115th MAINE LEGISLATURE

FIRST REGULAR SESSION-1991

Legislative Document **No. 1579**

S.P. 594 In Senate, April 18, 1991

Reported by Senator GAUVREAU of Androscoggin for the Commission to Study the Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services pursuant to Public Law 1989, chapter 588, section 56.

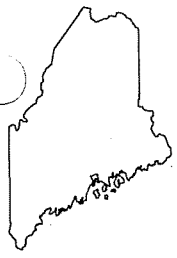
Reference to the Committee on Human Resources suggested and ordered printed pursuant to Joint Rule 18.

JOY J. O'BRIEN
Secretary of the Senate

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-ONE

An Act to Limit Major Third-party Payor Status to Governmental Payors.



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

Sec. 1. 22 MRSA §382, sub-§§9 and 10, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. 2. 22 MRSA §386, sub-§7, as enacted by PL 1983, c. 579, §10, is amended to read:

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.

Sec. 3. 22 MRSA §396-I, sub-§2, as repealed and replaced by PL 1989, c. 588, Pt. A, §33, is repealed and the following enacted in its place:

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 6, and for the hospital as a whole, the hospital's gross patient service revenue among the following categories:

A. The Medicare program administered under the federal Social Security Act, Title XVIII, and any payor acting as a fiscal intermediary for the Medicare program to the extent of the payor's obligations as a fiscal intermediary;

B. The Medicaid program administered by the department under the federal Social Security Act, Titles V and XIX; and

C. All other purchasers and payors, which together constitute one category.

Sec. 5. 22 MRSA §396-I, sub-§3, ¶¶A to C, as repealed and replaced by PL 1989, c. 588, Pt. A, §33, are amended to read:

A. Payments made by ~~major 3rd party payors shall be~~ the department in accordance with its obligations under the Medicaid program, determined pursuant to subsection 2, paragraph B are made in accordance with the following procedures.

(1) The commission shall require ~~major 3rd party payors~~ the department to make biweekly periodic interim payments to hospitals, provided that ~~any such payor~~ the department 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~~ to the Medicaid program based on actual utilization data for that year. Final settlement ~~shall~~ must 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,~~ Medicare and Medicaid and by purchasers ~~shall be~~ are made in accordance with the following procedures.

(1) Payors, other than ~~major 3rd party payors~~ Medicare and Medicaid, 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~~ the Medicare and Medicaid programs.

(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,~~ Medicare and Medicaid 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~~ be allocated to purchasers and payors other than ~~major 3rd party payors~~ Medicare and Medicaid. Adjustments to the succeeding year's gross patient service revenue limit ~~shall~~ are 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~~ are 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~~ Medicare and Medicaid.

STATEMENT OF FACT

This bill contains the statutory changes recommended in the 2nd and final report of the Commission to Study the Certificate of Need Law and the Impact of Competitive Market Forces on Ambulatory Health Services, pursuant to Public Law 1989, chapter 588, section 56.

The hospital care financing system administered by the Maine Health Care Finance Commission defines certain payors as "major 3rd-party payors" and imposes special obligations upon them. This bill removes all references to major 3rd-party payors from the Maine Health Care Finance Commission laws. The Medicaid program, which is a major 3rd-party payor under current law, would continue to have an obligation to make periodic, equal payments throughout each hospital's fiscal year. Under this bill, the statute would be silent as to the method and timing of Medicare payments, which are currently governed by federal law. Hospital revenues would continue to be apportioned in the same manner as they are under current law, except that the only payors treated as separate categories would be the Medicare and Medicaid programs. The general payment provisions formerly applicable to payors other than major 3rd-party payors would under this bill apply to all payors except Medicare and Medicaid.