotiate a waiver permitting the Medicare program to participate in the system and the establishment of advisory committees.

Title 22, chapter 107, subchapter IV, authorizes the commission to establish procedures governing its proceedings consistent with the Maine Administrative Procedure Act, Title 5, chapter 375. The commission is also given appropriate investigative authority.

Section 13 amends the Maine Health and Higher Educational Facilities Authority Act to require the coordination of the authority's activities with those of the Maine Health Care Finance Commission.