L.D. 371

DATE: 6/23/95 (Filing No. H- 600)

MINORITY

HUMAN RESOURCES

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STATE OF MAINE
HOUSE OF REPRESENTATIVES
117TH LEGISLATURE
FIRST REGULAR SESSION

COMMITTEE AMENDMENT "B" to H.P. 269, L.D. 371, Bill, "An Act to Abolish the Maine Health Care Finance Commission"

Amend the bill by striking out the title and substituting the following:

'**An Act Concerning Health Care Data and Policy Development**'

Further amend the bill by striking out everything after the enacting clause and before the statement of fact and inserting in its place the following:

'**Sec. 1. 2 MRSA §6-B,** as enacted by PL 1983, c. 579, §1, is amended to read:

§6-B. Salaries of certain employees of the Maine Health Data and Policy Development Organization

Notwithstanding any other provision of law, the salaries of certain employees of the Maine Health ~~Care Finance Commission shall be~~ Data and Policy Development Organization are as follows.

1. Director. The salary of the ~~executive~~ director ~~shall~~ must be within salary range ~~91~~ 89.

2. Deputy director. The salary of the deputy director ~~shall~~ must be within salary range ~~89~~ 88.

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

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Sec. 2. 5 MRSA §931, sub-§1, ¶L, as amended by PL 1991, c. 376, §17, is further amended to read:

L. The ~~executive~~ director, and deputy director, ~~general counsel and staff attorneys~~ of the Maine Health ~~Care Finance Commission~~ Data and Policy Development Organization;

Sec. 3. 5 MRSA §12004-E, sub-§1, as enacted by PL 1987, c. 786, §5, is repealed.

Sec. 4. 5 MRSA §12004-I, sub-§44-A, as enacted by PL 1991, c. 84, §1, is repealed.

Sec. 5. 5 MRSA §12004-I, sub-§§45 to 47, as enacted by PL 1987, c. 786, §5, are repealed.

Sec. 6. 20-A MRSA §12106, sub-§2, ¶C, as enacted by PL 1991, c. 830, §4 and c. 832, §10, is amended to read:

C. The ~~Executive~~ Director of the Maine Health ~~Care Finance Commission~~ Data and Policy Development Organization or the ~~executive~~ director's designee;

Sec. 7. 22 MRSA §303, sub-§3-A, as enacted by PL 1983, c. 579, §6, is repealed.

Sec. 8. 22 MRSA §304-D, sub-§2, as enacted by PL 1985, c. 661, §2, is amended to read:

2. Conditions of waiver. As a condition of receipt of a waiver of certificate of need review under subsection 1, paragraph A, the hospital ~~shall not be~~ is subject to any ~~adjustments to its financial requirements pursuant to section 396-D~~ conditions imposed by the department.

Sec. 9. 22 MRSA §304-D, sub-§5, as enacted by PL 1985, c. 661, §2, is repealed.

Sec. 10. 22 MRSA §304-E, sub-§1, as enacted by PL 1987, c. 725, §2, is amended to read:

1. Request for waiver. An applicant for a project requiring a certificate of need, other than a project related to acute patient care ~~or a project that could affect the financial requirements of a hospital under chapter 107~~, may request a waiver of the review requirements under this chapter. The applicant shall submit, with the request, sufficient written documentation to demonstrate that the proposed project meets the

conditions of this section and that sufficient public notice of the proposed waiver has been given.

Sec. 11. 22 MRSA §307, sub-§6-A, as amended by PL 1993, c. 410, Pt. FF, §2, is further amended to read:

6-A. Review cycles. The department shall establish review cycles for the review of applications. There must be at least one review cycle for each type or category of project each calendar year, the dates for which must be published at least 3 months in advance. An application must be reviewed during the next scheduled review cycle following the date on which the application is either declared complete or submitted for review pursuant to section 306-A, subsection 4, paragraph B. ~~Hospital projects that must be considered within the constraints established by the Certificate of Need Development Account established pursuant to section 396-K may be grouped for competitive review purposes at least once each year; provided that, for minor projects, as defined by the department through rules adopted pursuant to section 312, the department shall allocate a portion of the Certificate of Need Development Account for the approval of those projects and shall establish at least 6 review cycles each year for the review of those projects.~~ Nursing home projects that propose to add new nursing home beds to the inventory of nursing home beds within the State may be grouped for competitive review purposes consistent with appropriations made available for that purpose by the Legislature. A nursing home project that proposes renovation, replacement or other actions that will increase Medicaid costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs. The department may hold an application for up to 90 days following the commencement of the next scheduled review cycle if, on the basis of one or more letters of intent on file at the time the application is either declared complete or submitted for review pursuant to section 306-A, subsection 4, paragraph B, the department expects to receive within the additional 90 days one or more other applications pertaining to similar types of services, facilities or equipment affecting the same health service area. Pertinent health service areas must be defined in rules adopted by the department pursuant to section 312, based on recommendations by the State Health Coordinating Council.

