114th MAINE LEGISLATURE

FIRST REGULAR SESSION - 1989

Legislative Document No. 920

S.P. 348 In Senate, March 27, 1989

Reported by Senator GAUVREAU of Androscoggin for the Commission to Study the Regulation of Health Care Expenditures pursuant to Public Law 1987, chapter 440, section 5.

Reference to the Committee on Human Resources suggested and ordered printed pursuant to Joint Rule 18.

JOY J. O'BRIEN
Secretary of the Senate

STATE OF MAINE

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

An Act to Implement Recommendations Proposed by the Blue Ribbon Commission on the Regulation of Health Care Expenditures.

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

Sec. 1. 2 MRSA §6-B, as enacted by PL 1983, c. 579, §1, is repealed and the following enacted in its place:

§6-B. Salaries of commissioners and certain employees of the Maine Hospital Rate Setting Commission

1. Chair. The salary of the chair of the commission shall be within salary range 91, step G for fiscal year 1989-90 and salary range 91, step H for fiscal year 1990-91 and annually thereafter.

2. Commission members. The salary of other members of the commission shall be within salary range 90, step G for fiscal year 1989-90 and salary range 90, step H for fiscal year 1990-91, and annually thereafter.

3. Other employees. The salaries of the following employees shall be within:

A. Salary range 89:

(1) Deputy directors; and

B. Salary range 88:

(1) General counsel.

Sec. 2. 3 MRSA §507, sub-§8, ¶A, as repealed and replaced by PL 1985, c. 763, Pt. A, §4, is amended to read:

A. Unless continued or modified by law, the following Group D-1 independent agencies shall terminate, not including the grace period, no later than June 30, 1986:

(1) Maine Arts Commission; ~~and~~

(2) Maine State Museum~~.~~; and

(3) Maine Hospital Rate Setting Commission.

Sec. 3. 5 MRSA §12004-E, sub-§1, as enacted by PL 1987, c. 786, §5, is repealed.

Sec. 4. 22 MRSA §303, sub-§3-A, as enacted by PL 1983, c. 579, §6, is amended to read:

3-A. Commission. "Commission" means the Maine ~~Health Care Finance~~ Hospital Rate Setting Commission established pursuant to chapter ~~107~~ 1701.

Sec. 5. 22 MRSA §303, sub-§6-A, ¶¶C and D, as enacted by PL 1981, c. 705, Pt. V, §4, are amended to read:

C. For services commenced between January 1 and December 31, 1985, $145,000 for the 3rd fiscal year, including a partial first year; ~~and~~

D. For services commenced after December 31, 1985, $155,000 for the 3rd fiscal year, including a partial first year~~.~~; and

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

E. For services commenced by providers other than hospitals after October 1, 1990, $155,000 for the 3rd fiscal year, including a partial first year.

Sec. 7. 22 MRSA §303, sub-§12-A, as enacted by PL 1981, c. 705, Pt. V, §7, is amended to read:

12-A. Major medical equipment. "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions which is used to provide medical and other health services and which costs ~~$300,000~~ $1,000,000 or more. ~~This term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services, if the clinical laboratory is independent of a physician's office and a hospital and has been determined under the United States Social Security Act, Title XVIII, to meet the requirements of Section 1861 (s), paragraphs 10 and 11 of that Act.~~ In determining whether medical equipment costs more than ~~$300,000~~ $1,000,000, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquiring the equipment shall be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value.

Sec. 8. 22 MRSA §303, sub-§20, as enacted by PL 1977, c. 687, §1, is repealed.

Sec. 9. 22 MRSA §304-A, sub-§2, as amended by PL 1987, c. 363, §§1 and 2, is repealed and the following enacted in its place:

2. Acquisitions of major medical equipment. The acquisition by any person of major medical equipment.

There shall be a waiver for the use of major medical equipment on a temporary basis as provided in section 308, subsection 4;

Sec. 10. 22 MRSA §304-A, sub-§3, as amended by PL 1987, c. 436, §1, is further amended to read:

3. Capital expenditures. The obligation by or on behalf of a health care facility, except a skilled or intermediate care facility or hospital, of any capital expenditure of $350,000 or more. Hospitals shall have a threshold of $1,000,000. Intermediate care and skilled nursing care facilities shall have a threshold of $500,000, except that any transfer of ownership of an intermediate care or skilled nursing care facility or a hospital shall be reviewable;

Sec. 11. 22 MRSA §304-A, sub-§4, as enacted by PL 1981, c. 705, Pt. V, §16, is amended to read:

4. New health services. The offering or development of any new health service, except for hospital services on or after hospital payment years beginning October 1, 1991. For purposes of this section, "new health services" shall include only the following:

A. The obligation of any capital expenditures by or on behalf of a health care facility which is associated with the addition of a health service which was not offered on a regular basis by or on behalf of the facility within the 12-month period prior to the time the services would be offered;

B. The addition of a health service which is to be offered by or on behalf of a health care facility which was not offered on a regular basis by or on behalf of the facility within the 12-month period prior to the time the services would be offered, and which, for the 3rd fiscal year of operation, including a partial first year, following addition of that service, absent any adjustment for inflation, is projected to entail annual operating costs of at least the expenditure minimum for annual operating costs; or

C. The addition of a health service which falls within a category of health services which are subject to review regardless of capital expenditure or operating cost and which category the department has defined through regulations promulgated pursuant to section 312~~,--based--on recommendations-from-the-State-Health-Coordinating-Council~~;

Sec. 12. 22 MRSA §304-A, sub-§6, as enacted by PL 1981, c. 705, Pt. V, §16, is amended to read:

6. Changes in bed complement. Any change in the existing bed complement of a health care facility other than a hospital, in any 2-year period, which:

A. Increases or decreases the licensed or certified bed capacity of the health care facility by more than 10% or more than 5 beds, whichever is less;

B. Increases or decreases the number of beds licensed or certified by the department to provide a particular level of care by more than 10% of that number or more than 5 beds, whichever is less; or

C. Relocates more than 10% of the health care facility's licensed or certified beds or more than 5 beds, whichever is less, from one physical plant to another;

Sec. 13. 22 MRSA §304-A, sub-§6-A is enacted to read:

6-A. Increases in licensed bed capacity of a hospital. Any increase in the licensed bed capacity of a hospital by more than 10% or more than 5 beds, whichever is less;

Sec. 14. 22 MRSA §304-A, sub-§9, ¶B, as amended by PL 1985, c. 418, §4, is further 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 by an appropriate inflation deflator promulgated by the department, after consultation with the Maine ~~Health Care Finance~~ Hospital Rate Setting Commission, exceeds the expenditure minimum for annual operating cost in the 3rd fiscal year of operation following addition of these services.

Sec. 15. 22 MRSA §304-D, as enacted by PL 1985, c. 661, §2, is repealed.

Sec. 16. 22 MRSA c. 107, as amended, is repealed.

Sec. 17. 22 MRSA sub-t. 6 is enacted to read:

SUBTITLE 6

HOSPITAL RATE SETTING

CHAPTER 1701

HOSPITAL RATE SETTING

SUBCHAPTER I

GENERAL PROVISIONS

§9001. Findings and declaration of purpose

1. Findings. The Legislature makes the following findings.

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

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

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

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

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

(4) The current system of financing hospital care threatens the ability of some Maine hospitals to generate sufficient revenues to meet their reasonable financial requirements and, consequently, will inevitably have an adverse impact on the accessibility and the quality of the care available to those whom they serve.

