LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND ELEVENTH LEGISLATURE

FIRST REGULAR SESSION
December 1, 1982 to June 24, 1983
Chapters 453-End

AND AT THE

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PUBLISHED BY THE DIRECTOR OF LEGISLATIVE RESEARCH IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED, TITLE 3, SECTION 164, SUBSECTION 6.

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PUBLIC LAWS

OF THE

STATE OF MAINE

AS PASSED AT THE

FIRST REGULAR SESSION

CONTINUED

and

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1983

or program or a private school or program approved for tuition purposes. The commissioner may participate in informal conciliation efforts made pursuant to section 4612, subsection 3 and shall, upon request, have access to all information concerning these conciliation efforts.

Sec. 4. Report The Maine Human Rights Commission and the Department of Educational and Cultural Services shall report to the Joint Standing Committee on Education at the beginning of the First Regular Session of the 112th Legislature concerning the implementation of this Act.

Effective September 23, 1983.

CHAPTER 579

S.P. 608 - L.D. 1737

AN ACT to Limit Future Increases in the Cost of Hospital Care in Maine.

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

Sec. 1. 2 MRSA §6-B is enacted to read:

§6-B. Salaries of certain employees of the Maine Health Care Finance Commission

Notwithstanding any other provision of law, the salaries of certain employees of the Maine Health Care Finance Commission shall be as follows.

1. Executive director. The salary of the executive director shall be within salary range 91.

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

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

Sec. 2. 3 MRSA §507, sub-§10, ¶B, as repealed and replaced by PL 1979, c. 654, §3, is amended to read:

B. Unless continued or modified by law, the following Group E-2 independent agencies shall terminate, not including the grace period, no later than June 30, 1989:

(1) Board of Trustees Group Accident and Sickness or Health Insurance;

(2) Maine Vocational Development Commission;

(3) Post-secondary Education Commission of Maine;

(4) Advisory Committee on Maine Public Broadcasting;

(5) State Government Internship Program Advisory Committee;

(6) State Historian;

(7) Historic Preservation Commission;

(8) Maine State Commission on the Arts and the Humanities;

(9) Maine Occupational Information Coordinating Committee; ~~and~~

(10) Maine Historical Society; and

(11) Maine Health Care Finance Commission.

Sec. 3. 5 MRSA §711, sub-§1, ¶H, as repealed and replaced by PL 1977, c. 674, §6, is amended to read:

H. Officers and employees of the unorganized territory school system and the teachers and principals of the school systems in state vocational schools and state institutions; ~~and~~

Sec. 4. 5 MRSA §711, sub-§1, ¶I, as amended by PL 1979, c. 537, is further amended to read:

I. Deputies, assistants, staff attorneys, research assistants, business manager and the secretary to the Attorney General of the Attorney General's Department~~.~~; and

Sec. 5. 5 MRSA §711, sub-§1, ¶J is enacted to read:

J. The executive director, deputy director, general counsel and staff attorneys of the Maine Health Care Finance Commission.

Sec. 6. 22 MRSA §303, sub-§3-A is enacted to read:

3-A. Commission. "Commission" means the Maine

Health Care Finance Commission established pursuant to chapter 107.

Sec. 7. 22 MRSA §303, sub-§17, as enacted by PL 1977, c. 687, §1, is repealed and the following enacted in its place:

17. Project. "Project" means any acquisition, capital expenditure, new health service, termination or change in a health service, predevelopment activity or other activity which requires a certificate of need under section 304-A.

Sec. 8. 22 MRSA §304-A, sub-§9, ¶B, as enacted by PL 1981, c. 705, Pt. V, §16, is amended to read:

B. If a person adds a health service not subject to review under subsection 4, paragraph A or C and which was not deemed subject to review under subsection 4, paragraph B at the time it was established and which was not reviewed and approved prior to establishment at the request of the applicant, and its actual 3rd fiscal year operating cost, as adjusted ~~with~~ by an appropriate inflation deflator promulgated by the ~~Health Facilities Cost Review Board pursuant to sections 360 and 366~~ department, after consultation with the commission, exceeds the expenditure minimum for annual operating cost in the 3rd fiscal year of operation following addition of these services.

Sec. 9. 22 MRSA §309, sub-§6 is enacted 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.