Sec. 12. 22 MRSA §309, sub-§1, ¶D, as amended by PL 1993, c. 477, Pt. D, §4 and affected by Pt. F, §1, is further amended to read:

D. That the proposed services are consistent with the orderly and economic development of health facilities and

health resources for the State, that the citizens of the State have the ability to underwrite the additional costs of the proposed services and that the proposed services are in accordance with standards, criteria or plans adopted and approved pursuant to the state health plan developed by the department ~~and the findings of the Maine Health Care Finance Commission under section 396-J with respect to the ability of the citizens of the State to pay for the proposed services~~.

Sec. 13. 22 MRSA §309, sub-§6, as amended by PL 1989, c. 502, Pt. A, §65, is repealed.

Sec. 14. 22 MRSA c. 107, is amended by repealing the chapter headnote and enacting the following in its place:

CHAPTER 107

MAINE HEALTH DATA AND POLICY DEVELOPMENT ORGANIZATION

Sec. 15. 22 MRSA §381, sub-§1, ¶¶A and B, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. 16. 22 MRSA §381, sub-§2, ¶A, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 17. 22 MRSA §381, sub-§2, ¶C, as enacted by PL 1985, c. 278, is repealed.

Sec. 18. 22 MRSA §382, sub-§1, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 19. 22 MRSA §382, sub-§1-A, as enacted by PL 1989, c. 588, Pt. A, §5, is repealed.

Sec. 20. 22 MRSA §382, sub-§§3 and 5, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. 21. 22 MRSA §382, sub-§5-A is enacted to read:

5-A. Director. "Director" means the Director of the Maine Health Data and Policy Development Organization.

Sec. 22. 22 MRSA §382, sub-§8-B is enacted to read:

8-B. Organization. "Organization" means the Maine Health Data and Policy Development Organization established in this chapter.

Sec. 23. 22 MRSA §382, sub-§§15 and 16, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. 24. 22 MRSA §382, sub-§16-A, as enacted by PL 1989, c. 588, Pt. A, §6, is repealed.

Sec. 25. 22 MRSA §382, sub-§§17 to 20, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. 26. 22 MRSA §383, as amended by PL 1989, c. 503, Pt. B, §80, is further amended to read:

§383. Maine Health Data and Policy Development Organization

1. Establishment. The Maine Health ~~Care---Finance Commission, established by Title 5, section 12004-E, subsection 1, is defined~~ Data and Policy Development Organization is established as follows.

A. The Maine Health ~~Care Finance Commission shall function as~~ Data and Policy Development Organization is an independent executive agency, and shall perform the following functions:

(1) Oversee the collection of health data from health care facilities and providers of health care in this State;

(2) Research trends in managed care as experienced and anticipated in this State and in other jurisdictions;

(3) Work with hospitals to develop long-range plans for the provision of health care to residents of this State; and

(4) Publish annual reports based on data collected and the research and other work of the organization.

A-1. The organization is under the control and supervision of the director, who is appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over human resources matters and to confirmation by the Legislature, and serves at the pleasure of the Governor.

A-2. The organization is a state agency for purposes of representation by the Attorney General under Title 5, section 191.

~~B.--The commission shall be composed of 5 members, who shall be appointed by the Governor, subject to review by the joint standing committee of the Legislature having jurisdiction over health and institutional services and confirmation by the Legislature.~~

~~Persons eligible for appointment to, or to serve on, the commission shall be individuals conversant with the organization, delivery or financing of health care. At least 4 of the 5 members shall be consumers. At least one of the 5 members, whether or not a consumer member, shall be an individual who, within the 10 years preceding appointment, has had at least 5 years' experience as either a hospital trustee or a hospital official. For purposes of this section, "consumer" means a person who is neither affiliated with nor employed by any 3rd-party payor, any provider of health care, as defined in section 382, subsection 14, or any association representing these providers, provided that neither membership in nor subscription to a service plan maintained by a nonprofit hospital and medical service organization, nor enrollment in a health maintenance organization, nor membership as a policyholder in a mutual insurer or coverage under a policy issued by a stock insurer, nor service on a governmental advisory committee, nor employment by, or affiliation with, a municipality, may disqualify a person from serving as a consumer member of the commission.~~

~~C.--The terms of the members shall be staggered. Of the initial appointees, 2 shall be appointed for terms of 4 years, 2 for terms of 3 years and one for a term of 2 years. Thereafter, all appointments shall be for a term of 4 years each, except that a member appointed to fill a vacancy in an unexpired term shall serve only for the remainder of that term. Members shall hold office until the appointment and confirmation of their successors. No member may be appointed to more than 2 consecutive 4-year terms.~~

