L.D. 1322

(Filing No. H-653)

STATE OF MAINE
HOUSE OF REPRESENTATIVES
114TH LEGISLATURE
FIRST REGULAR SESSION

HOUSE AMENDMENT "A" to COMMITTEE AMENDMENT "A" to H.P. 954, L.D. 1322, Bill, "An Act to Improve Access to Health Care and Relieve Hospital Costs Due to Charity and Bad Debt Care Which are Currently Shifted to Third-party Payors"

Amend the amendment by inserting after the title the following:

'Amend the bill in the emergency preamble by inserting after the 4th paragraph the following:

'**Whereas,** this Act authorizes a study of important health finance issues which must be completed by December 15, 1989; and

Whereas, the study commission must begin its work as soon as possible to meet the completion date; and' '

Further amend the amendment by striking out all of sections 1 to 7 and inserting in their place the following:

'**Sec. 1. 3 MRSA §507, sub-§8, ¶A,** as repealed and replaced by PL 1985, c. 763, Pt.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 Health Care Finance Commission.

Sec. 2. 5 MRSA §12004-I, sub-§35-A is enacted to read:

35-A. Human Services	Maine Health Program Council	Expenses Only	22 MRSA §3189

Sec. 3. 22 MRSA §304-D, sub-§1, ¶B, as enacted by PL 1985, c. 661, §2, is repealed.

Sec. 4. 22 MRSA §304-D, sub-§4, as enacted by PL 1985, c. 661, §2, is repealed.

Sec. 5. 22 MRSA §382, sub-§1-A is enacted to read:

1-A. Border hospital. "Border hospital" means a hospital located in this State within 10 miles of the New Hampshire border.

Sec. 6. 22 MRSA §382, sub-§16-A is enacted to read:

16-A. Revenue limit. "Revenue limit" means the revenue per case, the rate per unit of outpatient service, the total outpatient revenue or the total revenue approved by the commission under section 396.

Sec. 7. 22 MRSA §388, sub-§1, ¶A, as amended by PL 1987, c. 73, is further amended to read:

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; and

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

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

Sec. 8. 22 MRSA §388, sub-§5 is enacted to read:

5. Review of exception threshold and variable adjustment factor. The basis for, and the commission's experience with, the threshold on exception requests in section 396-D, subsection 12, and the variable adjustment factor in section 396-D, subsection 1-A, shall be reviewed after these provisions have been in operation for 2 years. By October 1, 1993, 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.

Sec. 9. 22 MRSA §396, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

§396. Establishment of revenue limits and apportionment methods

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

2. Criteria. Subject to more specific provisions contained in this subchapter, the revenue limits and apportionment methods established by the commission shall ensure 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 inpatient admission.

B. For payment years beginning or deemed to begin on or after October 1, 1992, the commission shall regulate outpatient services by setting the rate per unit of service by department. For payment years beginning or deemed to begin before October 1, 1992, the commission shall establish revenue limits for outpatient services using methods consistent with those used in setting gross patient service revenue limits for payment years beginning prior to October 1, 1990. Nothing in this paragraph prohibits the commission from refining or modifying the method of adjusting for outpatient volume.

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

A. Criteria shall include, but not be limited to:

(1) Distance of the hospital in miles and travel time from the nearest other hospital; and

(2) Utilization of existing hospital services by patients within the catchment area.

B. The commission shall establish a procedure by which, and time limits within which, an eligible hospital may initially elect to participate in the total revenue system. The commission shall also establish the procedures and conditions under which an eligible hospital may choose to be regulated under the per case or total revenue system after the period provided for the initial election. These conditions may include, but are not limited to, reasonable limits on the frequency with which an eligible hospital may choose to transfer from one regulatory system to the other.

C. A hospital that is not eligible to choose to participate in the total revenue system may request the commission's approval to participate in the total revenue system for a period of no more than 2 years. The commission may approve the request if it determines that the hospital is experiencing significant financial problems and is in the process of making a transition to a different scope or type of service. The commission shall require the hospital to establish that the approval of its request to participate in the total revenue system would be consistent with the orderly and economic development of the health care system.

D. The commission shall establish the total gross patient service revenue limit for inpatient and outpatient services

for hospitals that apply for this system and 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. Specialty hospitals. The commission shall provide alternative regulatory options for hospitals defined by the commission as being specialty hospitals.

