117th MAINE LEGISLATURE

SECOND REGULAR SESSION-1996

Legislative Document **No. 1788**

H.P. 1307 House of Representatives, February 15, 1996

An Act to Implement the Recommendations of the Task Force to Monitor Deregulation of Hospitals.

(EMERGENCY)

Reported by Representative FITZPATRICK for the Task Force to Monitor Deregulation of Hospitals pursuant to Public Law 1995, chapter 368, Part W, section 12.

Reference to the Joint Standing Committee on Human Resources suggested and printing ordered under Joint Rule 20.

JOSEPH W. MAYO, Clerk

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, current law requiring the Maine Health Care Finance Commission to collect and analyze health care data will expire on June 30, 1996; and

Whereas, the Task Force to Monitor Deregulation of Hospitals has determined that the health data collection and analysis should continue after June 30, 1996; and

Whereas, it is necessary to provide for the transition from the Maine Health Care Finance Commission to the Maine Health Data Organization for the purpose of continuation of the health data collection and analysis functions; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

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

PART A

Sec. A-1. 22 MRSA §395-B, sub-§1, as enacted by PL 1995, c. 368, Pt. W, §4, is amended to read:

1. Charity care guidelines. The department 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 unable to pay for the services received. The department shall adopt income guidelines that are consistent with the guidelines applicable to the Hill-Burton Program established under 42 United States 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. <u>The department shall adopt rules to create a fair hearing mechanism to resolve disputes concerning the determination of eligibility of citizens of the State for charity care.</u>

Sec. A-2. 22 MRSA c. 1683 is enacted to read:

<u>CHAPTER 1683</u>

MAINE HEALTH DATA ORGANIZATION

§8701. Definitions

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

1. Board. "Board" means the Board of Directors of the Maine Health Data Organization established pursuant to section 8702.

2. Clinical data. "Clinical data" includes but is not limited to the data required to be submitted by providers pursuant to section 394, subsection 2, paragraph C, section 394, subsection 2-A, section 395 and section 395-A.

3. Financial data. "Financial data" includes but is not limited to financial information required to be submitted pursuant to section 394, subsection 2, paragraphs A and B and section 395.

4. Health care facility. "Health care facility" means a public or private, proprietary or not-for-profit entity or institution providing health services, including but not limited to a health care facility licensed under chapter 405, a home health care provider licensed under chapter 419, a residential care facility licensed under chapter 1665, a hospice provider licensed under chapter 1681, a community rehabilitation program licensed under Title 20-A, chapter 701, a state institution as defined under Title 34-B, chapter 1 and a mental health facility licensed under Title 34-B, chapter 1.

5. Managed care organization. "Managed care organization" means an organization that manages and controls medical services, including but not limited to a health maintenance organization, a preferred provider organization, a competitive medical plan, a managed indemnity insurance program and a managed Blue Cross and Blue Shield of Maine program, licensed in the State.

6. Organization. "Organization" means the Maine Health Data Organization established under this chapter.

7. Provider. "Provider" means a health care facility, health care practitioner or a health product manufacturer, health product vendor or pharmacy.

8. Restructuring data. "Restructuring data" includes but is not limited to information required to be submitted pursuant to section 396-L.

9. Third-party payor. "Third-party payor" means a health insurer, nonprofit hospital, medical services organization or managed care organization licensed in the State.

§8702. Maine Health Data Organization; established

The Maine Health Data Organization is established as an independent executive agency.

1. Objective. The purpose of the organization is to create and maintain an objective, accurate and comprehensive health information data base for the State built upon existing clinical and financial data bases currently administered and maintained by the Maine Health Care Finance Commission. The Maine Health Care Finance Commission shall collect, process and analyze clinical and financial data as defined in this section until such time as the Maine Health Data Organization becomes operational, as determined by the board, or December 31, 1996, whichever is earlier.

2. Board of directors. The organization operates under the supervision of a board of directors, which consists of 17 voting members.

A. The Governor shall appoint 15 board members, subject to review by the joint standing committee of the Legislature having jurisdiction over human resource matters and confirmation by the Legislature. The 15 board members appointed by the Governor must be selected in accordance with the following requirements.

(1) Three members must represent consumers. For the purposes of this section, "consumer" means a person who is not affiliated with or employed by a 3rd-party payor, a provider or an association representing those providers or those 3rd-party payors.