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

~~E. The Governor shall appoint a chair and a vice chair, who shall serve in these capacities at the Governor's pleasure.~~

2.--Meetings. ~~The commission shall meet as follows.~~

~~A.--The commission shall meet from time to time as required to fulfill its responsibilities. Meetings shall be called by~~

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~~the chairman or by any 3 members and, except in the event of an emergency meeting, shall be called by written notice. Meetings shall be announced in advance and open to the public, to the extent required by Title 1, chapter 13, subchapter I.~~

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

~~3. Compensation. Each member of the commission shall be compensated according to the provisions of Title 5, chapter 379.~~

Sec. 27. 22 MRSA §384, as amended by PL 1985, c. 785, Pt. B, §84, is further amended to read:

§384. Director and staff

~~The commission shall appoint an executive director, who shall have had experience in the organization, financing or delivery of health care and who shall perform the duties delegated to him by the commission. The executive director shall serve at the pleasure of the commission and his salary shall be set by the commission within the range established by Title 2, section 6-B.~~ The executive director shall appoint a deputy director, who shall perform the duties delegated ~~to him~~ by the executive director. The deputy director ~~shall serve~~ serves at the pleasure of the executive director ~~and his~~ at a salary ~~shall be~~ set by the executive director ~~within the range established by Title 2, section 6-B~~. The ~~commission~~ organization may employ such other staff as it ~~deems~~ considers necessary. The appointment and compensation of such other staff ~~shall be~~ is subject to the Civil Service Law.

Sec. 28. 22 MRSA §385, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 29. 22 MRSA §386, sub-§2, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 30. 22 MRSA §386, sub-§§3, 5 and 6, as enacted by PL 1983, c. 579, §10, are amended to read:

3. Receipt of grants, gifts and payments. The ~~commission~~ organization may solicit, receive and accept grants, gifts, payments and other funds and advances from any person, other than a provider of health care, as defined in section 382, subsection 14, or a ~~3rd party payor, as defined in section 382, subsection 19,~~ an entity that is responsible for payment for health care services rendered by a hospital and enter into agreements with

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respect to those grants, payments, funds and advances, including agreements that involve the undertaking of studies, plans, demonstrations or projects. The ~~commission~~ organization may only accept funds from providers of health care or from 3rd-party payors in accordance with subsection 9 and section 391.

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

6. Contract for services. The ~~commission~~ organization may contract with anyone ~~other than commission members~~ for any services necessary to carry out the activities of the ~~commission~~ organization. Any party entering into a contract with the ~~commission shall be~~ organization is 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~~ organization.

Sec. 31. 22 MRSA §386, sub-§7, as amended by PL 1991, c. 485, §4, is repealed.

Sec. 32. 22 MRSA §386, sub-§8, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 33. 22 MRSA §388, as amended by PL 1989, c. 588, Pt. A, §§7 and 8, is further amended to read:

§388. Reports

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

A. Prior to January 1st, the ~~commission~~ organization 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~~ must include such facts, suggestions and policy recommendations as the ~~commission~~ organization considers necessary. The report ~~shall~~ must 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~~ organization.

~~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~~ organization 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~~ organization shall, from time to time as it ~~deems~~ considers 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~~ organization.

4. Review by health care facility. If any studies or analyses undertaken by the commission pursuant to section 386, subsection 4, or if any consumer information developed pursuant

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to subsection 3 directly or indirectly identify a particular health care facility, the health care facility ~~shall~~ must 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 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. 34. 22 MRSA §389, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 35. 22 MRSA §390, as amended by PL 1989, c. 565, §3, is repealed.

Sec. 36. 22 MRSA §391, as amended by PL 1993, c. 410, Pt. UUU, §1, is further amended to read:

§391. Funding of the organization

1. Assessments. Every hospital subject to ~~regulation under~~ this chapter is subject to an assessment of not more than ~~.15%~~ .07% of its gross patient service revenues. ~~Notwithstanding any other provision of law, the commission shall reduce the assessment to hospitals by $159,077 in fiscal year 1993-94 and by $276,106 in fiscal year 1994-95. For the period of October 1, 1983, to June 30, 1984, each hospital shall pay an assessment equal to 75% of the total annual dues and fees for which it was liable to a voluntary budget review organization during its most recent fiscal year which ended prior to July 1, 1983. Each hospital shall pay this assessment in 3 equal installments, with payments due on or before November 1, 1983, January 1, 1984, and April 1, 1984. Thereafter, 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~~ are subject to legislative approval in the same manner as the budget of the ~~commission~~ organization is approved. The ~~commission~~ organization

shall also report annually, before February 1st, to the joint standing committee of the Legislature having jurisdiction over health and institutional ~~sevices~~ 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~~ must be deposited with the Treasurer of State in a separate account to be known as the Maine Health ~~Care Finance Commission~~ Data and Policy Development Organization Fund.