Sec. 10. 22 MRSA c. 107 is enacted to read:

CHAPTER 107

MAINE HEALTH CARE FINANCE COMMISSION

SUBCHAPTER I

GENERAL PROVISIONS

§381. Findings and declaration of purpose

1. Findings. The Legislature makes the following

findings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§382. Definitions

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

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

2. Bureau. "Bureau" means the Bureau of Health Planning and Development within the Department of Human Services.

3. Commission. "Commission" means the Maine Health Care Finance Commission established by this chapter.

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

5. Direct provider of health care. "Direct provider of health care" means an individual whose primary current activity is the provision of health care to other individuals or the administrator of a facility in which that care is provided.

6. Health care facility. Except as provided in subsection 14, "health care facility" means any health care facility required to be licensed under chapter 405 or its successor, with the exception of the Cutler Health Center and the Dudley Coe Infirmary.

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

8. Independent data organization. Except as provided in section 394, subsection 3, "independent data organization" means an organization of data users, a majority of whose members are not direct providers of health care services and whose purposes are the cooperative collection, storage and retrieval of health care information.

9. Major 3rd-party payor. "Major 3rd-party payor" means a 3rd-party payor, as defined in subsection 19, which, with respect to an individual hospital:

A. Is responsible for payment to the hospital of amounts equal to or greater than 10% of all payments to the hospital, as this amount is determined by the commission; and

B. Maintains a participating agreement with the hospital.

Notwithstanding paragraphs A and B, the department shall be deemed a major 3rd-party payor with respect to any hospital participating in the Medicaid program. In addition, any payor responsible for payment under the Medicare program shall be deemed a major 3rd-party payor with respect to any hospital participating in that program, provided that a payor which acts as a fiscal intermediary for the Medicare program shall not be considered a major 3rd-party payor with respect to payments it makes other than as a Medicare fiscal intermediary, unless it also meets

the provisions of paragraphs A and B with respect to these payments.

10. Participating agreement. "Participating agreement" means a written agreement between a hospital and a 3rd-party payor under which the payor is obligated to pay the hospital directly on behalf of its beneficiaries and under which the hospital is obligated to meet participation requirements which may include, but are not limited to, such areas as submission of claims information, utilization review programs and record keeping. Any such agreement in effect on the effective date of this chapter shall not be invalidated by this chapter except to the extent that specific provisions of this chapter are inconsistent with the provisions of those agreements and then only to the extent of the inconsistency.

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

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

13. Person. "Person" means an individual, trust or estate, partnership, corporation, including associations, joint stock companies and insurance companies, the State or a political subdivision or instrumentality, including a municipal corporation of the State, or any other legal entity recognized by state law.

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

A. A direct provider of health care;

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

C. A health product manufacturer.

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

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

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

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

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

20. Voluntary budget review organization. "Voluntary budget review organization" means a nonprofit organization established to conduct reviews of budgets and approved by the board pursuant to Public Law 1977, chapter 691, section 1.

§383. Maine Health Care Finance Commission

1. Establishment. The Maine Health Care Finance Commission shall be established as follows.

A. There is established the Maine Health Care Finance Commission, which shall function as an independent executive agency.

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 chairman and a vice-chairman, who shall serve in these capacities at his 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 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 receive a per diem allowance of $150 for each day he is actively engaged in performing the work of the commission and each member shall be reimbursed for the actual necessary and proper expenses incurred in the performance of his duties.

§384. Executive director and staff

The commission shall appoint an executive direc-

tor, 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 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 necessary. The appointment and compensation of such other staff shall be subject to the Personnel Law.

§385. Legal counsel

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

§386. Powers of commission generally

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

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

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

3. Receipt of grants, gifts and payments. The commission may solicit, receive and accept grants, gifts, payments and other funds and advances from any person, other than a provider of health care, as de-

fined in section 382, subsection 14, or a 3rd-party payor, as defined in section 382, subsection 19, and enter into agreements with respect to those grants, payments, funds and advances, including agreements that involve the undertaking of studies, plans, demonstrations or projects. The commission may only accept funds from providers of health care or from 3rd-party payors in accordance with subsection 9 and section 391.

4. Studies and analyses. The commission may conduct studies and analyses relating to health care costs, the financial status of any facility subject to this chapter and any other related matters it deems appropriate.

