MAINE STATE LEGISLATURE

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1 (New Draft of S.P. 446, L.D. 1353)

2 FIRST REGULAR SESSION
3

4 ONE HUNDRED AND ELEVENTH LEGISLATURE
5

6 **Legislative Document** **No. 1737**
7

8 S.P. 608 In Senate, June 6, 1983
9 Reported by Senator Bustin of Kennebec from the Committee on Health and Institutional Services and printed under Joint Rule 2.
10 Original bill presented by Senator Najarian of Cumberland. Cosponsored by Representative Brannigan of Portland, Representative Hall of Sangerville
11 and Representative Gwadosky of Fairfield.

JOY J. O'BRIEN, Secretary of the Senate

12

13 STATE OF MAINE
14

15 IN THE YEAR OF OUR LORD
16 NINETEEN HUNDRED AND EIGHTY-THREE
17

18 **AN ACT to Limit Future Increases in the**
19 **Cost of Hospital Care in Maine.**
20

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

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

24 §6-B. Salaries of certain employees of the Maine
25 Health Care Finance Commission

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

29 1. Executive director. The salary of the execu-
30 tive director shall be within salary range 91.

31 2. Deputy director. The salary of the deputy
32 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Sec. 2. 3 MRSA §507, sub-§10, ¶B, as repealed and replaced by PL 1979, c. 654, §3, is amended to read: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Sec. 3. 5 MRSA §711, sub-§1, ¶H, as repealed and replaced by PL 1977, c. 674, §6, is amended to read: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 §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~~ by 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

1 for annual operating cost in the 3rd fiscal year
2 of operation following addition of these ser-
3 vices.

4 **Sec. 9. 22 MRSA §309, sub-§6 is enacted to read:**

5 6. Hospital projects. Notwithstanding subsec-
6 tions 1, 4 and 5, the department may not issue a cer-
7 tificate of need for a project which is subject to
8 the provisions of section 396-D, subsection 5, and
9 section 396-K, if the associated costs exceed the
10 amount which the commission has determined will have
11 been credited to the Certificate of Need Development
12 Account pursuant to section 396-K, after accounting
13 for previously approved projects.

14 **Sec. 10. 22 MRSA c. 107 is enacted to read:**

15 CHAPTER 107

16 MAINE HEALTH CARE FINANCE COMMISSION

17 SUBCHAPTER I

18 GENERAL PROVISIONS

19 §381. Findings and declaration of purpose

20 1. Findings. The Legislature makes the following
21 findings.

22 A. The cost of hospital care in Maine has been
23 increasing much more rapidly than the ability of
24 its citizens to support these increases. This
25 disparity is detrimental to the public interest.
26 It diminishes the accessibility of hospital ser-
27 vices to the people of the State and materially
28 compromises their ability to address other
29 equally compelling needs.

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

34 (1) The current system of financing hospi-
35 tal care fails to assure that hospitals will

1 charge those they serve no more than is
2 needed to meet their reasonable financial
3 requirements;

4 (2) The current system of financing hospi-
5 tal care fails to assure or reward effi-
6 ciency and restraint in hospital spending;

7 (3) The current system of financing hospi-
8 tal care is inequitable in that it permits
9 hospitals to respond to the legitimate cost
10 containment efforts of the Federal Govern-
11 ment and the State by increasing their
12 charges to other patients; and

13 (4) The current system of financing hospi-
14 tal care threatens the ability of some Maine
15 hospitals to generate sufficient revenues to
16 meet their reasonable financial requirements
17 and, consequently, will inevitably have an
18 adverse impact on the accessibility and the
19 quality of the care available to those whom
20 they serve.

21 C. The informed development of public policy
22 regarding hospital and other necessary health
23 services requires that the State regularly assem-
24 ble and analyze information pertaining to the use
25 and cost of these services.

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

28 A. It is the intent of the Legislature to pro-
29 tect the public health and promote the public
30 interest by establishing a hospital financing
31 system which:

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

35 (2) Protects the quality and the accessi-
36 bility of the hospital care available to the
37 people of the State by assuring the finan-
38 cial viability of an efficient and effective
39 state hospital system;

1 (3) Affords those who pay hospitals a
2 greater role in determining their reasonable
3 financial requirements without unduly com-
4 promising the ability of those who govern
5 and manage hospitals to decide how the
6 resources made available to them are to be
7 used;

8 (4) Encourages hospitals to make the most
9 efficient use of the resources made avail-
10 able to them in the provision of quality
11 care to those whom they serve and the train-
12 ing and continuing education of physicians
13 and other health professionals;

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

17 (6) Assures greater equity among pur-
18 chasers, classes of purchasers and payors.

19 B. It is further the intent of the Legislature
20 that uniform systems of reporting health care
21 information shall be established; that all health
22 care facilities shall be required to file reports
23 in a manner consistent with these systems; and
24 that, using the least restrictive means practi-
25 cable for the protection of privileged medical
26 information, public access to those reports shall
27 be assured.

28 §382. Definitions

29 As used in this chapter, unless the context indi-
30 cates otherwise, the following terms have the follow-
31 ing meanings.

32 1. Board. "Board" means the Health Facilities
33 Cost Review Board established pursuant to Public Law
34 1977, chapter 691, section 1.

35 2. Bureau. "Bureau" means the Bureau of Health
36 Planning and Development within the Department of
37 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 3, "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 19, which, with respect to an individual hospital:

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

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. 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. Any such agreement in effect on the effective date of this chapter shall not be invalidated by this chapter except to the extent that specific provisions of this chapter are inconsistent with the provisions of those agreements and then only to the extent of the inconsistency.

11. Payment year. "Payment year" means any hospital fiscal year which begins, or is deemed to begin, on or after October 1, 1984.

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;

1 B. A health care facility, as defined in section
2 303, subsection 7; or

3 C. A health product manufacturer.

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

7 16. Revenue center. "Revenue center" means a
8 functioning unit of a hospital which provides iden-
9 tifiable services to patients for a charge.

10 17. Secretary. "Secretary" means the Secretary
11 of the United States Department of Health and Human
12 Services.

13 18. Small hospital. "Small hospital" means a
14 hospital having 55 or fewer licensed acute care beds.

15 19. Third-party payor. "Third-party payor" means
16 any entity, other than a purchaser, which is respon-
17 sible for payment, either to the purchaser or the
18 hospital, for health care services rendered by a
19 hospital. It includes, but is not limited to, federal
20 governmental units responsible for the administration
21 of the Medicare program, the department, insurance
22 companies, health maintenance organizations and non-
23 profit hospital and medical service corporations;
24 provided that it shall not be construed to include
25 any state agency or subunit of a federal agency other
26 than those directly administering programs under
27 which payment is made to hospitals for health care
28 services rendered to program beneficiaries.