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

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

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

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

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

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

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

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

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

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

C. It is further the intent of the Legislature that nothing in this chapter may be construed to prescribe the amounts hospitals may pay for particular goods and services, including professional services. Similarly, except as required by the specific provisions of this chapter and rules promulgated under this chapter, the decisions made by hospitals regarding the amounts to be expended for particular goods and services shall have no effect on the gross patient service revenue limits established by the commission.

§9002. Definitions

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

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

2. Commission. "Commission" means the Maine Hospital Rate Setting Commission established by this chapter.

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

4. 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.

5. Health care facility. Except as provided in subsection 13, "health care facility" means any health care facility required to be licensed under chapter 405 or its successor, with the exception of the Cutler Health Center and the Dudley Coe Infirmary.

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

7. Independent data organization. Except as provided in section 9021, 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.

8. 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.

9. 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.

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

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

12. 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.

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

A. A direct provider of health care;

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

C. A health product manufacturer.

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

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

16. Revenue limit. "Revenue limit" means the revenue per case, the rate per unit of outpatient service, or the total revenue approved by the commission pursuant to section 9031.

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

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

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

20. Voluntary budget review organization. "Voluntary budget review organization" means a nonprofit organization established to conduct reviews of budgets and approved by the board in chapter 105.

§9003. Maine Hospital Rate Setting Commission

1. Establishment. The Maine Health Care Finance Commission, governed by former chapter 107, shall be known after October 1, 1989, as the Hospital Rate Setting Commission. The commission is defined as follows.

A. The Maine Hospital Rate Setting Commission shall function as an independent executive agency.

B. Effective October 1, 1989, the commission shall be composed of 3 members, who shall be appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over human resources and confirmation by the Legislature. Members shall devote full time to their duties.

The powers and duties of the commission as set forth in this chapter shall be performed by the part-time commissioners appointed prior to October 1, 1989, until the 3 full-time members have been appointed and qualified pursuant to paragraph C. No full-time commissioner may exercise powers under this chapter until 3 full-time commissioners are qualified.

C. The terms of the members shall be staggered. The terms of members appointed before October 1, 1989, shall last until 3 full-time commissioners are qualified. Of the members appointed after October 1, 1989, one shall be appointed for a term of 4 years; one for a term 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.

D. The Governor may remove any member who becomes disqualified for neglect of any duty required by law.

2. Chair. The following provisions apply to the chair of the Maine Hospital Rate Setting Commission.

A. The Governor shall designate one member of the commission as chair.

B. The chair shall have the following duties:

(1) Serve as principal executive officer of the commission in carrying out its policies;

(2) Preside at meetings of the commission; and

(3) Be responsible for the expedient organization of the commission's work.

3. 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 chair or by any 2 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. Two members of the commission shall constitute a quorum. No action of the commission may be effective without the concurrence of at least 2 members.

C. The chair of each of the 3 advisory committees established according to section 9047 or another committee member designated by the chair shall be entitled to participate, in the manner of an ex officio nonvoting member, solely with respect to deliberations and actions of the commission directly related to the formulation and adoption of rules, but including neither deliberations and actions which are properly conducted in executive session nor deliberations and actions with respect to which the commission determines that one or more of the advisory committee chairs has a conflict of interest. This section may not be construed to authorize participation in

deliberations and actions of the commission related to the application or enforcement of rules.

4. Compensation. Each member of the commission shall be compensated according to the provisions of Title 2, section 6-B.

§9004. Deputy directors and staff

The commission shall appoint no more than 3 deputy directors, who shall have had experience in the organization, financing or delivery of health care and who shall perform the duties delegated to them by the commission. They shall serve at the pleasure of the commission and their salaries shall be set by the commission within the range established by Title 2, section 6-B. The commission may employ such other staff as it deems necessary. The appointment and compensation of such other staff shall be subject to the Civil Service Law.

§9005. Legal counsel

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

§9006. Powers of commission generally

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

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

2. Committees. In addition to the committees required to be established under section 9047, the commission may create committees from its membership and appoint advisory committees consisting of members, other individuals and representatives of interested public and private groups and organizations.

3. Receipt of grants, gifts and payments. The commission may solicit, receive and accept grants, gifts, payments and other

funds and advances from any person, other than a provider of health care, as defined in section 9002, subsection 13, or a 3rd-party payor, as defined in section 9002, 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 9011.

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 to support research or other activities undertaken in furtherance of the purposes of this chapter.

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

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

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

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

§9007. 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.

§9008. Reports

1. Annual reports. The commission shall prepare the following annual reports.

A. 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. The report shall include:

(1) Data citations, to the extent possible, to support the factual statements in the report;

(2) The administrative requirements for compliance with the system by hospitals to the extent possible;

(3) The commission's view of the likely future impact on the health care financing system of trends in the use or financing of hospital care, including federal reimbursement policies, demographic changes, technological advances and competition from other providers;

(4) The commission's view of likely changes in apportionment of revenues among classes of payers and purchasers as a result of trends set out in subparagraph (3);

(5) The relationship of the advisory committees to the commission;

(6) Comparisons of the impact of the hospital care financing system with relevant regional and national data, to the extent that such data is available;

(7) To the extent available, information on trends in utilization; and

(8) Demonstration projects considered or approved by the commission.

B. The commission shall prepare a report of the annual savings to the payors as a result of this chapter and shall submit this report annually to the Bureau of Insurance. The Bureau of Insurance shall take this savings into account in approving health insurance rates. A copy of this report shall be submitted to the joint standing committee of the Legislature having jurisdiction over human resources.

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 human resources, appear before the committee to discuss its annual reports 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 consumers in making informed choices in obtaining health care, including the results of any studies or analyses undertaken by the commission.

4. Review by health care facility. If any studies or analyses undertaken by the commission pursuant to section 9006, subsection 4, or if any consumer information developed pursuant to subsection 3 directly or indirectly identify a particular health care facility, the health care facility shall be afforded a reasonable opportunity, before public release, to review and comment upon the studies, analyses or other information.

5. Review of exception threshold and variable adjustment factor. The factors for the threshold on exception requests in section 9035, subsection 15 and the variable adjustment factor in section 9035, subsection 2, shall be reviewed after the system has been in operation for 2 years. At that time the commission shall recommend to the Legislature how these factors should be established and what the factors should be in light of the current status of hospital care in Maine and the United States.

§9009. Penalties

Any person who knowingly violates any provision of this chapter or any valid order or rule made or promulgated pursuant to this chapter, or who willfully fails, neglects or refuses to perform any of the duties imposed under this chapter, shall be deemed to have committed a civil violation for which a forfeiture of not more than $1,000 a day may be adjudged, unless specific penalties are elsewhere provided for, and provided that any forfeiture imposed under this section shall not exceed $25,000 for any one occurrence.

§9010. Enforcement

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

§9011. Funding of the commission

1. Assessments. Every hospital subject to regulation under this chapter shall be subject to an assessment of not more than .15% of its gross patient service revenues. The commission shall determine the assessments annually prior to July 1st and shall assess each hospital for its pro rata share. Each hospital shall pay the assessment charged to it on a quarterly basis, with payments due on or before July 1st, October 1st, January 1st and April 1st of each year.

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

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

4. Use of funds. The commission may use the revenues provided in this section to defray the costs incurred by the commission pursuant to this chapter, including salaries, administrative expenses, data system expenses, consulting fees and any other reasonable costs incurred to administer this chapter. The commission may not use the revenues provided in this section to make grants pursuant to section 9006, subsection 5, unless the allocation of revenues to this purpose has been approved in accordance with subsection 2.