(2) Two members must represent employers.

(3) Two members must represent 3rd-party payors.

(4) Six members must represent providers. Two provider members must represent hospitals and must be chosen from a list of at least 5 current hospital representatives provided by the Maine Hospital Association. Two provider members must be physicians, at least one of whom is chosen from a list of at least 5 physicians provided jointly by the Maine Medical Association and the Maine Osteopathic Association. Two provider members must be representatives of other

medical practices, at least one of whom is a current representative of a home health care company.

(5) Two ex officio members must represent the State's interest in maintaining health data to ensure that information collected is made available as a basis of determining public health policy.

B. Two members must represent the Legislature's interest in maintaining health data to ensure that information collected is made available as a basis of determining public health policy. One legislative member must be appointed by the President of the Senate and one legislative member must be appointed by the Speaker of the House.

3. Terms of office. For the initial appointed members of the board, the terms of office are staggered as follows: Five members serve one-year terms; 5 members serve 2-year terms; and 5 members serve 3-year terms. Of the initial appointees, representatives of the same group may not have the same term length, except that 2 provider representatives may have the same term length and the 2 legislative members serve 2-year terms coinciding with their legislative terms. Thereafter, members serve 3-year terms, except that a member appointed to fill a vacancy in an unexpired term serves only for the remainder of that term. Members hold office until the appointment and confirmation of their successors. Board members may serve a maximum of 2 consecutive terms.

4. Officers. Members of the board shall elect the chair of the board.

5. Legal counsel. The Attorney General, when requested, shall furnish any legal assistance, counsel or advice the organization requires in the discharge of its duties.

6. Compensation. The board members are entitled to compensation according to the provisions of Title 5, chapter 379.

§8703. Powers and duties of the board

The board has the following powers and duties.

1. Uniform reporting systems. The board shall establish uniform reporting systems.

A. The board shall develop and implement data collection policies and procedures that require, at a minimum, the collection, processing, storing and analysis of clinical, financial and restructuring data.

B. In addition to the data collection policies and procedures established in paragraph A, the board may require the submission of clinical, financial and restructuring data from providers, 3rd-party payors and managed care organizations that are not subject to the requirements of sections 394, 395 and 395-A.

C. The board shall provide analysis of data upon request.

2. Contracts for data collection; processing. The board shall contract with one or more qualified, nongovernmental, independent 3rd parties for services necessary to carry out the data collection and processing activities required under this chapter. For purposes of this subsection, a group or organization affiliated with the University of Maine System is not considered a governmental entity. Unless permission is specifically granted by the board, a 3rd party hired by the organization may not release, publish or otherwise use any information to which the 3rd party has access under its contract and shall otherwise comply with the requirements of this chapter.

3. Contracts generally. The board may enter into all other contracts necessary or proper to carry out the powers and duties of this chapter.

4. Rulemaking. The board shall adopt emergency and permanent rules necessary for the proper administration and enforcement of the requirements of this chapter, in accordance with the Maine Administrative Procedure Act.

5. Public hearings. The board may conduct any public hearings determined necessary to carry out its responsibilities.

6. Staff. The board shall appoint staff as needed to carry out the duties and responsibilities of the board under this chapter.

7. User fees. In order to fund the operation of the organization, the board may assess reasonable fees for the right to access and use the health data. The board shall set policies governing the release, publication and uses of analyses, reports or compilations derived from the health data. The board shall waive user fees for public health research conducted by the department. The board shall establish a sliding scale of user fees. The board may waive or set lower fees for a user that is engaged in research of value to the general public if that user can demonstrate to the satisfaction of the board that the user is unable to afford the standard fee. The board may use the

revenues collected for the purpose of defraying the operating expenses of the organization.

8. Annual report. The board shall prepare and submit an annual report on health care trends to the Governor and the joint standing committee of the Legislature having jurisdiction over human resource matters no later than January 15th of each year. The report must include an annual accounting of all outside revenue received by the board.

9. Grants. The board may solicit, receive and accept grants, funds or anything of value from any public or private organization and receive and accept contributions of money, property, labor or any other thing of value from any legitimate source, except that the board may not accept grants from any entity that might have a vested interest in the decisions of the board.

10. Other powers. The board may exercise all powers reasonably necessary to carry out the powers expressly granted and responsibilities expressly imposed by this chapter.