29 20. Voluntary budget review organiza-
30 tion. "Voluntary budget review organization" means a
31 nonprofit organization established to conduct reviews
32 of budgets and approved by the board pursuant to
33 Public Law 1977, chapter 691, section 1.

34 §383. Maine Health Care Finance Commission

35 1. Establishment. The Maine Health Care Finance
36 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.

Persons eligible for appointment to, or to serve on, the commission shall be individuals conversant with the organization, delivery or financing of health care. At least 4 of the 5 members shall be consumers. At least one of the 5 members, whether or not a consumer member, shall be an individual who, within the 10 years preceding appointment, has had at least 5 years' experience as either a hospital trustee or a hospital official. For purposes of this section, "consumer" means a person who is neither affiliated with nor 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 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 consumer member of the commission.

C. The terms of the members shall be staggered. Of the initial appointees, 2 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.

1 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 and, except in the event of an emergency meeting, shall be called by written notice. Meetings shall be announced in advance and open to the public, to the extent 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 have had experience in the organization, financing or delivery of health care and 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

1 the executive director and his salary shall be set by
2 the executive director within the range established
3 by Title 2, section 6-B. The commission may employ
4 such other staff as it deems necessary. The appoint-
5 ment and compensation of such other staff shall be
6 subject to the Personnel Law.

7 §385. Legal counsel

8 The commission shall appoint, with the approval
9 of the Attorney General, a general counsel and such
10 other staff attorneys as it deems necessary. The
11 general counsel shall serve at the pleasure of the
12 commission and his salary shall be set by the commis-
13 sion within the range established by Title 2, section
14 6-B. Other staff attorneys shall serve at the pleas-
15 ure of the commission and their salaries shall be set
16 by the commission. The general counsel and any other
17 staff attorneys may represent the commission or its
18 staff in any proceeding, investigation or trial. Pri-
19 vate counsel may be employed, from time to time, with
20 the approval of the Attorney General.

21 §386. Powers of commission generally

22 In addition to the powers granted to the commis-
23 sion elsewhere in this chapter, the commission is
24 granted the following powers.

25 1. Rulemaking. The commission may adopt, amend
26 and repeal such rules as may be necessary for the
27 proper administration and enforcement of this chap-
28 ter, subject to the Maine Administrative Procedure
29 Act, Title 5, chapter 375.

30 2. Committees. In addition to the committees re-
31 quired to be established under section 396-P, the
32 commission may create committees from its membership
33 and appoint advisory committees consisting of mem-
34 bers, other individuals and representatives of inter-
35 ested public and private groups and organizations.

36 3. Receipt of grants, gifts and payments. The
37 commission may solicit, receive and accept grants,
38 gifts, payments and other funds and advances from any
39 person, other than a provider of health care, as de-
40 fined in section 382, subsection 14, or a 3rd-party

payor, as defined in section 382, subsection 19, 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 391.

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 persons, other than hospitals, to support research or other activities undertaken in furtherance of the purposes of this chapter. The commission may only make grants to hospitals in accordance with section 396-J.

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. The commission shall also adopt rules establishing criteria for determining whether information is confidential commercial information or privileged medical information and establishing procedures to afford affected payors or hospitals, as applicable, notice and opportunity to comment in response to requests for information which may be considered confidential or privileged.

§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. Reports to legislative committee. While the Legislature is in session, the commission or its staff shall, upon request of the joint standing committee of the Legislature having jurisdiction over health and institutional services, appear before the committee to discuss its annual report and any other items requested by the committee.

3. Consumer reports. The commission shall, from time to time as it deems appropriate, publish and disseminate any information that would be useful to

1 consumers in making informed choices in obtaining
2 health care, including the results of any studies or
3 analyses undertaken by the commission.

4 4. Review by health care facility. If any
5 studies or analyses undertaken by the commission pur-
6 suant to section 386, subsection 4, or if any con-
7 sumer information developed pursuant to subsection 3
8 directly or indirectly identify a particular health
9 care facility, the health care facility shall be
10 afforded a reasonable opportunity, before public
11 release, to review and comment upon the studies,
12 analyses or other information.

13 §389. Penalties

14 Any person who knowingly violates any provision
15 of this chapter or any valid order or rule made or
16 promulgated pursuant to this chapter, or who
17 willfully fails, neglects or refuses to perform any
18 of the duties imposed upon him under this chapter,
19 shall be deemed to have committed a civil violation
20 for which a forfeiture of not more than $1,000 a day
21 may be adjudged, unless specific penalties are else-
22 where provided for, and provided that any forfeiture
23 imposed under this section shall not exceed $25,000
24 for any one occurrence.

25 §390. Enforcement

26 Upon application of the commission or the Attor-
27 ney General, the Superior Court shall have full
28 jurisdiction to enforce all orders of the commission
29 and the performance by health care facilities of all
30 duties imposed upon them by this chapter and any
31 valid regulations adopted pursuant to this chapter.

32 §391. Funding of the commission

33 1. Assessments. Every hospital subject to regu-
34 lation under this chapter shall be subject to an
35 assessment of not more than .15% of its gross patient
36 service revenues. For the period of October 1, 1983,
37 to June 30, 1984, each hospital shall pay an assess-
38 ment equal to 75% of the total annual dues and fees
39 for which it was liable to a voluntary budget review
40 organization during its most recent fiscal year which

1 ended prior to July 1, 1983. Each hospital shall pay
2 this assessment in 3 equal installments, with pay-
3 ments due on or before November 1, 1983, January 1,
4 1984, and April 1, 1984. Thereafter, the commission
5 shall determine the assessments annually prior to
6 July 1st and shall assess each hospital for its pro
7 rata share. Each hospital shall pay the assessment
8 charged to it on a quarterly basis, with payments due
9 on or before July 1st, October 1st, January 1st and
10 April 1st of each year.

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

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

26 4. Use of funds. The commission may use the
27 revenues provided in this section to defray the costs
28 incurred by the commission pursuant to this chapter,
29 including salaries, administrative expenses, data
30 system expenses, consulting fees and any other
31 reasonable costs incurred to administer this chapter.
32 The commission may not use the revenues provided in
33 this section to make grants pursuant to section 386,
34 subsection 5, unless the allocation of revenues to
35 this purpose has been approved in accordance with
36 subsection 2.

37 5. Unexpended funds. Except as specified in this
38 section, any amount of the funds that is not expended
39 at the end of a fiscal year shall not lapse, but
40 shall be carried forward to be expended for the pur-
41 poses specified in this section in succeeding fiscal
42 years. Any unexpended funds in excess of 7% of the
43 total annual assessment authorized in subsection 1

1 shall, at the option of the commission, either be
2 presented to the Legislature in accordance with sub-
3 section 2 for reallocation and expenditure for com-
4 mission purposes or used to reduce the hospital
5 assessment in the following fiscal year.

6 §392. Program audit and evaluation

7 1. Sunset provisions. The commission shall be
8 subject to review and termination or continuation by
9 the Legislature in accordance with Title 3, chapter
10 23.