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

§9012. Program audit and evaluation

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

2. Evaluation. In addition to the requirements as to contents of justification reports under Title 3, section 507, the commission shall include in its report an evaluation of the impact of the hospital financing system established under this chapter on the quality of hospital care, access to such care and the financial stability of hospitals in the State.

SUBCHAPTER II

HEALTH FACILITIES INFORMATION DISCLOSURE

§9021. Uniform systems of reporting generally

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

2. Information required. In addition to any other requirements applicable to specific categories of health care facilities, as set forth in section 9022, and in subchapters III and IV and pursuant to rules adopted by the commission for form, medium, content and time for filing, each health care facility shall file with the commission the following information:

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

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

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

3. Storage of discharge data. The commission may, subject to section 9006, 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 commission may require the filing of financial reports and data which, during the period from July 1, 1983, to the effective date of this chapter, would have been required to be filed pursuant to the board's regulations in effect on June 30, 1983, had the Health Facilities Information Disclosure Act not been repealed effective July 1, 1983. Except for such reports and data as have been made available to the Health Facilities Cost Review Board prior to July 1, 1983, the commission shall compensate any voluntary budget review organization for the reasonable costs incurred in transferring reports and data, provided that the voluntary budget review organization shall cooperate to the fullest extent possible in minimizing the costs incurred.

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

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

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

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

10. Filing schedules. The information and data required pursuant to this chapter shall be filed on an annual basis or more frequently as specified by the commission. The commission shall establish the effective date for compliance with the required uniform systems.

§9022. 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 9021, 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 9021 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 9021, 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 RATE SETTING SYSTEM

§9031. 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.

3. Average revenue per case payment system. The commission shall establish an average revenue per case payment system.

The per case system shall have 2 components.

A. The commission shall establish and approve limits on the average revenue per case mix adjusted admission.

B. The commission shall regulate outpatient services by setting the rate per unit of service by department.

4. Total revenue system. The commission shall establish a total revenue system which may be chosen by hospitals which are in relatively self-contained catchment areas, are not in direct competition with other hospitals, and which meet certain criteria developed by the commission.

Criteria shall include, but not be limited to:

A. Distance of the hospital in miles and travel time from the nearest other hospital; and

B. Utilization of existing hospital services by patients within the catchment area.

The commission shall establish the total gross patient service revenue limit for inpatient and outpatient services for hospitals which apply for this system, and which meet the established criteria.

5. Excess charges prohibited. No hospital may charge for services at rates that are inconsistent with the revenue limits approved by the commission.

6. Cross-subsidies. Cross-subsidization between inpatient and outpatient services and among outpatient services for hospitals regulated under the per case and total revenue systems shall be permitted based on historical levels of cross-subsidization. In the case of hospitals participating in the total revenue system, the commission shall approve cross-subsidies necessary to render effective and efficient service in the public interest consistent with payor equity.

7. Unique hospitals. The commission shall provide alternative regulatory options for hospitals defined by the commission as being unique within the Maine health care system. Unique hospitals may include, but are not limited to, psychiatric and rehabilitation hospitals.

8. Return on investment. The revenue limits established by the commission under this chapter shall, in the case of a proprietory, for-profit hospital, be established in a manner that provides a reasonable opportunity for the hospital to earn an amount that will provide a fair return to owners based on their investment in hospital resources.

§9032. 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.

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

§9033. Computation of base year financial requirements

1. Base year. The base year for each hospital shall be its most recent fiscal year ending on or before June 30, 1984, for which there is a budget which was approved prior to July 1, 1983, by a voluntary budget review organization. In the event that a hospital failed to secure, prior to July 1, 1983, the approval by a voluntary budget review organization of its budget for its most recent fiscal year ending on or before June 30, 1984, the base year for the hospital shall be its most recent fiscal year ending on or before June 30, 1983.

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

A. In computing base year financial requirements for each hospital whose base year is its most recent fiscal year ending on or before June 30, 1984, the commission shall adjust, or require to be adjusted, the budget approved by the voluntary budget review organization to conform to the

definition of base year financial requirements established in accordance with section 9032. 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 9035, subsections 1, 3, 5, 9, 10 and subsection 11, 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.

B. In computing base year financial requirements 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 9032. 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 9035, subsections 1, 3, 5, 9, 10 and subsection 11, 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.

§9034. 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 9022, 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 9033 and adjusted by the commission in accordance with section 9035.

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 9035.

§9035. 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 address 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.

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. Variable adjustment factor. The commission shall add a factor in the range of one to 1.75% to the economic trend factor established in subsection 1. This factor shall reflect the following:

A. Changes in technology not covered by certificate of need projects, including changes in drugs and supplies;

B. Changes in medical practice;

C. Increased severity of illness not accounted for by the case mix system and the aging of the population; and

D. Other changes specified by the commission that are expected to affect a substantial number of Maine hospitals.

3. 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 event of discrepancies, if any, between projected and actual case mix changes in the preceding

payment years or in the event it obtains substantial evidence that its initial projections for the current payment year will be in error. In making such further adjustments, the commission shall consider the special needs and circumstances of small hospitals.

The commission shall consider changes in case mix for hospitals regulated under the per case system and shall make prospective adjustments in years subsequent to the first payment year in which the hospital is subject to the per case system, using a marginal cost factor in the range of 80% to 100%.

4. Facilities and equipment. In determining payment year financial requirements, the commission shall include an allowance for the cost of facilities and equipment.

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

(1) Allowances for straight line depreciation and interest expense, less interest income on debt service reserve funds available to the hospital.

In determining payment year financial requirements, the commission shall include an adjustment in the allowance for facilities and fixed equipment to reflect changes in interest expense and to reflect any new increases or decreases in capital costs which result from the acquisition, replacement or disposition of facilities or fixed equipment and which are not related to projects for which an adjustment is required to be made under subsection 6. Any positive adjustments made to reflect such increases in capital costs shall not be effective until the facilities or fixed equipment have been put into use and the associated expenses would be eligible for reimbursement under the Medicare program.

B. An allowance for the cost of movable equipment shall be calculated on the basis of straight line depreciation and interest expense consistent with paragraph A.

C. Hospitals shall fund depreciation and use their funded depreciation as a first source of funds for payment for capital projects, proportional to the ratio between the capital cost of the new project and the gross book value of the hospital assets.

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

A. In determining payment year financial requirements, the commission shall consider the reasonable expected impact on

the hospital's financial requirements of changes in the volume of services required to be provided by the hospital.

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

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

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

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

These schedules shall be developed in such a manner as to introduce financial incentives for the efficient and effective delivery of services and to give due consideration to the special needs and circumstances of small hospitals.

C. The commission may, for hospitals regulated under the total revenue system, 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.

D. The commission shall consider changes in volume of services for hospitals regulated according to the per case system and shall make prospective volume adjustments in years subsequent to the first payment year in which the hospital is subject to the per case system using a marginal cost factor in the range of 80% to 100%.

6. **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. Except as provided in paragraph C, 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

that have been approved by the department in accordance with the Maine Certificate of Need Act and that otherwise meet the requirements of section 9042, subsection 2, paragraph B, or subsection 3, paragraph C. 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 4 and section 9032. 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.

C. In determining payment year financial requirements, if a project approved in accordance with the Maine Certificate of Need Act and section 9042 subsequent to October 1, 1985, involves an activity specified in subsection 10, the commission may elect to determine an adjustment to reflect any net decrease resulting from that project in a manner consistent with its determination of adjustments under subsection 10.