§8704. Enforcement

1. Fine. The failure to file data as required under this chapter is a civil violation. A provider who fails to file data required under this chapter may be fined not more than $1,000 a day if that provider is a health care facility or $500 a day for all other providers, except that a fine imposed under this section may not exceed $25,000 for health care facilities for any one occurrence and $12,500 for all other providers for any one occurrence.

2. License revoked. Upon a finding that a provider has repeatedly and intentionally refused to comply with the requirements of this chapter, the board may file a complaint with the provider's licensing board seeking the revocation of the provider's license.

3. Court order. If a provider refuses to file the data required, the board may obtain a court order requiring the provider to produce the data.

§8705. Revenues and expenditures

1. Transition funding. Every hospital is subject to an assessment of not more than .07% of its gross patient service revenues. For the period of July 1, 1996 through March 31, 1997, the aggregate assessment on all hospitals may not exceed $1,000,000. The organization shall assess each hospital for its

pro rata share prior to July 1, 1996. Each hospital shall pay the assessment charged to it on a quarterly basis, with payments due on or before July 1, 1996, October 1, 1996 and January 1, 1997.

2. Permanent funding. The board may determine an appropriate assessment to be applied to all providers of health data, including hospitals, to defray the expenses of maintaining the health data functions set forth in this chapter. The board may request an appropriation of general funds from the Legislature.

3. Use of funds. The board may use the revenues from provider assessments and user fees to defray the costs incurred by the board pursuant to this chapter, including staff salaries, administrative expenses, data system expenses, consulting fees and any other reasonable costs incurred to administer this chapter.

4. Budget. The organization's expenditures are subject to legislative approval. The organization shall report annually, before February 1st, to the joint standing committee of the Legislature having jurisdiction over human resource matters on its planned expenditures for the year and on its use of funds in the previous year.

5. Unexpended funds. Any funds not expended at the end of a fiscal year may not lapse, but must be carried forward to the succeeding fiscal year.

6. Deposit with Treasurer of State. The board shall deposit all payments made pursuant to this section with the Treasurer of State. The deposits must be used for the sole purpose of paying the expenses of the Maine Health Data Organization.

§8706. Public access to data

1. Public access. Information, except privileged medical information and confidential commercial information, provided to the organization under this chapter must be made available to any person upon request as long as individual patients or health care practitioners are not directly identified.

2. Notice and comment period. The board shall adopt rules establishing criteria for determining whether information is privileged medical information and adopt procedures to afford affected health care practitioners notice and opportunity to comment in response to requests for information that may be considered privileged.

3. Public health studies. The board by rule may allow, pursuant to subsection 1, exceptions to the rules adopted only to the extent authorized in this subsection.

A. The board may approve access to identifying information for patients or for health care practitioners to:

(1) The department; and

(2) Other researchers with established protocols approved by the board for safeguarding confidential or privileged information.

B. The board shall adopt rules that ensure that:

(1) Identifying information is used only to gain access to medical records and other medical information pertaining to public health;

(2) Medical information about any patient identified by name is not obtained without the consent of that patient except when the information sought pertains only to verification or comparison of health data and the board finds that confidentiality can be adequately protected without patient consent;

(3) Those persons conducting the research or investigation do not disclose medical information about any patient identified by name to any other person without that patient's consent;

(4) Those persons gaining access to medical information about an identified patient use that information to the minimum extent necessary to accomplish the purposes of the research for which approval was granted; and

(5) The protocol for any research is designed to preserve the confidentiality of all medical information that can be associated with identified patients, to specify the manner in which contact is made with patients or health care practitioners and to maintain public confidence in the protection of confidential information.

C. The board may not grant approval under this subsection if the board finds that the proposed identification of or contact with patients or health care practitioners would violate any state or federal law or diminish the

confidentiality of medical information or the public's confidence in the protection of that information in a manner that outweighs the expected benefit to the public of the proposed investigation.

Sec. A-3. Transition. The following provisions apply to the transfer of the health facilities data from the Maine Health Care Finance Commission to the Maine Health Data Organization.

1. The Maine Health Data Organization is the successor in every way to the Maine Health Care Finance Commission with respect to the authority to collect clinical, financial and restructuring data from health care facilities and providers of health care. All responsibilities, power and authority relating to the collection of such health care information that were formerly vested in the Maine Health Care Finance Commission are transferred to the Maine Health Data Organization.