11 2. Evaluation. In addition to the requirements
12 as to contents of justification reports under Title
13 3, section 504, the commission shall include in its
14 report an evaluation of the impact of the hospital
15 financing system established under this chapter on
16 the quality of hospital care, access to such care and
17 the financial stability of hospitals in the State.

18 SUBCHAPTER II

19 HEALTH FACILITIES INFORMATION DISCLOSURE

20 §394. Uniform systems of reporting generally

21 1. Establishment. The commission shall, after
22 consultation with appropriate advisory committees and
23 after holding public hearings, establish uniform sys-
24 tems of reporting financial and health care informa-
25 tion as required under this chapter.

26 2. Information required. In addition to any
27 other requirements applicable to specific categories
28 of health care facilities, as set forth in section
29 395, and in subchapters III and IV and pursuant to
30 rules adopted by the commission for form, medium,
31 content and time for filing, each health care facil-
32 ity shall file with the commission the following
33 information:

34 A. Financial information, including costs of
35 operation, revenues, assets, liabilities, fund
36 balances, other income, rates, charges, units of
37 services, wage and salary data and such other
38 financial information as the commission deems
39 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. 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.

4. Previously filed discharge data. The commission may direct the transfer to its possession and control 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.

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

1 commission may require the filing of financial
2 reports and data which, during the period from July
3 1, 1983, to the effective date of this chapter, would
4 have been required to be filed pursuant to the
5 board's regulations in effect on June 30, 1983, had
6 the Health Facilities Information Disclosure Act not
7 been repealed effective July 1, 1983. Except for such
8 reports and data as have been made available to the
9 Health Facilities Cost Review Board prior to July 1,
10 1983, the commission shall compensate any voluntary
11 budget review organization for the reasonable costs
12 incurred in transferring reports and data, provided
13 that the voluntary budget review organization shall
14 cooperate to the fullest extent possible in
15 minimizing the costs incurred.

16 6. Consideration of other systems. To the extent
17 feasible, the commission in establishing uniform sys-
18 tems shall take into account the data requirements of
19 relevant programs and the reporting systems previ-
20 ously established by the Health Facilities Cost
21 Review Board.

22 7. More than one licensed health facility oper-
23 ated. Where more than one licensed health facility is
24 operated by the reporting organization, the informa-
25 tion required by this chapter shall be reported for
26 each health facility separately.

27 8. Certification required. The commission may
28 require certification of such financial reports as it
29 may specify and may require attestation as to these
30 statements from responsible officials of the facility
31 that these reports have to the best of their knowl-
32 edge and belief been prepared in accordance with the
33 requirements of the commission.

34 9. Verification. If a further investigation is
35 considered necessary or desirable to verify the accu-
36 racy of information in reports made by health care
37 facilities under this chapter, the commission may
38 examine further any records and accounts as the com-
39 mission may by regulation provide. As part of the
40 examination, the commission may conduct a full or
41 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 years. Hospital fiscal years shall be as follows.

A. Unless otherwise approved by the commission, the fiscal year of each hospital subject to this chapter shall be the fiscal year on which it operated as of May 1, 1983. The commission shall approve the conversion to a fiscal year commencing October 1st for those hospitals whose fiscal years, as of May 1, 1983, begin between August 1st and September 19th, provided that the conversion is made prior to July 1, 1984.

B. For purposes of this chapter, a fiscal year which commences between September 20th and September 30th shall be deemed to be a fiscal year commencing October 1st of the same calendar year.

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. Subject to the requirements of section 394, subsection 6, 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 and that, in the case of a proprietary for-profit hospital subject to this chapter, will suffice to provide a fair return to owners based on the fair value of the institution's investment in hospital resources.

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 elements of base year financial requirements

The commission shall define by regulation the elements of base year financial requirements of hospitals.

1. Medicare costs. These elements shall consist of acute patient care related costs exclusive of capital costs and shall include those salaries and wages, fringe benefits, contracted services, supplies and other noncapital expenses which are defined as allowable costs under the Medicare program established pursuant to the United States Social Security Act, Title XVIII, including such offsets of operating revenues as prescribed by Medicare regulations.

2. Other costs. In addition, the following costs shall be included:

A. Costs associated with community education programs;

B. Costs associated with the recruitment of nonhospital-based physicians;

C. Compensation paid to physicians for professional services to the extent that such compensation is included on a hospital's trial balance of expenses as reported in its Medicare cost report; and

D. Such other costs, exclusive of development activity costs, as the commission may deem necessary and appropriate.

1 All costs shall be offset by operating revenues as
2 prescribed by Medicare regulations.

3 §396-B. Computation of base year financial require-
4 ments

5 1. Base year. The base year for each hospital
6 shall be its most recent fiscal year ending on or
7 before June 30, 1984, for which there is a budget
8 which was approved prior to July 1, 1983, by a volun-
9 tary budget review organization. In the event that a
10 hospital failed to secure, prior to July 1, 1983, the
11 approval by a voluntary budget review organization of
12 its budget for its most recent fiscal year ending on
13 or before June 30, 1984, the base year for the hospi-
14 tal shall be its most recent fiscal year ending on or
15 before June 30, 1983.

16 2. Computation. The commmission shall compute
17 base year financial requirements for each hospital
18 subject to this chapter which was in operation on
19 December 31, 1982, as follows.

20 A. In computing base year financial requirements
21 for each hospital whose base year is its most
22 recent fiscal year ending on or before June 30,
23 1984, the commission shall adjust, or require to
24 be adjusted, the budget approved by the voluntary
25 budget review organization to conform to the def-
26 inition of base year financial requirements
27 established in accordance with section 396-A. The
28 commission shall make appropriate adjustments to
29 the base year financial requirements to reflect
30 increases or decreases in financial requirements
31 occurring between the base year and the commence-
32 ment of the hospital's first payment year result-
33 ing from the factors specified in section 396-D,
34 subsections 1, 2, 4, 6 to 8 and subsection 9,
35 paragraph B, provided that any rate of increase,
36 on a per case basis, from the base year to the
37 commencement of the hospital's first payment
38 year, shall not exceed the rate of increase for
39 inpatient hospital costs allowed under the Tax
40 Equity and Fiscal Responsibility Act of 1982.

41 B. In computing base year financial requirements
42 for each hospital whose base year is its most

recent fiscal year ending on or before June 30, 1983, the commission shall adjust, or require to be adjusted, the hospital's audited Medicare cost report to conform to the definition of base year financial requirements established in accordance with section 396-A. The commission shall make appropriate adjustments to the base year financial requirements to reflect increases or decreases in financial requirements occurring between the base year and the commencement of the hospital's first payment year resulting from the factors specified in section 396-D, subsections 1, 2, 4, 6 to 8 and subsection 9, paragraph B, provided that any rate of increase, on a per case basis, from the base year to the commencement of the hospital's first payment year, 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. Subject to the provisions of section 395, subsection 1, payment years of each hospital shall coincide with its fiscal years and the first payment year of each hospital shall be its first fiscal year commencing on or after 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

The commission shall establish, by regulation, methodologies and procedures for consideration and inclusion of the adjustments to hospital financial requirements set forth in this section. In addition to providing for the submission of information required by the commission, these regulations shall addresss the manner in which hospitals will be afforded an opportunity to submit information they wish to be considered in determining adjustments under this section.