7. Other projects. The commission may make adjustments for the costs associated with projects which would have been subject to certificate of need review immediately prior to October 1, 1989, and which are proposed by hospitals regulated according to the total revenue system and are not longer subject to certificate of need review under the Maine Certificate of Need Act.

8. Standard component. The commission shall establish a standard component in establishing revenue limits in accordance with section 9031, to be phased in in equal installments over a 5-year period beginning no sooner than October 1, 1990. The standard may not exceed 50% of the payment at the end of the phase-in period, and shall include operating costs and the costs of movable equipment, but shall exclude costs associated with buildings and fixed equipment.

The commission may modify or waive the standard component for a hospital regulated under the total revenue system as established under section 9031, subsection 4, if the hospital would be

substantially disadvantaged by the incorporation of a standard, and could not avoid this disadvantage by management action.

9. 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.

10. 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 hospital restructuring, as defined pursuant to section 9043.

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

11. 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. 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 9011 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 9022, provided that, in the case of a conversion to an October 1st fiscal year which the commission is required to approve pursuant to section 9022, 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.

C. In determining payment year financial requirements, the commission shall include an adjustment to reflect the reasonable costs, including reasonable attorneys' fees, incurred by a hospital to prosecute an appeal of a commission decision pursuant to section 9061, subsection 4, provided that the adjustment shall reflect only those reasonable costs that are associated with the issues on which the hospital has prevailed in court, including costs associated with presenting those issues to the commission in the case from which the appeal was taken. The commission shall make an adjustment under this paragraph only to the extent that the costs found to be reasonable are not otherwise included in financial requirements.

D. Until August 4, 1991, in determining payment-year financial requirements, the commission shall include an adjustment to reflect the actual costs of the hospital's participation in the Health Occupations Training Project, Title 26, chapter 31. These costs shall be limited to actual payments made to lenders under the program. The commission shall make an adjustment under this paragraph only to the extent the costs found to be reasonable are not otherwise included in financial requirements.

E. Beginning August 4, 1991, in determining payment-year financial requirements, the commission shall include an adjustment for the hospital's assessment by the Maine High-Risk Insurance Organization pursuant to Title 24-A, section 6052, subsection 2.

F. In determining payment year financial requirements, the commission shall include an adjustment for the hospital's assessment under Title 36, section 2801.

12. **Base-year budget adjustment.** In determining financial requirements for the 3rd payment year, or any subsequent payment

year, the commission upon application of a hospital, may elect to make a base-year budget correction adjustment as follows:

A. An adjustment under this subsection shall be based upon a determination of the excess of:

(1) The applicant hospital's actual audited Medicare allowable costs for its base year, adjusted to conform to the definition of base-year financial requirements established in accordance with section 9032; and

(2) Its base-year financial requirements determined in accordance with section 9033.

B. In determining the amount of the excess upon which an adjustment may be based, the commission:

(1) Shall consider the extent to which other adjustments have been made under this section for changes that occurred during the base year; and

(2) Shall adjust the amount determined under paragraph A to reflect the impact, determined by means of the economic trend factor established in accordance with subsection 1, of inflation from the base year through the payment year prior to the year for which an adjustment has been requested.

C. The commission shall make an adjustment for all or part of the excess determined in accordance with paragraphs A and B, to the extent that the commission finds that the adjustment is in the public interest. In determining whether the adjustment is in the public interest and, if so, in what amount the adjustment shall be made, the commission shall consider the following factors, as well as any other factors pertinent to the findings and purposes set forth in section 9001:

(1) The hospital's justification for exceeding its budget as approved by the voluntary budget review organization;

(2) The hospital's costs, volume and intensity of services as compared to other comparable hospitals;

(3) The hardship to the hospital in the absence of treatment under this section; and

(4) The impact on quality and accessibility to health care.

D. No hospital may receive more than one adjustment under this subsection, nor shall any hospital be eligible for such an adjustment if the commission, after hearing, has made a final decision denying the adjustment. An adjustment under this subsection shall become part of payment year financial requirements for purposes of computing subsequent payment year requirements pursuant to section 9034.

13. 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.

14. 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 11, paragraph B, 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 9034 for a subsequent payment year. The commission may determine from the nature of the exception adjusted or in subsection 15, whether that adjustment is to be included in payment year financial requirements for purposes of computing financial requirements for a subsequent payment year.

15. Exception requests. The commission shall establish a mechanism whereby a hospital may request adjustments to its financial requirements to accommodate increases in expenses which it believes have not been adequately accommodated in the adjustments in this section.

The commission may reduce the proposed or established revenue limits if it deems that the total financial requirements of a hospital which has filed an exception request are unreasonable.

Exception requests shall be limited to one or more major items having a reasonable net impact on financial requirements of at

least 1.5% of the previous years's financial requirements adjusted for economic trends according to subsections 1 and 2 or $1,000,000, whichever is less, and which are not adequately taken into account in the factors and formulas used to develop the rates. The commission may establish reasonable limits on the number of items that may be accumulated to reach this threshold.

§9036. 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.

A. Except as provided in paragraphs C and D, restricted and unrestricted gifts, grants, devises or income from investment thereof shall not be considered available resources.

B. Except as provided in paragraph E, accumulated income from operations and income from investment thereof shall not be considered available resources.

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

D. Donor restricted gifts, grants, devises or restricted income from investment thereof shall be considered available resources only to the extent these funds are applied to the use for which they were donated, except that the purchase of movable equipment with any such funds in years following the completion of a hospital's base year shall not operate to reduce the allowance for facilities and equipment otherwise determined under section 9035, subsection 4.

E. Accumulated income from operations and income from investment thereof shall be offset against financial requirements in the first payment year to the extent such income resulted from a hospital exceeding, for its base year and the period between its base year and the commencement of its first payment year, combined, the following limits:

(1) For a hospital whose base year is its most recent fiscal year ending prior to July 1, 1984, the amount of its budgeted operating margin for the base year, as set forth in its approved base year budget, multiplied by 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; 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.

F. Financial resources of affiliated interests, as defined in section 9043, shall be considered as resources available to a hospital to the extent specified in section 9043.

G. 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 F 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 9007, the commission shall not publicly disclose the individual identity of sources of gifts and grants.

3. Financing certain projects. Nothing in this section or in section 9043 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.

§9037. Revenue deductions

In establishing revenue limits for an individual hospital, the commission shall make provision for the revenue deductions determined in accordance with subsections 1 to 3, offset as appropriate by any distributions that the hospital will receive in the same payment year from the fund established in subsection 4.

1. Charity care. The commission shall make provision for a reasonable amount of revenue deduction attributable to charity care. For purposes of this section, the amount of revenue deduction attributable to charity care shall be defined as the

amount of revenue, net of recoveries, which is expected to be written off as a result of a determination that the patient is unable to pay for the hospital services received, provided that the hospital's determination is made pursuant to a policy which was adopted by the hospital and filed with the commission and which is consistent with reasonable guidelines established by the commission in accordance with this section. The commission shall adopt income guidelines which are consistent with the current guidelines of the Hill-Burton Program, at 42 Code of Federal Regulations, Section 124.506, as revised as of October 1, 1986. The guidelines and policies shall include the requirement that upon admission, or in cases of emergency admission, before discharge of a patient, hospitals shall investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. If the hospital's services to the patients are not covered by insurance or a medical assistance program and the patient meets the financial guidelines established by the commission, the services shall be provided as charitable care. This section shall not prevent a hospital from establishing a policy of charitable care which includes services not included in this subsection, if permitted by the commission's guidelines. In no event may hospital services to a person who meets the financial eligibility guidelines, adopted pursuant to this section, be billed to the patient or to a municipality.