2. Notwithstanding the provisions of the Maine Revised Statutes, Title 5, all accrued expenditures, assets and liabilities and any balances, appropriations, allocations, transfers, revenues or other available funds in an account or subdivision of an account of the Maine Health Care Finance Commission must be transferred to the proper accounts of the Maine Health Data Organization by the State Controller upon the request of the Maine Health Data Organization when the organization is ready to assume its responsibilities under this chapter.

3. All rules and procedures in effect, in operation or adopted on the effective date of this Part by the Maine Health Care Finance Commission regarding data collection, enforcement provisions and requirements remain in effect until rescinded, revised or amended by the Maine Health Data Organization.

4. All contracts, agreements and compacts in effect on the effective date of this Part in the former Maine Health Care Finance Commission remain in effect until rescinded, revised or amended by the Maine Health Data Organization.

5. All data required to have been filed with the Maine Health Care Finance Commission pursuant to Title 22, chapter 107 are transferred to the Maine Health Data Organization. In the event that any data have not been filed with the Maine Health Care Finance Commission as of the effective date of this Part, the Maine Health Data Organization shall direct that data be filed with the Maine Health Data Organization.

6. All records, property and equipment previously belonging to or allocated for the use of the Maine Health Care Finance

Commission necessary for performing the data collecting activities are transferred to the Maine Health Data Organization.

Sec. A-4. Effective date. This Part takes effect July 1, 1996.

PART B

Sec. B-1. 5 MRSA §12004-G, sub-§14-B is enacted to read:

14-B. Health	Maine Health Data Organization	Expenses Only	22 MRSA §8702

Sec. B-2. 22 MRSA §381, sub-§1, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-3. 22 MRSA §381, sub-§2, ¶A, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-4. 22 MRSA §381, sub-§2, ¶B, as enacted by PL 1983, c. 579, §10, is amended to read:

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

Sec. B-5. 22 MRSA §381, sub-§2, ¶C, as enacted by PL 1985, c. 278, is repealed.

Sec. B-6. 22 MRSA §382, sub-§1, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-7. 22 MRSA §382, sub-§1-A, as enacted by PL 1989, c. 588, Pt. A, §5, is repealed.

Sec. B-8. 22 MRSA §382, sub-§§11 and 12, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. B-9. 22 MRSA §382, sub-§§15 and 16, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. B-10. 22 MRSA §382, sub-§16-A, as enacted by PL 1989, c. 588, Pt. A, §6, is repealed.

Sec. B-11. 22 MRSA §382, sub-§§17 and 18, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. B-12. 22 MRSA §382, sub-§20, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-13. 22 MRSA §384, as amended by PL 1985, c. 785, Pt. B, §84, is further amended to read:

§384. Executive director and staff

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

Sec. B-14. 22 MRSA §385, as amended by PL 1983, c. 579, §10, is further amended to read:

§385. Legal counsel

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

Sec. B-15. 22 MRSA §386, sub-§5, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-16. 22 MRSA §387, sub-§1, as enacted by PL 1989, c. 844, §1, is amended to read:

1. Public access. Any information, except confidential commercial information obtained from a payor or a hospital or privileged medical information, and any studies or analyses that are filed with, or otherwise provided to, the commission under this chapter must be made available to any person upon request, provided that individual patients or health care practitioners are not directly identified. The commission shall adopt rules governing public access in the least restrictive means possible to information that may indirectly identify a particular patient or health care practitioner.

Sec. B-17. 22 MRSA §388, sub-§1, ¶A, as amended by PL 1989, c. 588, Pt. A, §7, 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~~ must include such facts, suggestions and policy recommendations as the commission 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.~~

Sec. B-18. 22 MRSA §388, sub-§1, ¶B, as enacted by PL 1985, c. 778, §1, is repealed.

Sec. B-19. 22 MRSA §391, sub-§4-A is enacted to read:

4-A. Use of funds. The commission may use the revenues provided in this section to defray the costs incurred by the commission pursuant to this chapter, including salaries, administrative expenses, data system expenses, consulting fees and any other reasonable costs incurred to administer this chapter.