7. Return on investment. The revenue limits established by the commission under this chapter shall, in the case of a proprietary, 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.

Sec. 10. 22 MRSA §396-D, sub-§1, as enacted by PL 1983, c. 579, §10, is amended to read:

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.

The proxy or proxies chosen by the commission to measure the reasonable increase in employee compensation shall reflect the experience of workers in the Northeast and regions of this State who are reasonably representative of professional medical personnel and other hospital workers.

~~It~~ The commission 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.

Sec. 11. 22 MRSA §396-D, sub-§1-A is enacted to read:

1-A. Variable adjustment factor. In determining payment year financial requirements, the commission shall include an adjustment based upon a factor, fixed by the commission between 0.5% and 2.0%, which shall be added to the percentage adjustment for inflation determined pursuant to 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.

Sec. 12. 22 MRSA §396-D, sub-§2, ¶B, as enacted by PL 1983, c. 579, §10, is amended to read:

B. 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 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.

Sec. 13. 22 MRSA §396-D, sub-§2, ¶C is enacted to read:

C. 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 60% to 90%, giving consideration to the characteristics of inpatient and outpatient services and hospital size. This paragraph is repealed October 1, 1991.

Sec. 14. 22 MRSA §396-D, sub-§3, ¶A, as amended by PL 1985, c. 661, §7, is further amended to read:

A. An allowance for the cost of facilities and fixed equipment shall include~~:~~ allowances for straight line depreciation and interest expense, less interest income on debt service reserve funds available to the hospital.

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

~~(2) Annual contributions to a sinking fund sufficient to provide a down payment on replacement facilities and fixed equipment. The sinking fund shall be required to be maintained by each hospital and the commission may include in it price level depreciation on fixed equipment or a portion of price level depreciation on facilities.~~

In determining payment year financial requirements, the commission shall include an adjustment in the allowance for facilities and fixed equipment to reflect changes in ~~debt service~~ 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 5 ~~or subsection 9, paragraph D~~. 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.

Sec. 15. 22 MRSA §396-D, sub-§3, ¶B, as enacted by PL 1983, c. 579, §10, is amended to read:

B. An allowance for the cost of movable equipment shall be calculated on the basis of ~~price level~~ straight line depreciation and interest consistent with paragraph A. ~~The commission shall promulgate rules to define the manner in which price level depreciation is to be computed and adjustments are to be made to reflect changes from year to year. Funding of this depreciation shall be required as specified by the commission.~~

Sec. 16. 22 MRSA §396-D, sub-§3, ¶C is enacted to read:

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.

Sec. 17. 22 MRSA §396-D, sub-§4, ¶C, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 18. 22 MRSA §396-D, sub-§4, ¶D, as enacted by PL 1983, c. 579, §10, is amended is to read:

D. 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.

Sec. 19. 22 MRSA §396-D, sub-§4, ¶E is enacted to read:

E. 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 60% to 90%, giving consideration to the characteristics of inpatient and outpatient services and hospital size. This paragraph is repealed October 1, 1991.

Sec. 20. 22 MRSA §396-D, sub-§6, as repealed and replaced by PL 1987, c. 440, §2, is repealed.

Sec. 21. 22 MRSA §396-D, sub-§6-A is enacted to read:

6-A. Standard component. For payment years commencing on or after October 1, 1990, but no later than October 1, 1991, the commission shall establish reasonable standards of financial requirements or costs per case for hospitals. In determining financial requirements for payment years to which the standards apply, the commission shall include an adjustment to incorporate the standards into financial requirements as otherwise determined under this section.

A. The adjustment under this subsection shall apply to noncapital financial requirements and to the allowance for capital costs of movable equipment but shall exclude the allowance for the capital costs of facilities and fixed equipment determined under subsection 3.

B. The commission may exclude certain categories of operating costs in order to permit reasonable comparisons among hospitals.

C. The commission may exclude financial requirements associated with outpatient services from the adjustment under this subsection, either for all payment years or for some portion of the 5-year phase-in period.

D. The adjustment under this subsection shall be phased in over a 5-year period, distributed as equally over the 5 years as is practicable. At the end of the 5-year period, the standard component may not exceed 50% of those financial requirements to which the adjustment is applied.