2. Bad debts. The commission shall make provision for a reasonable amount of revenue deduction attributable to bad debts. For purposes of this section, bad debts shall be defined as the amount of revenue deduction, net of recoveries, which is expected to be attributable to patients who, after reasonable collection efforts, are determined to have uncollectible accounts, provided that the hospital's determination is made pursuant to a policy which was adopted by the hospital and filed with the commission and which is consistent with reasonable guidelines established by the commission.

3. Differentials. The commission shall provide for revenue deductions which reflect differentials established and approved pursuant to section 9038.

4. Uncompensated care fund. The commission shall establish and administer a fund called the Hospital Uncompensated Care Fund from which it will disburse amounts to hospitals most affected by bad debts, charity care and shortfalls in governmental payments relative to the financial requirements of the hospitals.

The commission shall develop standards for the distribution of the funds to individual hospitals which shall consider the following factors:

A. The impact of the proportion of Medicare and Medicaid payments;

B. The special disadvantages of the Medicare payment system for rural hospitals;

C. The proportion of charges to nonpaying patients;

D. The efficiency of the hospital; and

E. The financial distress of the hospital and the plan of the hospital to relieve that distress.

The Hospital Uncompensated Care Fund shall be funded by any appropriation the Legislature may make or an assessment authorized by the commission not to exceed .75% of net patient service revenues annually or both. Any unexpended funds appropriated by the Legislature to carry out the purposes of this program shall not lapse, but shall be carried forward for continued use in the program.

§9038. Differentials

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

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

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

C. Any other 3rd-party payors or purchasers who make prompt payments, as defined by the commission by regulation, shall be entitled to a differential, the value of which shall be related to the time value of money as determined by the commission, or such other differential as may be granted by a hospital pursuant to a policy which was in effect on May 1, 1983.

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

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

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

(1) The commission may institute a study of objective methods of computing a statewide differential, including a review and determination of the relevant and justifiable economic factors which can be considered in setting a differential. All hospitals and all payors shall cooperate fully with the commission in the conduct of the study and shall provide any data or other information which the commission may reasonably request. In the event that the commission requires the disclosure by a payor of privileged or confidential commercial or financial information, this information shall be exempt from public disclosure.

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

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

3. Approval of differentials. For payment years commencing on and after October 1, 1985, differentials may be approved in accordance with the following provisions.

A. Any 3rd-party payor or purchaser may apply to the commission for a reduction in the payments it would otherwise be required to make and the commission shall grant a reduction in payments commensurate with one or more components of the differential on a prospective basis if it finds:

(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 and those differentials for payments under the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, that are required, with respect to hospital admissions on or after January 1, 1987, as a condition of continued participation in the Medicare program administered under the United States Social Security Act, Title XVIII. 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.

§9039. Establishment of revenue limits

The commission shall establish revenue limits consistent with payment year financial requirements of the hospitals, adjusted for hospitals' available resources in accordance with section 9036 and deductions determined pursuant to section 9037.

§9040. Payments to hospitals

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

A. One component shall be designated "management fund revenue" and shall be equal to the adjustment, if any, for management support services determined under section 9035, subsection 11, paragraph A.

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

2. Apportionment among payors and purchasers. Based on historical or projected utilization data, the commission shall apportion, for each revenue center specified by the hospital subject to subsection 7, and for the hospital as a whole, the hospital's approved gross patient service revenue among the following categories:

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

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

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

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

(1) The commission shall require major 3rd-party payors to make biweekly periodic interim payments to hospitals, provided that any such payor may, on its own initiative, make more frequent payments.

(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 to hospitals regulated according to the total revenue system, 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 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.

C. In addition to any reductions in payments to hospitals under paragraphs A and B, if a hospital exceeds any 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 on a hospital regulated according to the total revenue system, the commission shall consider whether the revenues received by a hospital met its approved financial requirements.

4. **Per case system.** Payments to hospitals on the per case system shall be made on the basis of charges established consistent with limits set by the commission under that system

Those hospitals may negotiate discounts to charges provided that no adjustments for these discounts may be made in the determination of per case limits.

5. Adjustments. The commission shall establish by rule the necessary adjustments to approved revenues in subsequent payment years for hospitals determined to have exceeded revenue limits in the per case system.

6. 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 9041, the portion, if any, of the payment which corresponds to the management fund revenue.

7. 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.

§9041. Establishment and administration of Management Support Fund; disbursements from fund

1. Establishment. There is established a statewide Management Support Fund administered by the commission. The assets of this fund shall be derived from the portion of the approved gross patient service revenue of each hospital, if any, in a fiscal year designated as management fund revenue and transmitted to the Management Support Fund pursuant to section 9040, subsections 1 and 6.

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

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

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

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

3. Disbursements from fund. One or more hospitals may apply to the commission to receive disbursements from the Management Support Fund. The commission shall establish criteria governing the approval of disbursements from the fund which shall, at a minimum:

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

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

Disbursements under this section shall not be offset against payment year financial requirements in computing a hospital's gross patient service revenue limit under section 9039.

§9042. Establishment of Hospital Development Account

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

A. "Major project" means a hospital project subject to review under the Maine Certificate of Need Act that has incremental annual capital and operating costs in its 3rd year of implementation, including a partial first fiscal year, of $150,000 or more.

B. "Minor project" means a hospital project subject to review under the Maine Certificate of Need Act that has incremental annual capital and operating costs in its 3rd fiscal year of implementation, including a partial first fiscal year, of less than $150,000.

C. "Payment year cycle" means each annual period of October 1st to September 30th beginning with the first payment year cycle of October 1, 1984, to September 30, 1985.

2. Certificate of Need Development Account. For the first and 2nd payment year cycles, as defined in subsection 1, the commission shall establish a statewide Certificate of Need Development Account to support the development and undertaking of projects which are subject to review pursuant to the Maine Certificate of Need Act. This account shall be administered as follows.

A. The commission shall credit the Certificate of Need Account with the following amounts:

(1) For the first payment year cycle, 1% of the sum of:

(a) The total budgeted expenses, including capital costs, of all hospitals, for their most recent fiscal year ending prior to July 1, 1984, which were submitted to and approved by a voluntary budget review organization prior to July 1, 1983; and

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

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

The amount to be credited in a particular payment year cycle will be deemed credited to the Certificate of Need Account as of the first day of that payment year cycle.

B. The commission shall approve an adjustment to a hospital's financial requirements under section 9035, subsection 6, paragraph A, for a project if:

(1) The project was subject to review and was approved by the department under the Maine Certificate of Need Act; and

(2) The associated incremental annual capital and operating costs do not exceed the amount remaining in the Certificate of Need Development Account as of the date of approval of the project by the department, after accounting for previously approved projects.

C. Debits and carry-overs shall be determined as follows.

(1) Except as provided in subparagraph (2), the commission shall debit against the Certificate of Need Development Account the full amount of the incremental annual capital and operating costs associated with each project for which an adjustment is approved under paragraph B. Incremental annual capital and operating costs shall be determined in the same manner as adjustments to financial requirements are determined

under section 9035, subsection 6, for the 3rd fiscal year of implementation of the project.

(2) In the case of a project which is approved in the first or 2nd payment year cycle and whose associated incremental annual capital and operating costs are determined to exceed $2,000,000, debits shall be made as follows:

(a) In the payment year cycle in which the project is approved, the commission shall debit against the Certificate of Need Development Account an amount equal to $2,000,000; and

(b) In the payment year cycle immediately following the cycle in which the project is approved, the commission shall debit against the Certificate of Need Development Account established under this subsection or the statewide component of the Hospital Development Account established under subsection 3 an amount equal to the difference between the incremental annual capital and operating costs associated with the project and the amount debited under division (a) in the previous payment year cycle.