1. Economic trend factor. In determining payment year financial requirements, 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.

1 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, 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

1 event of discrepancies, if any, between projected
2 and actual case mix changes in the preceding pay-
3 ment years or in the event it obtains substantial
4 evidence that its initial projections for the
5 current payment year will be in error. In making
6 such further adjustments, the commission shall
7 consider the special needs and circumstances of
8 small hospitals.

9 3. Facilities and equipment. In determining
10 payment year financial requirements, the commission
11 shall include an allowance for the cost of facilities
12 and equipment.

13 A. An allowance for the cost of facilities and
14 fixed equipment shall include:

15 (1) Debt service requirements associated
16 with the hospital's facilities and fixed
17 equipment; and

18 (2) Annual contributions to a sinking fund
19 sufficient to provide a down payment on re-
20 placement facilities and fixed equipment.
21 The sinking fund shall be required to be
22 maintained by each hospital and the commis-
23 sion may include in it price level deprecia-
24 tion on fixed equipment or a portion of
25 price level depreciation on facilities.

26 In determining payment year financial require-
27 ments, the commission shall include an adjustment
28 in the allowance for facilities and fixed equip-
29 ment to reflect changes in debt service and to
30 reflect any new increases or decreases in capital
31 costs which result from the acquisition, replace-
32 ment or disposition of facilities or fixed equip-
33 ment and which are not related to projects sub-
34 ject to review under the Maine Certificate of
35 Need Act. Any positive adjustments made to
36 reflect such increases in capital costs shall not
37 be effective until the facilities or fixed equip-
38 ment have been put into use and the associated
39 expenses would be eligible for reimbursement
40 under the Medicare program.

1 B. An allowance for the cost of movable equip-
2 ment shall be calculated on the basis of price
3 level depreciation. The commission shall promul-
4 gate rules to define the manner in which price
5 level depreciation is to be computed and adjust-
6 ments are to be made to reflect changes from year
7 to year. Funding of this depreciation shall be
8 required as specified by the commission.

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

11 A. In determining payment year financial re-
12 quirements, the commission shall consider the
13 reasonable expected impact on the hospital's
14 financial requirements of changes in the volume
15 of services required to be provided by the hospi-
16 tal.

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

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

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

26 (3) Specified percentages of the variable
27 costs of each center to be added to or sub-
28 tracted from the approved revenues of the
29 center as a result of specified changes in
30 volume.

31 These schedules shall be developed in such a man-
32 ner as to introduce financial incentives for the
33 efficient and effective delivery of services and
34 to give due consideration to the special needs
35 and circumstances of small hospitals.

36 C. The commission shall establish by regulation
37 the methodology by which the volume adjustments
38 calculated subsequent to the close of a payment

year are to be included in the payment obligations of payors and purchasers.

D. 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. In making such further adjustments, the commission shall consider the special needs and circumstances of small hospitals.

5. Certificate of need projects. Adjustments to financial requirements for the impact on a hospital's costs of projects approved by the department pursuant to the Maine Certificate of Need Act shall be determined as follows.

A. In determining payment year financial requirements, the commission shall include an adjustment to reflect any net increases or decreases in the hospital's costs resulting from projects approved in accordance with the Maine Certificate of Need Act and section 396-K. These adjustments may be made subsequent to the commencement of a fiscal year and shall take effect on the date that expenses associated with the project would be eligible for reimbursement under the Medicare program.

B. In determining payment year financial requirements, the commission shall include an adjustment to reflect any net increases or decreases in the hospital's costs resulting from 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 subsection 3 and 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 hospital's fiscal years 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 efficiently, provided that appropriate consideration shall be given to quality and accessibility of care and to the special needs and circumstances of small hospitals and of hospitals with significant seasonal fluctuations in occupancy.

7. Working capital. In determining payment year financial requirements, the commission 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, 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. The transfer or assignment to another entity of functions performed by the hospital;

C. A merger or consolidation with another hospital; or

D. A reorganization, as defined pursuant to section 396-L.

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 shall include an adjustment for the reasonable impact on a hospital's costs of events, including events affecting all or a group of hospitals, which were reasonably unforeseen 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, the commission shall include an adjustment to reflect the difference between the assessment for the fiscal year imposed pursuant to section 391 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, the commission may 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 different fiscal year which has been approved pursuant to section 395, provided that, in the case of a conversion to an October 1st fiscal year which the commission is required to approve pursuant to section 395, subsection 1, the commission shall include an appropriate adjustment.

(3) In determining payment year financial requirements, the commission shall include an adjustment to reflect the impact, if any, on a hospital's costs of changes in hospital

reporting requirements imposed by the commission.

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 payment year for working capital, management support and those new regulatory costs specified in subsection 9, paragraph C, subparagraphs (1) and (2), 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; reporting requirements

1. Criteria established. 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 A. Except as provided in paragraphs C and D, re-
2 stricted and unrestricted gifts, grants, devises
3 or income from investment thereof shall not be
4 considered available resources.

5 B. Except as provided in paragraphs E and F, ac-
6 cumulated income from operations and income from
7 investment thereof shall not be considered avail-
8 able resources.

9 C. Gifts and grants from federal, state and
10 local governmental agencies shall be considered
11 available resources.

12 D. Donor restricted gifts, grants, devises or
13 restricted income from investment thereof shall
14 be considered available resources only to the
15 extent these funds are applied to the use for
16 which they were donated.

17 E. If a hospital's actual expenses for a payment
18 year are less than its approved financial re-
19 quirements, only 50% of the difference shall be
20 excluded from available resources for purposes of
21 computing its gross patient service revenue limit
22 in subsequent years.

23 F. Accumulated income from operations and income
24 from investment thereof shall be offset against
25 financial requirements in the first payment year
26 to the extent such income resulted from a hospi-
27 tal exceeding, for its base year and the period
28 between its base year and the commencement of its
29 first payment year, combined, the following
30 limits:

31 (1) For a hospital whose base year is its
32 most recent fiscal year ending prior to July
33 1, 1984, the amount of its budgeted oper-
34 ating margin for the base year, as set forth
35 in its approved base year budget, multiplied
36 by the sum of one and a fraction of which
37 the denominator is 12 and the numerator is
38 the number of months which elapse between
39 the base year and the commencement of its
40 first payment year; or

(2) For a hospital whose base year is its most recent fiscal year ending prior to July 1, 1983, 2% of its expenses allowed under the Medicare program in its base year times the sum of one and a fraction of which the denominator is 12 and the numerator is the number of months which elapse between the base year and the commencement of its first payment year.