E. The commission may waive or modify the standard component adjustment for a border hospital or a hospital regulated under the total revenue system if the commission finds that including the standard component in the hospital's financial requirements would impair the capacity of the hospital to provide needed services at acceptable levels of quality and the hospital could not avoid this impairment by management action.

Sec. 22. 22 MRSA §396-D, sub-§9, ¶B, as amended by PL 1987, c. 811, §12, is repealed.

Sec. 23. 22 MRSA §396-D, sub-§9, ¶D, as repealed and replaced by PL 1987, c. 402, Pt. A, §136, is repealed.

Sec. 24. 22 MRSA §396-D, sub-§9, ¶F, as amended by PL 1987, c. 542, Pt. H, §2 and as repealed and replaced by PL 1987, c. 777, §§1 and 6, is repealed.

Sec. 25. 22 MRSA §396-D, sub-§9, ¶¶F-1 and F-2 are enacted to read:

F-1. 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 that the costs found to be reasonable are not otherwise included in financial requirements.

F-2. 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.

Sec. 26. 22 MRSA §396-D, sub-§9, ¶G, as enacted by PL 1987, c. 769, Pt. A, §65, is repealed.

Sec. 27. 22 MRSA §396-D, sub-§9, ¶H, as enacted by PL 1987, c. 847, §1, is amended to read:

H. In determining payment year financial requirements, the commission shall include an adjustment for the hospital's assessment under Title 36, section ~~2800~~ 2801.

Sec. 28. 22 MRSA §396-D, sub-§11, ¶B, as enacted by PL 1983, c. 579, §10, is amended to read:

B. Adjustments made for a payment year for working capital, management support and those new regulatory costs specified in subsection 9, paragraph C, subparagraphs (1) and (2), shall not be considered part of base year or payment year financial requirements for purposes of computing payment year financial requirements pursuant to section 396-C for a subsequent payment year. The ~~commission may determine from the nature of the unforeseen circumstances whether that adjustment is to be included in~~ payment year ~~financial requirements for purposes of computing financial requirements for a subsequent payment year~~ or years to which an adjustment for an exception request applies shall be determined in accordance with subsection 12, paragraph C.

Sec. 29. 22 MRSA §396-D, sub-§12 is enacted to read:

12. Exception requests. The commission shall provide for a special exception adjustment whereby a hospital may request an adjustment to its financial requirements to reflect major, reasonable changes in expenses for which no adequate adjustment is otherwise provided under this chapter.

A. In determining whether and to what extent such an adjustment should be granted, the commission shall consider the following in addition to any more specific criteria that the commission may establish by rule:

(1) The nature and reasonableness of the changes in expenses for which an adjustment is under consideration, including any offsetting expense changes;

(2) The reasonableness and necessity of the hospital's total acute care operating expenses;

(3) The hospital's efficiency and its costs in comparison to other hospitals; and

(4) The effects on patients, purchasers and payors of any change in charges that would result from granting the adjustment.

After review of an exception request made pursuant to this subsection, the commission may, on the basis of the facts found, either increase or decrease the total financial requirements of a hospital.

B. A request that meets the requirements of paragraph A, but that would result in a positive adjustment equal to less than 1.5% of a hospital's financial requirements for the previous year or $1,000,000, whichever is less, shall not be granted, unless the applicant establishes either of the following:

(1) That the applicant's failure to receive the adjustment will immediately, seriously and irreparably impair its financial capacity to continue providing hospital services and that no alternative means of providing those services is available; or

(2) That denial of the adjustment would result in a groundless difference in regulatory treatment of similarly situated hospitals seeking relief under this subsection on the basis of essentially the same facts.

C. Except as provided in subparagraph (1), an adjustment pursuant to this subsection shall be included in a hospital's financial requirements only for periods of operation after the date on which the application for interim adjustment is deemed complete or the commencement of the payment year for which a timely notice of contest, requesting an adjustment under this subsection and containing supporting information specified by the commission, has been filed.

(1) An interim adjustment under this subsection may be applied to all or part of the period between the beginning of the payment year during which an application was filed and the date that the application was deemed complete if the commission finds that:

(a) The hospital would otherwise be unable to meet its cash requirements as a consequence of events beyond its control; or

(b) Such relief is consistent with the public interest.