(3) Amounts credited to the Certificate of Need Development Account for the first payment year cycle for which there are no debits shall be carried forward to the 2nd payment year cycle. Amounts credited to the Certificate of Need Development Account for the 2nd payment year cycle for which there are no debits shall be carried forward to the 3rd payment cycle as a credit to the statewide component of the Hospital Development Account established in accordance with subsection 3.

3. Hospital Development Account. For the 3rd and subsequent payment year cycles, the commission shall establish a Hospital Development Account to support the development of hospital facilities and services. This account shall be administered as follows.

A. The commission shall annually establish, by rule, the amount to be credited to the Hospital Development Account. In establishing the amount of the credit, the commission shall, at a minimum, consider:

(1) The State Health Plan;

(2) The ability of the citizens of the State to underwrite the additional costs;

(3) The limitations imposed on payments for new facilities and services by the Federal Government pursuant to the United States Social Security Act, Title XVIII and XIX;

(4) The special needs of small hospitals;

(5) The historic needs and experience of hospitals over the past 5 years;

(6) The amount in the account for the previous years and the level of utilization by hospitals in those years;

(7) Obsolescence of physical plants;

(8) Technological developments; and

(9) Management services or other improvements in the quality of care.

The commission shall report, no later than January 15th of each year, to the joint standing committee of the Legislature having jurisdiction over human resources regarding the rationale the commission used in establishing the amount credited to the Hospital Development Account in the previous year.

The amount to be credited in a particular payment year cycle will be deemed credited to the Hospital Development Account as of the first day of that payment year cycle.

B. The commission shall approve an adjustment to a hospital's financial requirements under section 9035, subsection 6, paragraph A, for a major or minor project if:

(1) The project was approved by the department under the Maine Certificate of Need Act; and

(2) The associated incremental annual capital and operating costs do not exceed the amount remaining in the Hospital Development Account as of the date of approval of the project by the department, after accounting for previously approved projects.

C. Debits and carry-overs shall be determined as follows.

(1) Except as provided in subparagraph (2), the commission shall debit against the Hospital Development Account the full amount of the incremental annual capital and operating costs associated with each project for which an adjustment is approved under

paragraph B. Incremental annual capital and operating costs shall be determined in the same manner as adjustments to financial requirements are determined under section 9035, subsection 6, for the 3rd fiscal year of implementation of the project.

(2) In the case of a project which is approved under paragraph B and which involves extraordinary incremental annual capital and operating costs, the commission may, in accordance with duly promulgated rules, defer the debiting of a portion of the annual costs associated with the project until a subsequent payment year cycle or cycles.

4. Repeal. This section is repealed effective October 1, 1990.

§9043. 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 who is a subsidiary of a hospital;

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

(3) Any person who is a subsidiary of a hospital's parent entity;

(4) Any person, other than an individual, who:

(a) Controls a hospital or which a hospital, or any of its affiliates as defined in subparagraphs (1) to (3), controls; and

(b) Which is engaged directly or indirectly in the provision of a health care service or services, the costs of which would be considered elements of financial requirements if performed by a hospital.

B. "Available assets" means the sum of board-designated funds and current assets less inventories and net receivables.

C. For purposes of paragraph A, to "control" means both:

(1) To have power, alone or in concert with other hospitals or affiliated interests, to direct the

management and policies of another person, other than an individual; and

(2) To have that power by means of any one of the following or any combination of the following:

(a) Common governing board members;

(b) Articles of incorporation, by-laws, partnership agreements, contracts, deeds, trust documents, assignments, leases or other legal documents; or

(c) In the case of a for-profit corporation, ownership of 10% or more of the corporation's voting securities, directly, indirectly or by a chain of successive ownership.

"Control" does not include the power to determine terms, conditions and prices only through an arms-length contract for the purchase of goods or services, such as a contract for professional services or the power to direct management and policies only through canonical or similar religious control.

D. "Hospital-capitalized affiliate" means any affiliated interest that was capitalized, in whole or in part, by transfers of assets from a hospital or another hospital-capitalized affiliate, unless one of the following applies:

(1) The affiliated interest has returned to the hospital, with interest at a market rate, all assets transferred to it by the hospital or another hospital-capitalized affiliate;

(2) All of the assets transferred to the affiliated interest by the hospital or hospital-capitalized affiliate were exempt under subsection 4, paragraph F; or

(3) The total assets received by the affiliated interest from the hospital or any hospital-capitalized affiliate do not exceed $10,000.

E. "Hospital restructuring" means any one of the following:

(1) Transfer of any assets of a hospital or hospital-capitalized affiliate to any person, provided that the transfer of assets to a title-holding company within the meaning of the United States Internal Revenue Code, Section 501, paragraph C, subparagraph

(2), that holds property on behalf of the transferor shall not be considered a hospital restructuring;

(2) Pledge of a hospital's assets or credit or pledge of the assets or credit of a hospital-capitalized affiliate, to secure the financial obligation of another person;

(3) Transfer of an existing service or function, directly or indirectly, by a hospital to an affiliated interest or an entity which, as a result of the transfer would become an affiliated interest;

(4) Undertaking by an affiliated interest or an entity which as a result of the undertaking would become an affiliated interest of any health care service whose associated costs would be considered elements of financial requirements if performed by a hospital;

(5) Entry of a hospital or hospital-capitalized affiliate into a partnership as a general partner, or any similar act by means of which a hospital or hospital-capitalized affiliate assumes or acquires general liability or responsibility for the obligations, acts or omissions of a business venture other than one undertaken solely by the hospital;

(6) Creation, organization, acquisition or transfer, directly or indirectly, of a subsidiary of a hospital;

(7) Creation or organization, directly or indirectly, of a parent entity of a hospital by any means, including without limitation, the acquisition by any person of ownership or control of a hospital or its existing parent entity; and

(8) Merger of a hospital or its parent entity with any person or any transaction functionally equivalent to a merger.

F. "Related party" means any person, other than an affiliated interest as defined in paragraph A, that would be considered related to the hospital, as defined under the Medicare program established pursuant to the United States Social Security Act, Title XVIII.

G. "Significant transaction" means a transaction if it has an actual or imputed value or worth in excess of $10,000 or more for a fiscal year or if the total amount of the contract price, consideration and other advances by the institution on account of the transactions is $10,000 or more for the fiscal year.

H. "Subsidiary" means a person over which another person exercises majority control by virtue of voting stock of a for-profit corporation or voting members of a not-for-profit corporation.

I. "Transfer of assets," for purposes of paragraphs D and E, means any transaction if, and to the extent that, the fair market value of any assets conveyed by the hospital or hospital-capitalized affiliate in that transaction exceeds the value of any consideration received by the hospital or hospital-capitalized affiliate. Transfers of assets under this definition include loans at interest rates below market levels.

2. Reporting and consideration of significant transactions; corporate plans. Statements of significant transactions and corporate plans shall be submitted and considered as follows.

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

B. In determining base year financial requirements pursuant to section 9033 or in establishing adjustments for productivity or other factors pursuant to section 9035, the commission may disregard unreasonable or unnecessary costs under significant transactions between a hospital and the persons specified in paragraph A.