G. Financial resources of affiliated interests, as defined in section 396-L, shall be considered as resources available to a hospital to the extent specified in section 396-L.

H. Available financial resources shall not include real estate, facilities, equipment, inventory or tangible personal property, except to the extent that the resources otherwise available pursuant to paragraphs A to G have been converted into such property.

2. Reporting. Each hospital shall file, on an annual basis and in accordance with regulations duly promulgated by the commission, the following information:

A. The source and amount of all gifts, grants, devises and income from investments; and

B. The amount of funds from gifts, grants, devises and investments expended and the purposes for which such funds were expended.

Notwithstanding the provisions of section 387, the commission shall not publicly disclose the individual identity of sources of gifts and grants.

3. Nothing in this section or in section 396-L may be construed to limit any authority the department may have to require the use of any gifts, grants, devises or income from investments, to finance projects subject to the Maine Certificate of Need Act.

§396-F. Revenue deductions

1 In establishing revenue limits for individual
2 hospitals, the commission shall make provision for
3 revenue deductions in the following categories.

4 1. Charity care. The commission shall make
5 provision for a reasonable amount of revenue deduc-
6 tion attributable to charity care. For purposes of
7 this section, the amount of revenue deduction attrib-
8 utable to charity care shall be defined as the amount
9 of revenue, net of recoveries, which is expected to
10 be written off as a result of a determination that
11 the patient is unable to pay for the hospital ser-
12 vices received, provided that the hospital's determi-
13 nation is made pursuant to a policy which was adopted
14 by the hospital and filed with the commission and
15 which is consistent with reasonable guidelines estab-
16 lished by the commission.

17 2. Bad debts. The commission shall make provi-
18 sion for a reasonable amount of revenue deduction
19 attributable to bad debts. For purposes of this
20 section, bad debts shall be defined as the amount of
21 revenue deduction, net of recoveries, which is
22 expected to be attributable to patients who, after
23 reasonable collection efforts, are determined to have
24 uncollectible accounts, provided that the hospital's
25 determination is made pursuant to a policy which was
26 adopted by the hospital and filed with the commission
27 and which is consistent with reasonable guidelines
28 established by the commission.

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

32 §396-G. Differentials

33 1. Interim differentials. For each hospital's
34 payment year commencing between October 1, 1984, and
35 September 19, 1985, differentials may only be
36 approved as follows.

37 A. Any nonprofit hospital and medical service
38 corporation receiving a differential from hospi-
39 tal charges as of the effective date of this
40 chapter shall be entitled to a statewide differ-
41 ential equal to 9%.

1 B. The department shall be entitled to a state-
2 wide differential equal to 75% of the audited
3 average differential in effect on July 1, 1982,
4 with respect to payments under the United States
5 Social Security Act, Titles V and XIX, unless a
6 greater differential is necessary for the depart-
7 ment to remain in compliance with the require-
8 ments of the United States Social Security Act.

9 C. Any other 3rd-party payors or purchasers who
10 make prompt payments, as defined by the commis-
11 sion by regulation, shall be entitled to a dif-
12 ferential, the value of which shall be related to
13 the time value of money as determined by the com-
14 mission, or such other differential as may be
15 granted by a hospital pursuant to a policy which
16 was in effect on May 1, 1983.

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

21 A. After review and consideration of studies
22 conducted or submitted pursuant to paragraph B,
23 the commission shall establish by regulation fac-
24 tors and methods to be used in computing a state-
25 wide differential no later than April 1, 1985.
26 The differential shall be allowed for only those
27 activities and programs provided or conducted by
28 payors which result in quantifiable savings to
29 the hospitals or reductions in the payments of
30 other payors. This differential shall reflect
31 only the cost savings to hospitals, rather than
32 the cost to the payors of implementing these ac-
33 tivities and programs. Each component utilized in
34 determining the differential shall be individu-
35 ally quantified so that the differential shall
36 equal the total of the values assigned to each
37 component.

38 B. In establishing the factors and methods for
39 determining the differential, the commission may
40 conduct its own study or rely upon studies con-
41 ducted by other persons as provided in this
42 section.

1 (1) The commission may institute a study of
2 objective methods of computing a statewide
3 differential, including a review and deter-
4 mination of the relevant and justifiable
5 economic factors which can be considered in
6 setting a differential. All hospitals and
7 all payors shall cooperate fully with the
8 commission in the conduct of the study and
9 shall provide any data or other information
10 which the commission may reasonably request.
11 In the event that the commission requires
12 the disclosure by a payor of privileged or
13 confidential commercial or financial infor-
14 mation, this information shall be exempt
15 from public disclosure.

16 (2) The nonprofit hospital and medical ser-
17 vice corporations and the companies author-
18 ized to sell accident and health insurance
19 under Title 24-A shall each, collectively,
20 have the option of conducting a study of the
21 differential issue or of contracting with a
22 person or entity to conduct such a study.
23 All such studies shall be completed by
24 November 1, 1984. During the course of these
25 studies, each hospital subject to this chap-
26 ter shall cooperate fully with the persons
27 or entities conducting these studies in pro-
28 viding any data or other information these
29 persons or entities may reasonably request.

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

34 3. Approval of differentials. For payment years
35 commencing on and after October 1, 1985, differen-
36 tials may be approved in accordance with the follow-
37 ing provisions.

38 A. Any 3rd-party payor or purchaser may apply to
39 the commission for a reduction in the payments it
40 would otherwise be required to make and the com-
41 mission shall grant a reduction in payments com-
42 mensurate with one or more components of the dif-
43 ferential on a prospective basis if it finds:

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

(2) That the applicant is willing and able to implement reasonable activities or programs which, pursuant to the commission's rules, qualify for a reduction, but which a hospital will not permit to be implemented.

B. The commission may establish rules under which any 3rd-party payor or purchaser who makes prompt payments, as defined by the commission, will be entitled to a differential without the necessity of making individual application to the commission therefor. The value of such differential shall be established in accordance with subsection 2.

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 payment 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

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

3 §396-I. Payments to hospitals

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

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

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

17 2. Apportionment among payors and purchasers.
18 Based on historical or projected utilization data,
19 the commission shall apportion, for each revenue cen-
20 ter specified by the hospital subject to subsection
21 5, and for the hospital as a whole, the hospital's
22 approved gross patient service revenue among the fol-
23 lowing categories:

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

26 B. All purchasers and payors, other than major
27 3rd-party payors, which shall together constitute
28 one category.

29 3. Payments by payors and purchasers. Payments
30 by payors and purchasers shall be determined as fol-
31 lows.