(2) The commission may determine from the nature of the expenses for which the adjustment is made whether

it shall become a part of financial requirements for purposes of computing financial requirements for subsequent payment years.

Sec. 30. 22 MRSA §396-F, first ¶, as enacted by PL 1983, c. 579, §10, is amended to read:

In establishing revenue limits for an individual ~~hospitals~~ hospital, the commission shall make provision for the revenue deductions ~~in the following categories~~ 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.

Sec. 31. 22 MRSA §396-F, sub-§4, as enacted by PL 1987, c. 847, §2, is repealed and the following enacted in its place:

4. Hospital payments fund. There is established the Hospital Uncompensated Care and Governmental Payment Shortfall Fund, which may be referred to as the "hospital payments fund," administered by the commission. The assets of this fund shall be derived from any appropriation that the Legislature may make or from any portion of the approved gross patient service revenue of each hospital designated as hospital payments fund revenue pursuant to section 396-I, subsection 1, or from both of these sources.

A. The hospital payments fund shall be administered as follows.

(1) Except as otherwise provided, the Treasurer of State shall be the custodian of the hospital payments 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 for 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 authority for making payments upon these vouchers.

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

(3) 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.

B. The commission shall disburse amounts from the hospital payments fund to those hospitals most affected by bad debts,

charity care and shortfalls in governmental payments. The commission shall develop standards for the distribution of the funds to individual hospitals. The standards shall address the following factors:

(1) The impact of the proportion of Medicare and Medicaid payments;

(2) The special disadvantages of the Medicare payment system for rural hospitals;

(3) The proportion of charges to nonpaying patients;

(4) The efficiency of the hospital; and

(5) The financial distress of the hospital and the plan of the hospital to relieve that distress.

Sec. 32. 22 MRSA §396-H, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

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

The commission shall establish a gross patient service revenue limit or limits for each hospital for each payment year commencing on or after October 1, 1984. This limit shall be established as follows.

1. General computation. The gross patient service revenue limit or limits shall be computed to allow the hospital to charge an amount calculated to recover its payment year financial requirements, offset by its available resources pursuant to section 396-E, taking into consideration the revenue deductions determined pursuant to section 396-F and the payment system applicable to the hospital.

2. Hospital payments fund adjustment. For payment years or partial payment years on or after October 1, 1990, the commission may include in the gross patient service revenue limit an adjustment, based on a uniform percentage to be applied to all hospitals, to provide revenue to be transmitted to the hospital payments fund in accordance with section 396-I, subsections 1 and 6. The adjustment shall not exceed .75% of net patient service revenues annually.

Sec. 33. 22 MRSA §396-I, as enacted by PL 1983, c. 579, §10, is repealed and the following enacted in its place:

§396-I. Payments to hospitals

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

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

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

C. One component shall be designated "hospital payments fund revenue" and shall be equal to the adjustment, if any, determined under section 396-H, subsection 2, for the support of the hospital payments fund.

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

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

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

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

D. In addition to any reductions in payments to hospitals under paragraphs A, B and C, 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. Negotiated discounts. As of March 1, 1991, any hospital that is participating, or has chosen to participate or must participate, in the rate per case system, may negotiate discounts to charges with payors. Between March 1, 1991 and September 30, 1991, negotiated discounts may not exceed 5% of the hospital's established charges for inpatient services or 7% of its established charges for outpatient services. There shall be no limit on the magnitude of negotiated discounts after September 30, 1991. Hospitals in the total revenue system may negotiate discounts with the approval of the commission according to standards adopted by rule of the commission. The revenue losses resulting from negotiated discounts shall not be reflected in the computation of a hospital's revenue limit.

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

6. 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 ensure that such allocation, to the extent it results in internal departmental subsidies, is reasonable and does not result in undue price discrimination.

7. Transmittal of hospital payments fund revenue. No later than 30 days following the close of each quarter of each fiscal year, each hospital shall transmit to the hospital payments fund, established in section 396-F, that portion of its revenues which corresponds to the hospital payments fund revenue determined under subsection 1.

Sec. 34. 22 MRSA §396-K, sub-§3, ¶B, as repealed and replaced by PL 1985, c. 661, §10, is repealed.