4. Use of funds. The ~~commission~~ organization may use the revenues provided in this section to defray the costs incurred by the ~~commission~~ organization or the former Maine Health Care Finance 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~~ organization may not use the revenues provided in this section to make grants pursuant to section 386, 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~~ does not lapse, but ~~shall~~ must 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~~ must, at the option of the ~~commission~~ organization, either be presented to the Legislature in accordance with subsection 2 for reallocation and expenditure for ~~commission~~ organization purposes or used to reduce the hospital assessment in the following fiscal year.

~~**6. Nonhospital data collection expenses.** The funds required to support the collection, storage and analysis by the commission of data from providers of health care other than hospitals must be provided by means of the assessment provided for in subsection 1.~~

Sec. 37. 22 MRSA §392, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 38. 22 MRSA §394, as amended by PL 1989, c. 595, is further amended to read:

§394. Uniform systems of reporting generally

1. Establishment. The ~~commission~~ organization 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 395, and in subchapters III and IV and pursuant~~ Pursuant to rules adopted by the ~~commission~~ organization for form, medium, content and time for filing, each health care facility and provider of health care shall file with the ~~commission~~ organization 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~~ organization considers necessary for the performance of its duties if such financial information is prepared by the health care facility or provider of health care in the ordinary course of business;

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~~ organization determines 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~~; and for each major ambulatory service listed pursuant to subsection 11, ~~occurring after January 1, 1990~~.

2-A. Additional information on ambulatory surgery. Pursuant to rules adopted by the ~~commission~~ organization for form, medium, content and time for filing, each provider of health care shall file with the ~~commission~~ organization a completed data set, comparable to data filed by health care facilities under subsection 2, paragraph C, for each ambulatory surgery listed pursuant to subsection 11, ~~occurring after January 1, 1990~~. This subsection ~~shall~~ may not be construed to require duplication of information also required to be filed under subsection 2.

3. Storage of data. The ~~commission~~ organization may, subject to section 386, subsection 6, contract with any entity, including an independent data organization, to store discharge

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data filed with the ~~commission~~ organization and comparable data filed with the ~~commission~~ organization with respect to major ambulatory services. 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~~ must be reported for each health facility separately.

7-A. More than one location. When a provider of health care operates in more than one location, the ~~commission~~ organization may require that information be reported separately for each location.

8. Certification required. The ~~commission~~ organization 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~~ organization.

~~**9. Verification.** If a further investigation is considered necessary or desirable to verify the accuracy of information in reports made 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~~ must be filed on an annual basis or more frequently as specified by the ~~commission~~ organization. The ~~commission~~ organization shall establish the effective date for compliance with the required uniform systems.

11. Data lists. ~~Beginning on October 1, 1989, and at least annually thereafter, the commission~~ The organization shall by rule prepare a list of major ambulatory services for which data is to be collected pursuant to subsection 2, paragraph C, and a list of ambulatory surgeries for which data is to be collected pursuant to subsection 2-A. The ~~commission~~ organization shall distribute the lists to those providers of health care that are required to file information under subsection 2 or 2-A.

Sec. 39. 22 MRSA §395, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. 40. 22 MRSA §395-B is enacted to read:

§395-B. Charity care

1. Charity care guidelines. The organization shall adopt reasonable guidelines for policies to be adopted and implemented by hospitals with respect to the provision of health care services to patients who are determined to be unable to pay for the services received. The organization shall adopt income

guidelines that are consistent with the guidelines applicable to the Hill-Burton Program established under 42 U.S. Code, Section 291, et seq. (1988). The guidelines and policies must include the requirement that upon admission or, in cases of emergency admission, before discharge of a patient, hospitals must investigate the coverage of the patient by any insurance or state or federal programs of medical assistance.

2. Charity care requirement. 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 organization, the services must be provided as charitable care. This section does not prevent a hospital from establishing a policy of charitable care that includes services not included in this subsection, if permitted by the organization's guidelines. Hospital services provided to a person who meets the financial eligibility guidelines adopted pursuant to this section may not be billed to the patient or to a municipality.

Sec. 41. 22 MRSA c. 107, sub-cc. III and IV, as amended, are repealed.

Sec. 42. 22 MRSA §1708, sub-§§1-A and 1-B are enacted to read:

1-A. Cross-over payments. Payments to hospitals for copayment and deductible amounts paid by the department on behalf of the following persons must be based on the established charges of the hospital, reduced by a differential factor equal to 22.01%:

A. Qualified Medicare beneficiaries; and

B. Persons eligible for benefits under both the Medicare program administered under the United States Social Security Act, Title XVIII, and under the Medicaid program administered by the department pursuant to the United States Social Security Act, Titles V and XIX.