32 A. Payments made by major 3rd-party payors shall
33 be made in accordance with the following proce-
34 dures.

35 (1) The commission shall require major
36 3rd-party payors to make biweekly periodic
37 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 payment 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 payment year, the commission shall determine the amount of overcharges or undercharges, if any, made to payors, other than major 3rd-party payors, and to purchasers and shall adjust, by the percentage amount of the overcharges or undercharges, the portion of the succeeding year's gross patient service revenue limit which would otherwise have been allocated to purchasers and payors other than major 3rd-party payors. Notwithstanding the preceding sentence, adjustments to the succeeding year's gross patient service revenue limit shall not be made for undercharges if such undercharges resulted

1 from an affirmative decision by the hospital's governing body to undercharge. Any such decision to undercharge must be disclosed to the commission in order that it may be taken into account in the apportionment of the hospital's approved gross patient service revenue among all payors and purchasers, including major 3rd-party payors.

10 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 equal to 5% for small hospitals and 3% for all other hospitals, the commission may impose a penalty equal to 120% 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. In determining whether to impose a penalty, the commission shall consider whether the revenues received by a hospital met its approved financial requirements.

26 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.

32 5. Review of allocations. Notwithstanding the provisions of subsection 2, the commission shall review the allocation of revenues to revenue centers specified by each hospital and shall assure that such allocation, to the extent it results in internal departmental subsidies, is reasonable and does not result in undue price discrimination.

39 §396-J. Establishment and administration of Management Support Fund; disbursements from fund

41 1. Establishment. There is established a statewide Management Support Fund administered by the com-

1 mission. The assets of this fund shall be derived
2 from the portion of the approved gross patient ser-
3 vice revenue of each hospital, if any, in a fiscal
4 year designated as management fund revenue and trans-
5 mitted to the Management Support Fund pursuant to
6 section 396-I, subsections 1 and 4.

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

9 A. Except as otherwise provided, the Treasurer
10 of State shall be the custodian of the Management
11 Support Fund. Upon receipt of vouchers signed by
12 a person or persons designated by the commission,
13 the State Controller shall draw a warrant on the
14 Treasurer of State of the amount authorized. A
15 duly attested copy of the resolution of the com-
16 mission designating these persons and bearing on
17 its face specimen signatures of these persons
18 shall be filed with the State Controller as his
19 authority for making payments upon these vouch-
20 ers.

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

24 C. The commission shall publish annually, for
25 each fiscal year, a report showing fiscal trans-
26 actions of funds for the fiscal year and the
27 assets and liabilities of the funds at the end of
28 the fiscal year.

29 3. Disbursements from fund. One or more hospi-
30 tals may apply to the commission to receive dis-
31 bursements from the Management Support Fund. The com-
32 mission shall establish criteria governing the
33 approval of disbursements from the fund which shall,
34 at a minimum:

35 A. Require a finding by the commission that the
36 proposed use of funds will result in a signifi-
37 cant improvement in medical care management and
38 information systems; and

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

1 Disbursements under this section shall not be offset
2 against payment year financial requirements in com-
3 puting a hospital's gross patient service revenue
4 limit under section 396-H.

5 §396-K. Establishment of Certificate of Need Develop-
6 ment Account

7 The commission shall establish, on a statewide
8 basis, a Certificate of Need Development Account as
9 follows.

10 1. Amount established. Subject to the require-
11 ments of paragraphs A and B, for each payment year
12 cycle, as defined in subsection 4, the commission
13 shall consider the need for, and may credit the Cer-
14 tificate of Need Development Account with, an amount
15 to support the development and undertaking of
16 projects which are subject to review pursuant to the
17 Maine Certificate of Need Act. This amount shall be
18 established by rule after consideration of the State
19 Health Plan, the ability of the citizens of the State
20 to underwrite the additional costs and the limita-
21 tions imposed on these payments by the Federal Gov-
22 ernment pursuant to the United States Social Security
23 Act, Titles XVIII and XIX. For the first 2 payment
24 year cycles, the commission shall establish the
25 amounts as follows:

26 A. For the first payment year cycle, 1% of the
27 sum of:

28 (1) The total budgeted expenses, including
29 capital costs, of all hospitals, for their
30 most recent fiscal year ending prior to July
31 1, 1984, which were submitted to and
32 approved by a voluntary budget review orga-
33 nization prior to July 1, 1983; and

34 (2) The total actual expenses, including
35 capital costs, which were incurred, in its
36 most recent fiscal year ending prior to July
37 1, 1983, by any hospital which did not
38 secure approval, prior to July 1, 1983, of
39 its budget for its most recent fiscal year
40 ending prior to July 1, 1984; and

B. For the 2nd payment year cycle, 1% of the first payment year financial requirements determined for all hospitals in the State.

2. Approval of adjustments. The commission shall approve an adjustment to a hospital's financial requirements under section 396-D, subsection 5, paragraph A, for 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 annual capital and operating costs would not exceed the amount which the commission has determined will have been credited to the Certificate of Need Development Account by the date of implementation of the project, after account for previously approved projects.

3. Debits and carry overs. The commission shall debit against the Certificate of Need Development Account the total capital and operating costs associated with each proposal for which an adjustment is approved under subsection 2. Amounts credited to this account for which there are no debits shall be carried forward to subsequent payment year cycles.

4. Payment year cycles. For the purposes of this section, a payment year cycle is each annual period of October 1st through September 30th beginning with the first payment year cycle of October 1, 1984, through September 30, 1985.

§396-L. 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 which is a subsidiary of a hospital;

(2) Any person which is a parent entity of a hospital;

1 (3) Any person which is a subsidiary of a
2 hospital's parent entity;

3 (4) Any person, other than an individual,
4 which a hospital, or any of its affiliates
5 as defined in subparagraphs (1) to (3), con-
6 trols through common governing board mem-
7 bers, contracts or other legal documents
8 that give the hospital or its affiliates the
9 authority to direct the person's activities,
10 management and policies, but not including
11 control exercised only through canonical or
12 similar religious control;

13 (5) Any person to whom a hospital has
14 transferred some of its resources and sub-
15 stantially all of whose resources are held
16 for the benefit of the hospital or any of
17 its affiliated interests;

18 (6) Any person to whom a hospital has
19 assigned certain of its functions and who is
20 operating primarily for the benefit of the
21 hospital or any of its affiliated interests;

22 (7) Any person, other than an individual,
23 and other than an auxiliary, which has
24 solicited funds in the name of and with
25 expressed or implied approval of the hospi-
26 tal or any of its affiliated interests, and
27 substantially all the funds solicited by
28 that person were intended by the contributor
29 or were otherwise required to be transferred
30 to the hospital or any of its affiliated
31 interests or used at their discretion or
32 direction; and

33 (8) Notwithstanding subparagraphs (1) to
34 (7), any person which would be considered a
35 person related to the hospital, as defined
36 under the Medicare program established pur-
37 suant to the United States Social Security
38 Act, Title XVIII.