C. Each hospital which has or will have affiliated interests, and which has not elected to determine the resources available from those affiliates under subsection 5, paragraph C, shall file, at such time as may be reasonably established by the commission, a 5-year corporate plan containing information as specified by the commission. 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 9036, subsection 1, paragraph F. 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 interests 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 9007, 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 or related party 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. Hospital restructuring. Unless exempt by rule or order of the commission or by paragraph F, no hospital restructuring may take place without the approval of the commission. No hospital restructuring may be approved by the commission unless it is established by the applicant for approval that the hospital restructuring is consistent with the interests of the people of the State.

A. The following procedures shall apply to an application for approval of a hospital restructuring.

(1) Except as provided in subparagraph (2), the commission shall rule upon all requests for approval of a hospital restructuring within 90 days of the filing

date. The filing date shall be the date when the commission notifies the applicant that the filing is complete.

(2) If the commission deems that the necessary investigation cannot be concluded within 90 days after the filing date, the commission may extend the period for a further period of no more than 90 days. If the commission fails to make a final ruling on or before the end of the 2nd 90-day period or such later date as may be fixed by agreement of all parties, the application shall be deemed disapproved.

(3) Review of hospital restructurings that are also subject to review under the Maine Certificate of Need Act shall, to the maximum extent practicable, be conducted simultaneously with the department's review under the Act.

B. In granting its approval, the commission shall impose such terms, considerations or requirements as, in its judgment, are necessary to protect the interests of payors and purchasers. These conditions shall include provisions which assure the following.

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

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

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

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

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

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

(7) The requirements of subsection 5 will be met.

C. The commission may adopt rules providing for the filing by hospitals of information by means of which the commission

may verify that acts or events that require approval under this subsection are not occurring without such approval. This rule-making authority shall not be construed to permit general review of the prudence of ordinary hospital investments of endowments.

D. For purposes of this subsection, the commission shall review a filing and, if additional information is necessary to determine the filing complete, shall make its initial request for such additional information within 30 days of its receipt of the filing and shall make any subsequent requests within 15 days of its receipt of the previously requested information.

E. Any hospital or affiliated interest of a hospital may apply to the commission for an advance determination as to the applicability of this subsection to a particular set of facts. The commission shall issue such an advance determination within 30 days of the filing of a complete request. A completed request is one containing such information as the commission may specify by rule and with respect to which the requesting party has given such reasonable notice to other affected persons as may be required by commission rule.

F. A hospital or hospital-capitalized affiliate may engage in a hospital restructuring without commission approval if:

(1) The hospital restructuring is a transfer or pledge that falls solely within subsection 1, paragraph E, subparagraph (1) or (2); and

(2) The aggregate value of all such transfers and pledges, as of the time immediately following the hospital restructuring, does not exceed 10% of the lesser of the net worth or the available assets of the hospital or hospital-capitalized affiliate, as determined as of the end of the most recent fiscal year for which a complete financial statement is available prior to the restructuring.

5. Determination of available resources; exemption from corporate plan requirement. Unless a hospital has elected to have available resources determined under paragraph C, such resources shall be determined under paragraph B.

A. For purposes of this subsection, the "hospital's portion" shall be the proportion of the total capitalization of the affiliated interest that is owned by or was provided by the hospital and any hospital-capitalized affiliate.

B. 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 to be applied to hospital financial requirements pursuant to section 9036.

(1) Gifts, grants and income from investments received by affiliated interests shall not be considered available resources.

(2) The hospital's portion of excess revenues of nonprofit affiliated interests and the hospital's portion of 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 the 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.

(3) Of the amounts determined under subparagraph (2), 50% shall be offset generally against hospital financial requirements.

C. A hospital may elect not to file corporate plans and updates under subsection 2. A hospital that makes such an election shall annually file complete financial statements of each of its affiliated interests and, if available, audited, consolidated financial statements with the commission. Available resources from the affiliated interests of a hospital that makes an election under this paragraph shall be determined as follows: Fifty percent of the hospital's portion of all excess revenues of nonprofit affiliated interests and 50% of the hospital's portion of all profits of for-profit affiliated interests shall be applied to hospital financial requirements. In determining total profits or excess revenues, the commission may consider the reasonableness of reported expenses. The amount of 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. Gifts, grants and income from investments received by affiliated interests shall not be considered available resources.

6. By November 1, 1986, the commission shall adopt rules governing hospital restructuring and significant transactions as

defined in this chapter, including, but not limited to, rules addressing the following subjects:

A. The nature and format of applications for hospital restructuring;

B. The content of requests for advance determinations under subsection 4, paragraph E, and the procedure governing such determinations;

C. A mechanism for providing and updating a list of entities or corporations to which the significant transactions reporting requirements in subsection 2, paragraph A, apply;

D. The information filings referred to in subsection 4, paragraph C; and

E. The filing of corporate plans under subsection 2, paragraph C.

7. Repeal. This section is repealed effective October 1, 1990.

§9044. 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.

§9045. 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.

§9046. 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.

The commission may waive any statutory requirements for hospital demonstration projects which further the goals described in section 9001, subsection 2. The commission shall review hospitals with approved demonstration projects and may collect data to monitor performance, and require compliance adjustments if the conditions of deregulation are contravened. The commission may terminate a demonstration if it determines that the hospital has not substantially complied with the terms of the demonstration project.

§9047. Advisory committees

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

A. The commission shall appoint 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 appoint 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 appoint a Payor Advisory Committee consisting of one representative of nonprofit hospital and medical service corporations, one representative of commercial insurance companies, one representative of self-insured groups and one representative of the department. This committee shall advise the commission and its staff with respect to analytical techniques, data requirements and other technical matters involved in implementing and administering the health care financing system established under this subchapter.

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

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

4. Meetings; assistance. Each committee established under subsection 1 may meet as it deems appropriate and the commission shall provide it such staff assistance and information as it reasonably requires in the performance of its functions.

§9048. Quarterly report

By September 15, 1988, and quarterly thereafter, the commission shall report to the Bureau of Taxation the amount of financial requirements for the most recently completed quarter of each hospital's payment year, determined by dividing the financial requirements for the applicable payment year by 4.

SUBCHAPTER IV

PROCEDURES

§9061. Proceedings generally

1. Proceedings. Proceedings before the commission shall be subject to such provisions of the Maine Administrative Procedure

Act, Title 5, chapter 375, as may apply to each type of proceeding that the commission conducts under this chapter. All proceedings shall also be subject to such additional rules of practice as the commission may promulgate consistent with the Maine Administrative Procedure Act, Title 5, chapter 375.

2. Substantial compliance. A substantial compliance with the requirements of this chapter shall be sufficient to give effect to all the rules, orders, acts and regulations of the commission and, except as otherwise provided in Title 5, section 8057 with respect to rules, they shall not be declared inoperative, illegal or void for any omission of a technical and immaterial nature in respect thereto.

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

§9062. 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. No less than 150 days before the start of each payment year, every hospital shall file, on forms provided by the commission, the revenue limit or limits for which it requests approval for that payment year. The forms specified by the commission shall require disclosure of all information in support of the computation of the requested revenue limits and any information needed to evaluate the requested limits. If no notice of opposition or inquiry with respect to the requested limits is filed within the period of time specified by the commission by an affected hospital, affiliated interest, payor, group of purchasers, or commission staff designated for that purpose by the commission, then the requested limits shall take effect on the first day of the applicable payment year. Otherwise, the commission, after hearing before it or a duly appointed and sworn hearing examiner, shall decide whether to approve, disapprove, or modify the requested limit or limits. If the commission does not 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 150 days after the start of the payment year.