1-B. Managed care payments. Payments to hospitals for services rendered under a Medicaid managed care plan are subject to the requirements of this subsection.

A. For purposes of this subsection, "managed care contractor" means any person or agency under contract with the department to provide or purchase services to Medicaid beneficiaries or others covered by a Medicaid managed care plan or demonstration project, pursuant to the United States Social Security Act, Title XIX and in accordance with a waiver granted to the department under section 3174-N or

under the United States Social Security Act, Section 1115 or Section 1915-B.

B. Payments to hospitals made by any managed care contractor must be based on the established charges of the hospital, reduced by a differential factor calculated by the department on an individual hospital basis, subject to any further discount agreed upon by the hospital and the managed care contractor.

Sec. 43. 22 MRSA §1714-A, sub-§2, as amended by PL 1991, c. 568, §1, is further amended to read:

2. Establishment of debt. A debt is established by the department when it notifies a provider of debt, or when the ~~Maine Health Care Finance Commission~~ department notifies a hospital that the hospital owes the department pursuant to a final ~~reconciliation, decision and order~~ determination. A debt is collectible by the department 31 days after exhaustion of all administrative appeals and any judicial review available under Title 5, chapter 375.

Sec. 44. 22 MRSA §1715, as enacted by PL 1989, c. 919, §15 and affected by §18, is amended to read:

§1715. Access requirements applicable to certain health care providers

1. Access requirements. Any person, including, but not limited to, an affiliated interest as defined in this section ~~396-L~~, that is subject to the requirements of this subsection, shall provide the services listed in paragraph C to individuals who are eligible for charity care in accordance with a charity care policy adopted by the affiliate or provider that is consistent with rules applicable to hospitals under section ~~396-F~~ 395-B. A person is subject to this subsection if that person:

A. Is either a direct provider of major ambulatory service, as defined in this section ~~382, subsection 8-A~~, or is or has been required to obtain a certificate of need under the former section 304 or 304-A;

B. Provides outpatient services as defined in this section ~~382, subsection~~ 9-A; and

C. Provides one or more of the following services:

(1) Imaging services, including, but not limited to, magnetic resonance imaging, computerized tomography,

mammography and radiology. For purposes of this section, imaging services do not include:

(a) Screening procedures that are not related to the diagnosis or treatment of a specific condition; or

(b) Services when:

(i) The services are owned by a community health center, a physician or group of physicians;

(ii) The services are offered solely to the patients of that center, physician or group of physicians; and

(iii) Referrals for the purpose of performing those services are not accepted from other physicians;

(2) Laboratory services performed by a hospital or by a medical laboratory licensed in accordance with the Maine Medical Laboratory Commission, or licensed by an equivalent out-of-state licensing authority, excluding those licensed laboratories owned by community health centers, a physician or group of physicians where the laboratory services are offered solely to the patients of that center, physician or group of physicians;

(3) Cardiac diagnostic services, including, but not limited to, cardiac catheterization and angiography but excluding electrocardiograms and electrocardiograph stress testing;

(4) Lithotripsy services;

(5) Services provided by free-standing ambulatory surgery facilities certified to participate in the Medicare program; or

(6) Any other service performed in an outpatient setting requiring the purchase of medical equipment costing in the aggregate $500,000 or more and for which the charge per unit of service is $250 or more.

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

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A. "Affiliated interest" means:

(1) A person who is a subsidiary of a hospital;

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

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

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

(a) Controls a hospital or is controlled by a hospital or any of its affiliates as defined in subparagraphs (1) to (3); and

(b) Is engaged directly or indirectly in the provision of a health care service or services, the costs of which would have been considered by the former Maine Health Care Finance Commission elements of financial requirements if performed by a hospital.

B. "Major ambulatory service" means surgical procedures, chiropractic methodologies or medical procedures, including diagnostic procedures and therapeutic radiological procedures, that require special facilities such as operating rooms or suites, special equipment such as fluoroscopic equipment or computed tomographic scanners or special rooms such as a post-procedure recovery room or short-term convalescent room.

C. "Outpatient services" means all therapeutic or diagnostic health care services rendered to a person who has not been admitted to a hospital as an inpatient.

2. Enforcement. The requirements of subsection 1 are enforced through the following mechanisms.

A. Any person who knowingly violates any provision of this section or any valid order or rule made or adopted pursuant to section ~~396-F~~ 395-B, or who willfully fails, neglects or refuses to perform any of the duties imposed under this section, commits a civil violation for which a forfeiture of not less than $200 and not more than $500 per patient may be adjudged with respect to each patient denied access unless specific penalties are elsewhere provided. Any forfeiture imposed under this section may not exceed $5,000 in the case of the first judgment under this section against the provider, $7,500 in the case of a 2nd judgment against the provider or $10,000 in the case of the 3rd or subsequent

judgment against the provider. The Attorney General is authorized to prosecute the civil violations.