39 B. "Reorganization" means any creation, orga-
40 nization, extension, consolidation, merger,
41 transfer of ownership or control, liquidation,

1 dissolution or termination, direct or indirect,
2 in whole or in part, of an affiliated interest,
3 as defined in paragraph A, subparagraphs (1) to
4 (7), accomplished by the issue, sale, acquisi-
5 tion, lease, exchange, distribution or transfer
6 of control or property.

7 C. "Significant transaction" means a transaction
8 if it has an actual or imputed value or worth in
9 excess of $10,000 or more for a fiscal year or if
10 the total amount of the contract price, consider-
11 ation and other advances by the institution on
12 account of the transactions is $10,000 or more
13 for the fiscal year.

14 2. Reporting and consideration of significant
15 transactions; corporate plans. Statements of signifi-
16 cant transactions and corporate plans shall be sub-
17 mitted and considered as follows.

18 A. Each hospital shall annually submit to the
19 commission a written statement of significant
20 transactions, as defined in subsection 1, between
21 itself and any person in which an officer,
22 trustee or director of a hospital is an employee,
23 partner, director, officer or beneficial owner of
24 3% or more of the capital stock, or between
25 itself and any affiliated interest, or between
26 itself and any auxiliary.

27 B. In determining base year financial require-
28 ments pursuant to section 396-B or in establish-
29 ing adjustments for productivity or other factors
30 pursuant to section 396-D, the commission may
31 disregard unreasonable or unnecessary costs under
32 significant transactions between a hospital and
33 the persons specified in paragraph A.

34 C. Each hospital which has or will have affili-
35 ated interests, as defined in subsection 1, para-
36 graph A, subparagraphs (1) to (7), shall file,
37 either as part of its filing under section 396-D
38 or as part of its application for approval of a
39 reorganization pursuant to subsection 4, which-
40 ever is earlier, a 5-year corporate plan contain-
41 ing information as specified by the commission.
42 At a minimum, the plan shall set forth the manner

in which financial resources of the affiliated interests will be applied to offset financial requirements of the hospital in accordance with subsection 5 and section 396-E, subsection 1, paragraph G. The commission shall review and approve or disapprove each corporate plan taking into account, at a minimum, the following factors as the commission deems appropriate in the interest of the people of the State:

(1) Long-term capital and operating needs of the affiliated interests to meet market conditions and achieve reasonable growth;

(2) Federal reimbursement and burdens imposed on other payors;

(3) The effect which the services of the affiliated interests would have on the quality and efficiency of health services; and

(4) Requirements associated with maintaining tax-exempt status.

The hospital shall submit annual updates of its corporate plan which shall not require approval unless significant modifications are made to the plan. Notwithstanding the provisions of section 387, confidential commercial information submitted by a hospital or its affiliates under this paragraph or under subsection 4 shall not be subject to public disclosure. The commission shall adopt rules establishing criteria for determining the confidentiality of such information and establishing procedures to afford hospitals and affiliated interests notice and opportunity to comment in response to requests for information which may be considered confidential.

3. Access to accounts and records. The commission may require the production of books, accounts, records, papers and memoranda of an auxiliary which is engaged in commercial activities or of an affiliated interest which relate, directly or indirectly, to any of its dealings with a hospital which affect the hospital's costs or charges. The commission may, in determining financial requirements of a hospital,

disallow all or a portion of the payments under such dealings, the account or record of which is not made available to the commission.

4. Reorganization. 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. Reviews of reorganizations which are also subject to review under the Maine Certificate of Need Act shall be conducted simultaneously with the department's review under the Act.

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.

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

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

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

D. The ability of the hospital to provide reasonable and adequate care is not impaired.

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

F. The hospital's credit is not impaired or adversely affected.

G. The requirements of subsection 5 will be met.

5. Determination of available resources. After review of corporate plans submitted in accordance with subsection 2, the commission shall, consistent with the following provisions, determine the amount of financial resources of an affiliated interest, as defined in subsection 1, paragraph A, subparagraphs (1) to (7), to be applied to hospital financial requirements pursuant to section 396-E.

A. Gifts, grants and income from investments thereof received by affiliated interests shall not be considered available resources.

B. Excess revenues of nonprofit affiliated interests and profits of for-profit affiliated interests shall be offset, except to the extent that the retention of such funds by the affiliated interest is required to meet its capital and operating needs as defined in the plan submitted to and approved by the commission pursuant to subsection 2. The amount of these excess revenues or profits shall be determined without regard to any gifts, grants or other transfers of funds by the affiliated interest to the hospital or to other affiliates but shall otherwise be determined on a consolidated after-tax basis.

C. Of the amounts determined under paragraph B, 50% shall be offset generally against hospital financial requirements and 50% may be designated by the hospital for a particular use by the hospital.

§396-M. Medicare waiver

The commission shall exercise its best efforts to design a program which qualifies for a waiver of hospital reimbursement requirements under the United

States Social Security Act, Title XVIII, as authorized by Section 1886 of that Act, and shall apply to the Secretary for such a waiver. 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 and provided further that the acceptance of any conditions under such a waiver would not be detrimental to the interests of the people of the State.

§396-N. Coordination with department

The commission and the department shall jointly undertake a study of the likely effects of the hospital care financing system established under this subchapter on hospitals which are also licensed to provide skilled nursing facility services or intermediate care facility services and shall make such modifications to the rules implementing either the hospital care financing system or the prospective payment system for long-term care facilities administered by the department or both as may be necessary to assure that the revenue limits established for such hospitals will permit them to render effective and efficient services in the public interest. In carrying out the requirements of this section, the commission and the department shall consult with the affected hospitals.

§396-O. Experimental and demonstration projects

The commission may, with the written agreement of any directly affected hospital, 3rd-party payor or purchaser, implement experimental or demonstration projects designed to assess methods of establishing revenue limits or payment methodologies other than those established generally under this chapter. The commission shall consult with appropriate advisory committees prior to initiating any experimental or demonstration project and shall include the results of any project as part of its annual report. These experimental or demonstration projects may include, but need not be limited to, the following:

1. Regional hospital corporations. Establishment of regional hospital corporations;

2. Diagnostic related groups. Payment on the basis of diagnostic related groups;

3. Capitation. Payment on a capitation basis; and

4. Preferred provider relationships. Preferred provider relationships.

§396-P. Advisory committees

1. Establishment. The commission shall, after consultation with representative groups, establish the following advisory committees.

A. 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 advise 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.

B. The commission shall establish a Hospital Advisory Committee consisting of 2 representatives of hospitals which have 55 or fewer beds, 2 representatives of hospitals which have 56 to 110 beds and 2 representatives of hospitals which have more than 110 beds. This committee shall advise the commission and its staff with respect to analytical techniques, data requirements, financial and other requirements of hospitals, and the effects of the health care financing system established under this subchapter on the hospitals of the State.