Sec. B-20. 22 MRSA §392, sub-§2, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-21. 22 MRSA §394, sub-§1, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-22. 22 MRSA §394, sub-§2, ¶C, as amended by PL 1989, c. 565, §5 and c. 595, is further amended to read:

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; and for each hospital outpatient service occurring after February 9, 1993.

Sec. B-23. 22 MRSA §394, sub-§§4 to 6, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-24. 22 MRSA §395, sub-§6, as enacted by PL 1983, c. 579, §10, is amended to read:

6. Authority to obtain information. Nothing in this subchapter may be construed to limit the commission's authority to obtain information from hospitals ~~which~~ that it ~~deems~~ considers necessary to carry out its duties ~~under subchapter III~~.

Sec. B-25. 22 MRSA §395-A, sub-§1, as amended by PL 1993, c. 121, §1, is further amended to read:

1. Development of health care information systems. In addition to the commission's authority to obtain information to

carry out the specific provisions of this subchapter, the commission may require providers of health care to furnish information with respect to the nature and quantity of services provided to the extent necessary to develop proposals for the modification, refinement or expansion of the systems of information disclosure established under this subchapter. The commission's authority under this subsection includes the design and implementation of pilot information reporting systems affecting selected categories of providers of health care or representative samples of providers. ~~Pilot information reporting systems established under this subsection may be implemented on a statewide basis.~~

Sec. B-26. 22 MRSA §395-A, sub-§2, as amended by PL 1993, c. 121, §1, is repealed.

Sec. B-27. 22 MRSA §395-A, sub-§3, as amended by PL 1993, c. 121, §§2 and 3, is repealed.

Sec. B-28. 22 MRSA §396, as amended by PL 1995, c. 497, §3, is repealed.

Sec. B-29. 22 MRSA §§396-A, 396-B and 396-C, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. B-30. 22 MRSA §396-D, as amended by PL 1995, c. 497, §4, is repealed.

Sec. B-31. 22 MRSA §396-E, sub-§1, as amended by PL 1991, c. 830, §§5 and 6, is repealed.

Sec. B-32. 22 MRSA §396-F, as amended by PL 1993, c. 733, §1, is repealed.

Sec. B-33. 22 MRSA §396-G, as amended by PL 1993, c. 673, §1 and affected by §10, is repealed.

Sec. B-34. 22 MRSA §396-H, as repealed and replaced by PL 1989, c. 588, Pt. A, §32, is repealed.

Sec. B-35. 22 MRSA §396-I, as amended by PL 1993, c. 645, Pt. A, §1, is repealed.

Sec. B-36. 22 MRSA §396-J, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. B-37. 22 MRSA §396-K, as amended by PL 1991, c. 771, §1, is repealed.

Sec. B-38. 22 MRSA §396-L, sub-§1, ¶E, as amended by PL 1987, c. 402, Pt. A, §138, is further amended to read:

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

(1) Transfer of any assets of a hospital or hospital-capitalized affiliate to any person, provided that the transfer of assets to a title-holding company within the meaning of the United States Internal Revenue Code, Section 501, paragraph C, subparagraph (2), that holds property on behalf of the transferor ~~shall~~ may not be considered a hospital restructuring;

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

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

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

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

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

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

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

(9) Spin-offs of services to subsidiaries and for-profit and not-for-profit organizations.

Sec. B-39. 22 MRSA §396-L, sub-§2, ¶B, as repealed and replaced by PL 1985, c. 778, §5, is repealed.

Sec. B-40. 22 MRSA §396-L, sub-§3, as repealed and replaced by PL 1985, c. 778, §5, is amended to read:

3. Access to accounts and records. The commission may require the production of books, accounts, records, papers and memoranda of an auxiliary ~~which~~ that is engaged in commercial activities or of an affiliated interest or related party ~~which~~ that relate, directly or indirectly, to any of its dealings with a hospital ~~which~~ that affect the hospital's costs or charges. ~~The commission may, in determining financial requirements of a hospital, disallow all or a portion of the payments under such dealings, the account or record of which is not made available to the commission.~~

Sec. B-41. 22 MRSA §396-L, sub-§4, ¶¶A to F, as repealed and replaced by PL 1985, c. 778, §5, are repealed.

Sec. B-42. 22 MRSA §396-L, sub-§4, ¶H, as amended by PL 1991, c. 786, §3, is repealed.