B. Upon application of the Attorney General or any affected patient, the Superior Court or District Court has full jurisdiction to enforce the performance by providers of health care of all duties imposed upon them by this section and any valid rules adopted pursuant to section ~~396-F~~ 395-B.

C. In any civil action under this section, the court, in its discretion, may allow the prevailing party, other than the Attorney General, reasonable attorney's fees and costs and the Attorney General is liable for attorney's fees and costs in the same manner as a private person.

D. It is an affirmative defense to any legal action brought under this section that the person subject to this section denied access to services on the grounds that the economic viability of the facility or practice would be jeopardized by compliance with this section.

Sec. 45. 22 MRSA §2061, sub-§2, as amended by PL 1993, c. 390, §24, is further amended to read:

2. Review. Each project for a health care facility has been reviewed and approved to the extent required by the agency of the State that serves as the Designated Planning Agency of the State or by the Department of Human Services in accordance with the provisions of the Maine Certificate of Need Act of 1978, as ~~amended, or, in the case of a project for a hospital, has been reviewed and approved by the Maine Health Care Finance Commission to the extent required by chapter 107~~;

Sec. 46. 22 MRSA §3189, sub-§4, ¶E, as enacted by PL 1989, c. 588, Pt. A, §43, is amended to read:

E. The committee may study issues relating to implementation of the program as it ~~deems~~ determines advisable. The committee shall study what asset limits, if any, are appropriate to determine eligibility for benefits under the program. The study of asset limits ~~shall~~ must include consideration of:

(1) The treatment of assets in other federal and state medical programs serving the population with greater income than the Medicaid program, including the Hill-Burton program of hospital community care described in United States Code, Title 42, Chapter 6-A, Subchapter IV; the Medicaid expansion under the United States Omnibus Budget Reconciliation Act of 1986,

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Public Law 99-509; and the United States Family Support Act of 1988, Public Law 100-482; and the treatment of assets under the charity care income guidelines adopted pursuant to section ~~396-F,-subsection-1~~ 395-B;

(2) The needs of working and nonworking participants for funds to pay transportation and other work-related costs, noncovered medical costs and other emergencies and reasonable incentives for savings; and

(3) Program administrative costs.

The committee shall recommend a policy on assets to the department for review.

Sec. 47. 22 MRSA §4311, sub-§1-A, as enacted by PL 1983, c. 824, Pt. X, §4, is amended to read:

1-A. Municipalities reimbursed. When a municipality pays for expenses approved pursuant to section 4313 for hospital inpatient or outpatient care at any hospital during the time preceding the hospital's first payment year,~~--as--defined--in section--396-G,--subsection--1,~~ on behalf of any person who is otherwise eligible and who would have been entitled to receive payments for hospital care if that care had been rendered prior to May 1, 1984, for services under the Catastrophic Illness Program, section 3185, the department shall reimburse the municipality for 100% of those payments.

Sec. 48. 22 MRSA §4313, sub-§1, as repealed and replaced by PL 1987, c. 542, Pt. H, §§4 and 8, is amended to read:

1. Emergency care. In the event of an admission of an eligible person to the hospital, the hospital shall notify the overseer of the liable municipality within 5 business days of the person's admission. In no event may hospital services to a person who meets the financial eligibility guidelines, adopted pursuant to section ~~396-F,--subsection-1~~ 395-B, be billed to the patient or to a municipality.

Sec. 49. 24-A MRSA §6304, sub-§1, as enacted by PL 1989, c. 931, §5, is amended to read:

1. Assessment from policyholders and self-insureds. With respect to professional liability insurance policies for physicians and hospitals issued on or after July 1, 1990, each insurer shall collect an assessment from each policyholder. With respect to professional liability insurance for self-insureds issued on or after July 1, 1990, each self-insured shall pay an assessment as directed by the superintendent. The superintendent

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shall determine the amount of the assessment in accordance with this chapter. Notwithstanding any provision of law, assessments made and collected pursuant to this chapter do not constitute premium, as defined in section 2403, for purposes of any laws of this State relating to taxation, filing of insurance rates or assessment purposes other than as expressly provided under this chapter. The assessments are considered as premium only for purposes of any laws of this State relating to cancellation or nonrenewal of insurance coverage ~~and--the--determination--of hospital-financial-requirements-under-Title-22,-chapter-107~~.

Sec. 50. 36 MRSA §2801-A, sub-§1, as amended by PL 1991, c. 780, Pt. R, §6, is further amended to read:

1. Initial assessment. For hospital payment years as defined in Title 22, section 382 that ~~end-in-state-fiscal-year 1991-92--and--thereafter~~ begin before January 1, 1996, each hospital licensed under Title 22, chapter 405, excluding state hospitals, must be assessed 6% of the hospital's final gross patient service revenue limit as established by the former Maine Health Care Finance Commission. For hospital payment years that begin on or after January 1, 1996, each hospital licensed under Title 22, chapter 405, excluding state hospitals, must be assessed 6% of the hospital's final gross patient service revenue limit as computed by the Department of Human Services pursuant to subsection 1-A or 1-B.