Sec. 35. 22 MRSA §396-K, sub-§3, ¶B-1 is enacted to read:

B-1. On the basis of additional information received after an annual credit is established pursuant to paragraph A, including information provided by the department concerning

the State Health Plan or projects then under review, the commission may by rule increase or decrease the amount of the annual credit during the course of the payment year cycle to which it applies. The commission may not act under this paragraph to decrease the credit below the amount that would, in combination with any amounts carried over from prior years, equal the total of any debits associated with projects approved on or before the date that the commission notifies the department of a proposed rule that would decrease the credit. For any payment year cycle in which the annual credit is apportioned to "statewide" and "individual hospital" components, the increase or decrease authorized by this paragraph shall apply solely to the "statewide" component of the credit.

Sec. 36. 22 MRSA §396-K, sub-§3, ¶C, as repealed and replaced by PL 1985, c. 661, §10, is amended to read:

C. The commission shall approve an adjustment to a hospital's financial requirements under section 396-D, subsection 5, 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 ~~statewide component of the~~ Hospital Development Account as of the date of approval of the project by the department, after accounting for previously approved projects.

Sec. 37. 22 MRSA §396-K, sub-§3, ¶D, as repealed and replaced by PL 1985, c. 661, §10, is repealed.

Sec. 38. 22 MRSA §396-K, sub-§3, ¶E, as enacted by PL 1985, c. 661, §10, is repealed.

Sec. 39. 22 MRSA §396-K, sub-§3, ¶F, as enacted by PL 1985, c. 661, §10, is amended to read:

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

(1) Except as provided in subparagraph (2), the commission shall debit against the ~~statewide component of 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 C. Incremental annual capital and operating costs shall be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 5, for the 3rd fiscal year of implementation of the project.

(2) In the case of a project which is approved under paragraph C 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.

~~(3) The commission shall debit against a hospital's individual development account the full amount of the incremental annual capital and operating costs associated with each proposal of the hospital for which an adjustment is approved under paragraph E. Incremental annual capital and operating costs shall be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 9, paragraph D, for the 3rd fiscal year of implementation of the proposal.~~

(4) Amounts credited to the ~~statewide component of the~~ Hospital Development Account for which there are no debits shall be carried forward to subsequent payment year cycles as a credit ~~to the statewide component. Amounts credited to an individual hospital account for which there are no debits shall be carried forward to subsequent payment year cycles as a credit to that account.~~

Sec. 40. 22 MRSA §396-K, sub-§4, as repealed and replaced by PL 1985, c. 661, §10, is repealed.

Sec. 41. 22 MRSA §396-O, as enacted by PL 1983, c. 579, §10, is amended by inserting at the end a new paragraph to read:

The commission may waive any statutory requirements for hospital demonstration projects which further the goals described in section 381. The commission shall review hospitals with approved demonstration projects and may collect data to monitor performance, and require compliance adjustments if the conditions of the demonstration 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.

Sec. 42. 22 MRSA §400, as enacted by PL 1987, c. 440, §4, is repealed.'

Further amend the amendment in section 8 in that part designated "§3191." in subsection 2 in the 7th line (page 14, line 12 in amendment) by striking out the underlined figure "5" and inserting in its place the underlined figure '4'

HOUSE AMENDMENT "A" to COMMITTEE AMENDMENT "A" to H.P. 954, L.D. 1322

Further amend the amendment by striking out all of section 21 and inserting in its place the following:

'**Sec. 21. Study.** The Commission to Study the Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services is established.

1. Scope. The study commission shall study the following subjects.

A. The study commission shall review the provisions of Maine law relating to health services planning, including the certificate of need law and provisions of the health care finance law relating to the hospital development account and to affiliated interests. The study commission shall submit its report, including any necessary legislation to implement its recommendations, to the Joint Standing Committee on Human Resources by December 15, 1989.

B. The study commission shall study the current and potential impact of competitive market forces on outpatient volumes and the cost, quality and accessibility of ambulatory health services. Its study shall include an evaluation of the advisability of deregulating various outpatient services. The study commission shall submit its recommendations, including any necessary legislation to implement its recommendations, to the Joint Standing Committee on Human Resources by December 15, 1990. In the course of this study, the commission shall consider the likely impact of deregulating the charges made by hospitals for outpatient services and the elimination of any continuing restrictions on the establishment of preferred provider arrangements.