2. Interim adjustments. Upon application by a hospital, affiliated interest, payor or group of purchasers, for an interim adjustment to financial requirements permitted under section 9035, or upon application by a payor or group of purchasers for a modification of its approved differential or of the apportionment of the gross patient service revenue, and after opportunity for hearing, a final order shall be promulgated within 120 days from the date a completed application was filed, except that the commission may extend the 120-day period by an additional 60 days with respect to an application for an adjustment under section 9035, subsection 12. Any proposed change shall take effect upon the date specified in the order. At any time during the period between the filing date and the commission's final decision on the request, the commission may extend provisional approval to any part of the request. This provisional approval shall be superseded by the commission's final decision on the request. The commission may establish reasonable limits on the frequency of requests filed under this subsection.

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

4. Informal participation in commission deliberations on rulemaking. The commission, in its discretion, shall permit informal participation of members of the public and representatives of affected groups in its deliberations relating to rulemaking. This participation is limited solely to matters which clarify the deliberations.

§9063. Other powers

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

Sec. 18. Transition. Sections 5 to 15 of this Act shall take effect October 1, 1991. The remainder of this Act shall take effect October 1, 1989. The hospital care financing system established in section 17 of this Act shall apply to hospital payment years beginning on or after October 1, 1990.

The commission shall administer the hospital care financing system established by the Maine Revised Statutes, Title 11, chapter 107 as those provisions of law existed prior to the effective date of this Act, with respect to all hospital payment years beginning before October 1, 1990. The continuing authority provided by this section shall extend to the determination and enforcement of compliance with revenue limits for those earlier payment years and to the settlement of payments and adjustments of overcharges and undercharges for those years, in proceedings that may be commenced after the close of those years. Nothing in this Act shall be construed to limit the authority of the commission to enforce compliance with or seek penalties for violation of any provision of Title 22, chapter 107 that was in effect at the time of the act, event, or failure to act with respect to which enforcement action is taken or penalties are sought.

Sec. 19. Advisory Commission.

1. Establishment. The Hospital Rate Setting Advisory Commission is established to study and develop recommendations regarding retention, amendment or repeal of provisions of this Act relating to the hospital development account and affiliated interests of hospitals.

2. Composition. The commission shall be composed of 7 members.

The Governor shall appoint one representative of the Maine Hospital Rate Setting Commission and one representative of the Department of Human Services. The President of the Senate and Speaker of the House shall jointly appoint one Legislator; one physician or other medical professional; one representative of the hospital community; one payor; and one consumer of health care services. Appointments shall be made within 30 days of the effective date of this Act. The Chair of the Legislative Council shall call the first meeting of the advisory commission. The commission shall elect a chair from among its membership.

3. Reports. The advisory commission shall report its findings to the Joint Standing Committee on Human Resources, by January 15, 1990.

4. Staff. The Department of Human Services shall provide staff to the advisory commission for the duration of the study. If legislation is recommended, the Office of the Attorney General shall provide assistance with drafting.

5. Expenses. The member of the advisory commission who is a Legislator shall receive the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2 for each day's

attendance at advisory commission meetings. All members who do not represent state agencies shall receive expenses for attending commission meetings upon application to the Executive Director of the Legislative Council.

6. Sunset. This section is repealed January 16, 1990.

Sec. 20. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1989-90	1990-91
MAINE HOSPITAL RATE SETTING COMMISSION		
Hospital Uncompensated Care Fund		
All Other	$30,000,000	$30,000,000
Provides funds to distribute to hospitals most affected by bad debts, charity care and shortfalls in governmental payments relative to the financial requirements of hospitals.		
Hospital Rate Setting Advisory Commission		
Personal Services	$275	
All Other	1,750	
TOTAL	$2,025	
Provides funds for per diem for the legislative member and expenses for other members of the Hospital Rate Setting Advisory Commission.		
MAINE HOSPITAL RATE SETTING COMMISSION TOTAL	$30,002,025	$30,000,000

STATEMENT OF FACT

This bill amends the Maine Certificate of Need Act and repeals the current laws relating to the State's health care financing system and replaces them with a new law which incorporates the recommendations of the Blue Ribbon Commission on the Regulation of Health Care Expenditures. It should not be interpreted to indicate that the commission either supports or endorses sections of the laws for which the commission has made no recommendations.

This bill provides for the following key changes.

1. The bill retains the certificate of need process, but amends the Maine Certificate of Need Act to change the scope for hospital and other acute care services. The bill makes the following types of projects subject to certificate of need review:

A. Any hospital renovation or expansion project with a capital cost of $1,000,000 or more;

B. Purchase of movable equipment costing $1,000,000 or more, whatever the setting for that equipment; or

C. Any increase in licensed bed capacity of hospitals by more than 10% or more than 5 beds, whichever is less.

2. The bill changes the name of the regulatory body, the Maine Health Care Finance Commission, to the Maine Hospital Rate Setting Commission and provides for the gubernatorial appointment of 3 full-time commission members, whose appointments shall take effect on October 1, 1989. The chair shall serve as the executive director.

3. The bill directs the commission to establish a number of alternative systems to be available for the regulation of hospital rates or revenues. These systems include:

A. An average revenue per case payment system, which has 2 components. The first component requires the commission to establish a limit on average revenue that a hospital may charge per case mix adjusted admission for inpatient services. The 2nd component directs the commission to regulate outpatient services by setting the rate per unit of service by department for outpatient services;

B. A total revenue system which may be chosen by hospitals which are in relatively self-contained catchment areas, not in direct competition with other hospitals. This system covers both inpatient and outpatient services;

C. Encouragement of demonstration projects. The commission has the authority to waive regulatory requirements for projects which prove to further the goals of accessible,

affordable and quality health care. An example of the authority is the authority to permit low cost providers to be essentially deregulated for inpatient and outpatient services. The providers would continue to be subject to oversight by the commission; and

D. Alternative regulatory options for hospitals defined by the commission as being unique or different within the Maine Health Care System. Examples of unique hospitals are psychiatric and rehabilitation hospitals.

4. The bill directs the commission to establish a standard component in the payment rates of hospitals regulated according to the per case and total revenue systems, to be phased in over a 5-year period.

5. The bill adds a variable adjustment or "plus" factor to the current law's inflation adjustment factor to allow for changes in technology, changes in medical practice and increased severity of illness not accounted for by the case mix system and the aging of the population.

6. The bill allows hospitals on the per case payment system to negotiate discounts to charges provided that no adjustments for these discounts may be made in the determination of per case limits.

7. The bill includes an exception request provision, which is limited to major items, that is, items having an impact on costs or revenues greater than the lesser of $1,000,000 or 1.5% of the total costs of the hospital, and which are not taken into account in the formula and factors used to develop the rates.

The commission may reduce the charges if a hospital files an exception request and the commission determines that the hospital charges are too high.

8. The bill provides for an annual appropriation of $30,000,000 from the General Fund to a fund administered by the commission to provide relief to hospitals most affected by bad debts, charity care and shortfalls in governmental payments relative to the financial requirements of the hospitals.

9. The bill repeals the provision which sunseted the existing commission as of October 1, 1989, and provides a transition provision. According to the transition provision, the changes to the Maine Certificate of Need Act will not take effect until after October 1, 1991. The changes to the financing system will not take effect until October 1, 1990. The current financing system will continue under the administration of the full-time commission members appointed on October 1, 1989 until the changes take effect in 1990.

10. The bill sunsets the sections relating to the hospital development account and affiliated interests and establishes an advisory commission to review these sections and make recommendations to the Legislature and the Maine Hospital Rate Setting Commission by January 15, 1990.