Sec. 51. 36 MRSA §2801-A, sub-§§1-A and 1-B are enacted to read:

1-A. Computation of revenue limits. The Department of Human Services shall annually compute a gross patient service revenue limit for each hospital, excluding state hospitals, for the purposes of determining the base upon which the assessment required by this section will be calculated. The department shall calculate gross patient service revenue limits based upon the limits previously established for each hospital by the former Maine Health Care Finance Commission, adjusted as appropriate.

1-B. Transitional provisions. Notwithstanding subsections 1 and 1-A, the Department of Human Services must calculate the final gross patient service limit for every case in which a final gross patient service revenue limit was not calculated by the former Maine Health Care Finance Commission prior to January 1, 1996.

Sec. 52. 36 MRSA §2801-A, sub-§§2 and 3, as enacted by PL 1991, c. 591, Pt. Q, §8, are amended to read:

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2. Notice. Each hospital must be notified in writing by the Bureau of Taxation of the estimated annual assessment based on the hospital's gross patient service revenue limit in effect on July 1, 1991, and at the beginning of each hospital's ~~payment~~ fiscal year thereafter considering subsequent modifications. The notice must be provided to each hospital as soon as practicable after it is provided to the Bureau of Taxation by the former Maine Health Care Finance Commission or the Department of Human Services.

3. Future assessments. Subsequent payment year assessments must be based on the proposed gross patient service revenue limit established by the former Maine Health Care Finance Commission or the Department of Human Services with adjustment for modifications. If the commission or the department makes an interim adjustment ~~under Title 22, section 398, subsection 2~~, no change in the assessment may be made until the final assessment is determined.

Sec. 53. 36 MRSA §2801-A, sub-§4, as corrected by RR 1991, c. 1, §56, is amended to read:

4. Basis of assessments; reporting. The Bureau of Taxation shall base each hospital's final assessment on the final decision and order of the former Maine Health Care Finance Commission issued after the close of a payment year to determine compensation by a hospital with its revenue limits and the final obligations of its payors according to former Title 22, section 396-I , or the final determination of the Department of Human Services pursuant to subsection 1-A or 1-B. The commission and the department shall promptly report ~~its~~ final ~~decision~~ determinations to the Bureau of Taxation. Upon notice, the Bureau of Taxation shall promptly report to the affected hospital the ~~Maine Health Care Finance Commission's~~ final ~~decision and order~~ determination as it affects the final assessment of the hospital under this section for the ~~payment~~ year involved.

If the estimated assessment paid exceeds the actual liability, a refund must be authorized by the Bureau of Taxation in the amount of the excess payment. The refund must be paid from the Medical Care - Payments to Providers Special Revenue Account.

If the estimated assessment paid is less than the actual liability, the underpayment must be assessed and payment to the Bureau of Taxation is due within 30 days of notice.

Sec. 54. 38 MRSA §1310-X, sub-§4, amended by PL 1993, c. 355, §52, is further amended to read:

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4. Exemption. A commercial biomedical waste disposal or treatment facility is exempt from the prohibitions of this section if at least 51% of the facility is owned by a hospital or hospitals as defined in Title 22, section ~~382~~ 303, subsection ~~7~~ 11-B or an affiliated interest or interests as defined in Title 22, section ~~396-L~~ 1715, subsection ~~1, paragraph A~~ 1-A.

Sec. 55. Pending proceedings. Notwithstanding any other provision of law, if on January 1, 1996 any case or proceeding is pending before the former Maine Health Care Finance Commission in which approval of a restructuring or other transaction or activity is requested, the case or proceeding will terminate and the restructuring, transaction or activity may be undertaken and completed without any order of approval from the commission. Notwithstanding any other provision of law, any case or proceeding that was pending before the commission on December 31, 1995 with respect to any revenue limit or limits determined pursuant to the Maine Revised Statutes, Title 36, section 2801-A, subsections 1 to 4 must be finalized by the Department of Human Services.