2. Composition. The study commission shall be composed of 13 members. The President of the Senate shall appoint one member of the Senate. The Speaker of the House of Representatives shall appoint 2 members of the House of Representatives. The Governor shall appoint one representative of the Department of Human Services. The President of the Senate and the Speaker of the House of Representatives shall jointly appoint 2 hospital officials, one physician, one representative of a 3rd-party payor other than the Department of Human Services, one representative of the Maine Health Care Finance Commission, one representative of the Maine Health Policy Advisory Council, and 3 consumer members including at least one representative of business and one representative of labor. All 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 commission. The President of the Senate and the Speaker of the House of Representatives shall jointly designate a chair from among the members of the study commission.

3. Staff. The Maine Health Care Finance Commission shall provide staff to the commission for the duration of the study.

4. Expenses. The members of the commission who are Legislators shall receive the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2, for each day's attendance at commission meetings. All members who do not represent state agencies shall receive expenses for attending meetings upon application to the Executive Director of the Legislative Council.

5. Sunset. This section is repealed December 15, 1990.

Sec. 22. Commission study and rule revisions. The Maine Health Care Finance Commission is directed to conduct studies and propose rules as follows.

1. Outpatient services. The commission shall conduct a study for the purpose of improving the method that it currently employs to adjust the financial requirements of hospitals for changes in the volume of outpatient services provided and developing a method of regulating outpatient revenues on the basis of rate per unit of service. On or before March 1, 1992, the commission shall release to the Joint Standing Committee on Human Resources, to hospitals subject to its jurisdiction and to the general public a report of the results of its study and an outline of the changes that it proposes to make. The commission shall propose new rules or amendments to its existing rules, in accordance with the requirements of the Maine Revised Statutes, the Maine Administrative Procedure Act, Title 5, chapter 375, for the purpose of implementing the results of its study for payment years beginning on and after October 1, 1992.

2. Marginal cost rates and volume corridors. The commission shall conduct a study to determine whether changes in the marginal cost percentages and volume corridors specified in its existing rules to implement adjustments for volume and case mix are reasonable and appropriate, taking into account the effects of those rules on hospitals with increasing, decreasing and stable volume, as well as the effects of those rules upon those who pay for hospital services. The commission shall release a report of the results of its study to the Joint Standing Committee on Human Resources, to all hospitals subject to its jurisdiction and to the general public on or before March 1, 1991. To the extent that the study concludes that changes in the marginal cost percentages or the volume corridors, or both, should be made, the commission shall propose amendments to its existing rules or new rules for the purpose of implementing those changes for payment years beginning on and after October 1, 1991.

3. Participation. In conducting the studies required by subsections 1 and 2, the commission shall seek comments and

active participation from the advisory committees established by the Maine Revised Statutes, Title 22, section 396-P, and from other interested and affected hospitals, payors and members of the general public.

Sec. 23. Level of licensure review. The Department of Human Services shall review systems of licensure for health care facilities to determine what additional levels of licensure might be created to ease the problems of hospitals which are experiencing financial difficulty operating at the current level of licensure and which could continue to provide selected community health care services at a lower level of licensure. The department shall develop standards of licensure at lower levels and submit any legislation necessary to implement them to the Joint Standing Committee on Human Resources by February 1, 1990.

Sec. 24. Transition. The hospital care financing system, as amended by this Act, shall apply to hospital payment years beginning on or after October 1, 1990, except that section 35 of this Act shall apply to payment year cycles beginning on or after October 1, 1989.

The commission shall administer the hospital care financing system established by the Maine Revised Statutes, Title 22, 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 may 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. 25. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1989-90	**1990-91**
HUMAN SERVICES, DEPARTMENT OF		
Bureau of Health		
All Other		$2,000,000

Provides funds for community health program grants to be awarded beginning July 1, 1990.

Medical Care - Payments to Providers

All Other		$1,000,000

Provides funds for an increase in Medicaid reimbursement to providers to increase access to health care for Medicaid recipients.

Maine Health Program

All Other		$25,717,137

Provides funds for the Maine Health Program.

Medical Care Administration

Positions	(2)	(19)
Personal Services	$52,927	$449,061
All Other	95,893	353,845
Capital Expenditures	1,180	11,203
TOTAL	$150,000	$814,109

Provides funds for the development and administration of the Maine Health Program and expenses for the Maine Health Program Council.