C. The commission shall establish a Payor Advisory Committee consisting of one representative of nonprofit hospital and medical service corporations, one representative of commercial insurance companies, one representative of

1 self-insured groups and one representative of the
2 department. This committee shall advise the com-
3 mission and its staff with respect to analytical
4 techniques, data requirements and other technical
5 matters involved in implementing and administer-
6 ing the health care financing system established
7 under this subchapter.

8 2. Chairman. The chairman of each committee
9 shall be appointed by the chairman of the commission
10 and shall be rotated on an annual basis.

11 3. Consultation. The commission shall consult,
12 on a regular basis, with the committees established
13 pursuant to subsection 1 and shall consider their
14 recommendations.

15 4. Meetings; assistance. Each committee estab-
16 lished under subsection 1 may meet as it deems appro-
17 priate and the commission shall provide it such staff
18 assistance and information as it reasonably requires
19 in the performance of its functions.

20 SUBCHAPTER IV

21 PROCEDURES

22 §397. Proceedings generally

23 1. Proceedings. Proceedings before the commis-
24 sion shall be subject to the Maine Administrative
25 Procedure Act, Title 5, chapter 375, subchapter IV,
26 and such additional rules of practice as the commis-
27 sion may promulgate consistent with that Act.

28 2. Substantial compliance. A substantial compli-
29 ance with the requirements of this chapter shall be
30 sufficient to give effect to all the rules, orders,
31 acts and regulations of the commission and, except as
32 otherwise provided in Title 5, section 8057 with
33 respect to rules, they shall not be declared inopera-
34 tive, illegal or void for any omission of a technical
35 and immaterial nature in respect thereto.

36 3. Burden of proof. In all trials, actions and
37 proceedings arising under this chapter, the burden of
38 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 proceedings 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 each payment year of each hospital subject to this chapter, the executive director shall propose a gross patient service revenue limit 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, affiliated interest, 3rd-party payor or group of purchasers, and if the commission does not disapprove or modify the proposed limit or apportionment, the limit and apportionment shall take effect on the first day of the applicable payment 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 the first day of the applicable payment year, except that, if the proposed limit or apportionment for a hospital's first payment year is timely contested, and the commission, after due diligence, is unable to issue a final order by the first day of the payment year, it shall issue a provisional order by that date which shall be superseded by a final order no later than 90 days after the start of the payment year.

1 2. Interim adjustments. Upon application by a
2 hospital, affiliated interest, payor or group of pur-
3 chasers, for an interim adjustment to financial re-
4 quirements permitted under section 396-D, or upon
5 application by a payor or group of purchasers for a
6 modification of its approved differential or of the
7 apportionment of the gross patient service revenue,
8 and after opportunity for hearing, a final order
9 shall be promulgated within 120 days from the date a
10 completed application was filed. Any proposed change
11 shall take effect upon the date specified in the
12 order. At any time during the period between the
13 filing date and the commission's final decision on
14 the request, the commission may extend provisional
15 approval to any part of the request. This provisional
16 approval shall be superseded by the commission's
17 final decision on the request. The commission may
18 establish reasonable limits on the frequency of
19 requests filed under this subsection.

20 3. Commission to make adjustments. Nothing in
21 this section may be construed to limit the authority
22 of the commission to make adjustments during the
23 course of a payment year, on its own initiative, with
24 appropriate notice and opportunity for hearing for
25 affected persons.

26 §399. Other powers

27 In addition to the powers granted to the commis-
28 sion elsewhere in this chapter, the commission may
29 conduct investigations, require the filing of infor-
30 mation, and subpoena witnesses, papers, records,
31 documents and all other data sources relevant to the
32 establishment and apportionment of gross patient ser-
33 vice revenue limits and compliance therewith, reor-
34 ganizations and significant transactions, and other
35 matters regulated by the commission pursuant to sub-
36 chapter III.

37 **Sec. 11. 22 MRSA §2061, sub-§2,** as amended by PL
38 1981, c. 455, is further amended to read:

39 2. Review. Each project for a hospital or nurs-
40 ing home has been reviewed and approved to the extent
41 required by the agency of the State which serves as
42 the Designated Planning Agency of the State in accor-

1 dance with the provisions of section 1122 of the ~~Fed-~~
2 ~~eral~~ United States Social Security Act, as amended,
3 or by the Department of Human Services in accordance
4 with the provisions of the Maine Certificate of Need
5 Act of 1978, as amended, or, in the case of a project
6 for a hospital, has been reviewed and approved by the
7 Maine Health Care Finance Commission to the extent
8 required by chapter 107;

9 **Sec. 12. Advisory committees established.** The
10 Maine Health Care Finance Commission shall establish
11 the advisory committees required pursuant to Title
12 22, section 396-P, as soon as possible. Upon estab-
13 lishment, and until September 30, 1984, the chairman
14 of each of the 3 advisory committees shall be enti-
15 tled to participate, in the manner of an ex officio
16 nonvoting member, solely with respect to delibera-
17 tions and actions of the commission directly related
18 to the formulation and adoption of rules, but not
19 including, deliberations and actions which are prop-
20 erly conducted in executive session. After September
21 30, 1984, the commission may, in its sole discretion,
22 permit such participation to continue. This section
23 may not be construed to authorize participation in
24 deliberations and actions of the commission related
25 to the application or enforcement of rules.

26 **Sec. 13. Transfer of property.** All reports,
27 files, records, books, periodicals, supplies, equip-
28 ment and other property of the Health Facilities Cost
29 Review Board shall be transferred to the Maine Health
30 Care Finance Commission upon the effective date of
31 this Act.

32 STATEMENT OF FACT

33 As in the original bill, this new draft estab-
34 lishes a Maine Health Care Finance Commission empow-
35 ered to implement a mandatory prospective hospital
36 payment system with hospital specific revenue limits.

37 The original bill has been amended to provide
38 that only 4 of the 5 members of the Health Care
39 Finance Commission are required to be consumers and
40 that at least one of the 5 members must be a person
41 with significant prior experience in the hospital

field. The role of the technical and professional advisory committees has also been enhanced.

In addition to numerous clarifying amendments, the major changes to proposed hospital payment systems are as follows. The provisions for the establishment of regional hospital groups and regional hospital corporations are eliminated, as well as the provision for a regional development fund for new and expanded services. Instead, a statewide limit on costs associated with projects subject to review under the Maine Certificate of Need Act is established. The provisions relating to affiliated interests and hospital reorganizations have been made more specific, particularly with respect to the use of financial resources to offset financial requirements of hospitals. Charitable gifts are not required to be offset against general operating expenses. Hospitals would no longer be required to adopt a uniform fiscal year. A new section would allow the commission, hospitals and payors to undertake jointly demonstration or experimental payment programs.

Additional amendments clarify procedures to be followed by the commission, including the application of the Maine Administrative Procedure Act, Title 5, chapter 375, the imposition of penalties and the procedures for determining confidentiality of information obtained by the commission.

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