Sec. 56. Apportionment and settlement of Medicaid obligations. Notwithstanding any other provision of law, the Department of Human Services may adjust the apportionment of a hospital's gross patient service revenue, as determined by any order of the Maine Health Care Finance Commission issued prior to January 1, 1996, for purposes of adjusting any interim payments to hospitals for services provided under the Medicaid program and for purposes of determining a final settlement amount, to be paid by the department to the hospital or by the hospital to the department, based on actual utilization of Medicaid services after the close of a hospital's fiscal year. The department may elect to continue calculating apportionments and settlements of Medicaid program payments to hospitals using the forms and methods formerly employed by the former Maine Health Care Finance Commission or may employ such other methods and procedures as would fairly compensate the hospital for services provided under the Medicaid program. Determinations by the department with respect to apportionment of hospital revenues and settlement of obligations after the close of the payment year constitute final agency actions for purposes of any appeal from these determinations in accordance with the Maine Revised Statutes, Title 5, chapter 375, subchapter 7. This section may not be construed to authorize the department to reopen any prior final order of the former Maine Health Care Finance Commission with respect to which the time for appeal has expired, unless the affected hospital consents to the reopening.

Sec. 57. Authorization to expend funds. The Maine Health Data and Policy Development Organization shall exercise authority

over all funds remaining in all accounts of the former Maine Health Care Finance Commission, shall pay all bills and expenses of the former Maine Health Care Finance Commission and any expenses incurred as a result of the termination of the commission and shall pay from the funds all bills and expenses of the organization necessary for the operation of the organization.

Sec. 58. Report required. The Executive Director of the Maine Health Care Finance Commission and the Commissioner of Human Services shall submit to the joint standing committee of the Legislature having jurisdiction over human resources matters and to the Legislature by December 30, 1995, a report detailing the budgetary and statutory changes necessary to fully implement the requirements of this Act and any legislation necessary to accomplish those changes. The report must include legislation required as a result of the termination of the Maine Health Care Finance Commission, the establishment of the Maine Health Data and Policy Development Organization and the transfer of functions to the Department of Human Services.

Sec. 59. Effective dates. This Act takes effect January 1, 1996, except that section 58 takes effect December 1, 1995.

Further amend the bill by inserting at the end before the statement of fact the following:

FISCAL NOTE

This bill requires that the specific budgetary adjustments required to implement this bill be presented in future legislation no later than December 30, 1995.

Eliminating the regulatory function of the Maine Health Care Finance Commission effective January 1, 1996, establishing the Maine Health Data and Policy Development Organization and lowering the limit on the amount of Other Special Revenue that may be generated by an assessment on hospitals will result in a net loss of dedicated revenue which will require corresponding deallocations.

The Department of Human Services will incur additional costs to perform the functions that are transferred to the department from the Maine Health Care Finance Commission which are not expected to require additional resources or personnel. The department will also experience savings in the Medicaid program due to the reduction in the assessment used to fund the Maine Health Data and Policy Development Organization and the elimination of the Management Support Fund.

The proposed current services the Budget may include changes that affect this bill's impact on Maine Health Care Finance Commission. This assessment of the fiscal impact may need to be adjusted based on final legislative actions on the current services budget.'

STATEMENT OF FACT

This amendment replaces the bill. It is the minority report of the committee. On January 1, 1996, it replaces the Maine Health Care Finance Commission with the Maine Health Data and Policy Development Organization. The organization is an independent agency run by a director, appointed by the Governor, subject to confirmation by the Legislature.

It repeals the provisions of the statutes that establish the Maine Health Care Finance Commission and establish salaries for the director, deputy director and general counsel. It enacts a provision establishing a salary at range 89 for the Director of the Maine Health Data and Policy Development Organization.

It provides for the continuation of hospital charity care obligations in a new Maine Revised Statutes, Title 22, section 395-B, consistent with repealed provisions of the statutes of the Maine Health Care Finance Commission. It changes cross-references in Title 22 to refer to the new Title 22, section 395-B, and corrects other cross-references to the Maine Health Care Finance Commission. It establishes that the Department of Human Services will continue to receive the same discount for cross-over claims that presently exists under Maine Health Care Finance Commission rules.

It corrects an error in the bill by removing the repeal of the hospital tax established in Title 36, proceeds of which are dedicated to the Medicaid program. It makes technical amendments to the tax statute so that calculations formerly made by the Maine Health Care Finance Commission will be continued by the Department of Human Services to provide a base for the tax assessment.

It ensures that any Medicaid managed care program implemented by the Department of Human Services will receive a differential calculated by the department on an individual hospital basis, subject to any further discount agreed upon by the hospital and the managed care contractor. It provides for disposition of pending proceedings and the apportionment and settlement of Medicaid obligations.

COMMITTEE AMENDMENT "B" to H.P. 269, L.D. 371

It establishes the Maine Health Data and Policy Development Organization as a state agency for purposes of receiving representation in legal matters from the Attorney General as needed by the organization.

It adds an effective date of January 1, 1996 for all of the provisions except the report provision. The report provision requires a report and legislation from the Executive Director of the Maine Health Care Finance Commission and the Commissioner of Human Services to the joint standing committee of the Legislature having jurisdiction over human resources matters and to the Legislature by December 30, 1995, on legislation required to accomplish the purposes of the amendment. The report provision takes effect December 1, 1995.

It adds a fiscal note.