Sec. B-43. 22 MRSA §396-L, sub-§4, ¶I, as amended by PL 1991, c. 786, §3, is further amended to read:

I. ~~No less than 21 days prior to the effective date of any hospital restructuring that is exempt from approval under paragraph H, each affected hospital shall file with the commission a notice including a description of the contemplated restructuring, the date on which it is expected to occur and other information the commission may reasonably require about the characteristics and expected effects of the restructuring.~~ No more than 30 days after each restructuring described in a notice under this subsection occurs, each affected hospital shall file with the commission a report of the date on which the restructuring took place, any differences between the restructuring that occurred and the description furnished in the notice and any corrections or amendments of the other information in the notice that are necessary to reflect the results of the restructuring that actually took place.

Sec. B-44. 22 MRSA §396-L, sub-§5, as repealed and replaced by PL 1985, c. 778, §5, is repealed.

Sec. B-45. 22 MRSA §§396-M and 396-N, as enacted by PL 1983, c. 579, §10, are repealed.

Sec. B-46. 22 MRSA §396-O, as amended by PL 1989, c. 588, Pt A, §41, is repealed.

Sec. B-47. 22 MRSA §396-P, as corrected by RR 1991, c. 2, §73, is repealed.

Sec. B-48. 22 MRSA §396-Q, as enacted by PL 1987, c. 847, §3, is repealed.

Sec. B-49. 22 MRSA §396-R, as enacted by PL 1991, c. 830, §8, is repealed.

Sec. B-50. 22 MRSA §396-S, as enacted by PL 1993, c. 733, §2, is repealed.

Sec. B-51. 22 MRSA §398, as amended by PL 1991, c. 771, §3, is repealed.

Sec. B-52. 22 MRSA §399, as enacted by PL 1983, c. 579, §10, is amended to read:

§399. Other powers

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

PART C

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

Sec. C-2. 5 MRSA §12004-I, sub-§§45, 46 and 47, as enacted by PL 1987, c. 786, §5, are repealed.

Sec. C-3. 22 MRSA §304-D, sub-§5, as enacted by PL 1985, c. 661, §2, is repealed.

Sec. C-4. 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 these 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. C-5. 22 MRSA §309, sub-§1, ¶D, as amended by PL 1995, c. 462, Pt. A, §41, 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-K~~ with respect to the ability of the citizens of the State to pay for the proposed services.

Sec. C-6. 22 MRSA §309, sub-§6, as amended by PL 1989, c. 502, Pt. A, §65, is further amended to read:

6. Hospital projects. ~~Notwithstanding subsections 1, 4 and 5, the department may not issue a certificate of need for a project which is subject to the provisions of section 396-D, subsection 5, and section 396-K, if the associated costs exceed the amount which the commission has determined will have been credited to the Certificate of Need Development Account pursuant to section 396-K, after accounting for previously approved projects. A project shall not be denied solely on the basis of exceeding the amount remaining in the Certificate of Need Development Account or Hospital Development Account in a particular payment year and shall be held for further consideration by the department in the first appropriate review cycle beginning after the Certificate of Need Development Account or Hospital Development Account is credited with additional amounts.~~ Projects ~~which~~ that are carried forward ~~shall~~ must compete equally with newly proposed projects. For the purposes of this subsection, a project may be held for a final decision beyond the time frames set forth in section 307, subsection 3.

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

2. Committees. ~~In addition to the committees required to be established under section 396-P, the~~ The commission may create committees from its membership and appoint advisory committees consisting of members, other individuals and representatives of interested public and private groups and organizations.

Sec. C-8. 22 MRSA §395, sub-§2, as enacted by PL 1983, c. 579, §10, is amended to read:

2. Hospital reporting. The commission shall, after consultation with appropriate advisory committees and after public hearing, direct hospitals to use a uniform system of financial reporting. ~~Subject to the requirements of section 394, subsection 6, this~~ This system ~~shall~~ must include such cost allocation and revenue allocation methods as the commission may prescribe for use in reporting revenues, expenses, other income and other outlays, assets, liabilities and units of service.