Income Maintenance - Regional

Positions	(47)
Personal Services	$1,125,745
All Other	78,984
Capital Expenditures	30,973
TOTAL	$1,235,702

Provides funds for additional staff and related expenses to implement and administer the

provisions of the Maine Health Program.		
DEPARTMENT OF HUMAN SERVICES TOTAL	$150,000	$30,766,948
MAINE HEALTH CARE FINANCE COMMISSION		
Health Care Finance Commission		
All Other		$15,000,000
Provides funds for the Hospital Uncompensated Care and Governmental Payment Shortfall Fund.		
Commission to Study the Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services		
Personal Services	$1,485	$825
All Other	4,950	1,250
TOTAL	$6,435	$2,075
Provides funds for per diem for legislative members and expenses for other members of the study commission.		
MAINE HEALTH CARE FINANCE COMMISSION TOTAL	$6,435	$15,002,075
TOTAL APPROPRIATIONS	$156,435	$45,769,023

Sec. 26. Allocation. The following funds are allocated from the Federal Expenditures funds to carry out the purposes of this Act.

	1990-91
HUMAN SERVICES, DEPARTMENT OF	
Medical Care - Payments to Providers	
All Other	$1,800,336

	Allocates federal matching funds for a provider fee increase.	
Income Maintenance - Regional		
	Positions	(47)
	Personal Services	$1,125,745
	All Other	78,984
	Capital Expenditures	30,973
	TOTAL	$1,235,702
	Allocates federal matching funds for additional staff and related expenses.	
DEPARTMENT OF HUMAN SERVICES TOTAL		$3,036,038

Sec. 27. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Act.

	1989-90	1990-91
HUMAN SERVICES, DEPARTMENT OF		
Maine Health Program		
All Other		$3,358,200
Allocates participant contributions toward cost of the health program.		
DEPARTMENT OF HUMAN SERVICES TOTAL		$3,358,200
MAINE HEALTH CARE FINANCE COMMISSION		
Health Care Finance Commission		
Positions	(5)	(5)
Personal Services	$97,562	$188,620
All Other	150,000	
Allocates funds for 2 Health Care Financial Analysts, one Planning and Research		

Associate II, one Programmer Analyst and one Staff Attorney and funds to carry out the required study.		
MAINE HEALTH CARE FINANCE COMMISSION TOTAL	$247,562	$188,620
PROFESSIONAL AND FINANCIAL REGULATION, DEPARTMENT OF		
Bureau of Insurance		
All Other	$4,000	$3,000
Allocates funds for hearings, rulemaking and annual reports with respect to preferred provider arrangements.		
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION TOTAL	$4,000	$3,000
TOTAL ALLOCATIONS	$251,562	$3,549,820

Emergency clause. In view of the emergency cited in the preamble, this Act shall take effect when approved, except that sections 44 to 55 shall be effective 90 days after adjournment of the First Regular Session of the 114th Legislature and sections 3, 4 and 40 are effective October 1, 1990.'

Further amend the amendment by renumbering the sections to read consecutively.

Further amend the amendment by inserting before the statement of fact the following:

FISCAL NOTE

The estimated future costs of the Maine Health Program, including administrative costs, will be approximately $49,000,000 in fiscal year 1991-92 and are expected to increase by nearly $5,000,000 each year thereafter. The projected increase in cost is due to the fact that the phase-in provisions apply to the first year of the program only.

The Bureau of Insurance will increase dedicated revenue to $4,000 in fiscal year 1989-90 and $3,000 in fiscal year 1990-91

through the annual assessment on insurers to cover the additional costs to the bureau.

There is a potential for cost savings to some programs which currently provide medical services for individuals, as these individuals may become eligible for participation in the Maine Health Program. The amount of these savings cannot be determined at this time.'

STATEMENT OF FACT

This amendment adds the contents of the committee amendment to Senate Paper 348, Legislative Document 921, which responds to recommendations proposed by the Blue Ribbon Commission on the Regulation of Health Care Expenditures.

Filed by Rep. Manning of Portland
Reproduced and distributed under the direction of the Clerk of the House
6/20/89 (Filing No. H-653)