Sec. C-9. 22 MRSA §396-L, sub-§1, ¶D, as enacted by PL 1985, c. 778, §5, is amended to read:

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

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

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

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

Sec. C-10. 22 MRSA §396-L, sub-§2, ¶B-1, as enacted by PL 1989, c. 919, §11 and affected by §18, is amended to read:

B-1. As a result of its review of significant transactions reported pursuant to paragraph A, or its examination of significant transactions in the course of any proceeding to determine hospital financial requirements, the commission may, with respect to the significant transactions between hospitals and affiliated interests, establish reasonable limits on the actual prices paid by hospitals or charged by hospitals. ~~The commission may not exercise this authority with respect to transfers and pledges that are exempt from commission review under subsection 4, paragraph F.~~

Sec. C-11. 22 MRSA §396-L, sub-§2, ¶C, as repealed and replaced by PL 1985, c. 778, §5, is repealed.

Sec. C-12. 22 MRSA §396-L, sub-§4, as amended by PL 1991, c. 786, §3, is further amended by amending the first paragraph to read:

4. Hospital restructuring. Unless exempt by rule or order of the commission ~~or by paragraph F or~~ H, no hospital restructuring may take place without the approval of the commission. No hospital restructuring may be approved by the commission unless it is established by the applicant for approval

that the hospital restructuring is consistent with the interests of the people of the State.

Sec. C-13. 22 MRSA §396-L, sub-§6, as enacted by PL 1985, c. 778, §5, is amended to read:

6. Rules. By November 1, 1986, the commission shall adopt rules governing hospital restructuring and significant transactions as defined in this chapter, including, but not limited to, rules addressing the following subjects:

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

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

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

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

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

Sec. C-14. 22 MRSA §396-L, sub-§7, ¶A, as enacted by PL 1989, c. 919, §14 and affected by §18, is amended to read:

A. No hospital or hospital-capitalized affiliate may transfer assets to or otherwise subsidize the operation of any affiliated interest, except to the extent that:

(1) The activities of the affiliated interest and any subsidies of them have been expressly approved by the commission in the course of a proceeding to approve an application for restructuring under subsection 4; ~~or~~.

~~(2) The transfer or pledge, as applicable, is exempt from commission review subject to subsection 4, paragraph F.~~

Sec. C-15. 22 MRSA §1715, sub-§1, as enacted by PL 1989, c. 919, §15 and affected by §18, is amended by amending the first paragraph to read:

1. Access requirements. Any person, including, but not limited to an affiliated interest as defined in 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~~. A person is subject to this subsection if that person:

Sec. C-16. 22 MRSA §1715, sub-§2, ¶¶A and B, as enacted by PL 1989, c. 919, §15 and affected by §18, are amended to read:

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~~, 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~~.

Sec. C-17. 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~~ considers 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,

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;~~

Sec. C-18. 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. C-19. 22 MRSA §4313, sub-§1, as repealed and replaced by 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, be billed to the patient or to a municipality.~~

Sec. C-20. 36 MRSA §2801-A, sub-§3, as enacted by PL 1991, c. 591, Pt. Q, §8, is amended to read:

3. Future assessments. Subsequent payment year assessments must be based on the proposed gross patient service revenue limit established by the Maine Health Care Finance Commission with adjustment for modifications. ~~If the commission 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. C-21. 36 MRSA §2801, 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 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 Title 22, section 396-I~~. The commission

shall promptly report its final decision 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 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.

(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.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect April 1, 1996.

STATEMENT OF FACT

Part A of the bill establishes the Maine Health Data Organization, an independent executive organization that will oversee and coordinate the collection and analysis of health care data. The bill enacts provisions to ensure that the Maine Health Data Organization has the authority to collect health data from all health care facilities, 3rd-party payor, managed care organizations and practitioners providing health services, including pharmacists and health product manufacturers. The bill requires the Maine Health Data Organization to collect and analyze clinical, financial and restructuring data. The bill also provides for a mechanism of funding, including assessments and user fees, for the Maine Health Data Organization. The bill sets forth the transition provision necessary to ensure continuation of the data collection and analysis functions of the Maine Health Care Finance Commission until such time as the new organization becomes operational, as determined by the board or December 31, 1996, whichever is earlier.

Part A of the bill expressly requires the Department of Human Services to adopt rules to create a fair hearing mechanism for resolution of disputes over eligibility determinations for charity care.

Part B of the bill contains the changes recommended by the Maine Health Care Commission to repeal the commission's cost containment functions as recommended by the Task Force to Monitor Deregulation of Hospitals.

Part C of the bill corrects cross-references that needed to be changed due to the recommendations of the Maine Health Care Commission.