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

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

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

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

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

§387. Public information

Any information, except confidential commercial information obtained from a payor or privileged medi-

cal information, and any studies or analyses which are filed with, or otherwise provided to, the commission under this chapter shall be made available to any person upon request, provided that individual patients or health care practitioners are not directly identified. The commission shall adopt rules governing public access in the least restrictive means possible to information which may indirectly identify a particular patient or health care practitioner. The commission shall also adopt rules establishing criteria for determining whether information is confidential commercial information or privileged medical information and establishing procedures to afford affected payors or hospitals, as applicable, notice and opportunity to comment in response to requests for information which may be considered confidential or privileged.

§388. Reports

1. Annual reports. Annually, prior to January 1st, the commission shall prepare and transmit to the Governor and to the Legislature a report of its operations and activities during the previous year. This report shall include such facts, suggestions and policy recommendations as the commission considers necessary.

2. Reports to legislative committee. While the Legislature is in session, the commission or its staff shall, upon request of the joint standing committee of the Legislature having jurisdiction over health and institutional services, appear before the committee to discuss its annual report and any other items requested by the committee.

3. Consumer reports. The commission shall, from time to time as it deems appropriate, publish and disseminate any information that would be useful to consumers in making informed choices in obtaining health care, including the results of any studies or analyses undertaken by the commission.

4. Review by health care facility. If any studies or analyses undertaken by the commission pursuant to section 386, subsection 4, or if any consumer information developed pursuant to subsection 3 directly or indirectly identify a particular health care facility, the health care facility shall be afforded a reasonable opportunity, before public release, to review and comment upon the studies, analyses or other information.

§389. Penalties

Any person who knowingly violates any provision

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

§390. Enforcement

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

§391. Funding of the commission

1. Assessments. Every hospital subject to regulation under this chapter shall be subject to an assessment of not more than .15% of its gross patient service revenues. 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 subject to legislative approval in the same manner as the budget of the commission is approved. The commission shall also report annually, before February 1st, to the joint standing committee of the Legislature having jurisdiction over health and institutional sevices on its planned expenditures for the year and on its use of funds in the previous year.

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

Care Finance Commission Fund.

4. Use of funds. The commission may use the revenues provided in this section to defray the costs incurred by the commission pursuant to this chapter, including salaries, administrative expenses, data system expenses, consulting fees and any other reasonable costs incurred to administer this chapter. The commission may not use the revenues provided in this section to make grants pursuant to section 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 not lapse, but shall be carried forward to be expended for the purposes specified in this section in succeeding fiscal years. Any unexpended funds in excess of 7% of the total annual assessment authorized in subsection 1 shall, at the option of the commission, either be presented to the Legislature in accordance with subsection 2 for reallocation and expenditure for commission purposes or used to reduce the hospital assessment in the following fiscal year.

§392. Program audit and evaluation

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

2. Evaluation. In addition to the requirements as to contents of justification reports under Title 3, section 504, the commission shall include in its report an evaluation of the impact of the hospital financing system established under this chapter on the quality of hospital care, access to such care and the financial stability of hospitals in the State.

SUBCHAPTER II

HEALTH FACILITIES INFORMATION DISCLOSURE

§394. Uniform systems of reporting generally

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

2. Information required. In addition to any other requirements applicable to specific categories

of health care facilities, as set forth in section 395, and in subchapters III and IV and pursuant to rules adopted by the commission for form, medium, content and time for filing, each health care facility shall file with the commission the following information:

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

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

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

3. Storage of discharge data. The commission may, subject to section 386, subsection 6, contract with any entity, including an independent data organization, to store discharge data filed with the commission. For purposes of this subsection, "independent data organization" means an organization of data users, a majority of whose members are neither providers of health care, organizations representing providers of health care, nor individuals affiliated with those providers or organizations, and whose purposes are the cooperative collection, storage and retrieval of health care information.

4. Previously filed discharge data. The commission may direct the transfer to its possession and control of all discharge data required to have been filed with an independent data organization pursuant to the Health Facilities Information Disclosure Act prior to July 1, 1983. In the event that any such discharge data have not been filed with an independent data organization as of the effective date of this chapter, the commission shall direct such discharge data to be filed with the commission.

5. Previously filed financial data. The commission may direct the transfer to its possession and control of all financial reports and data required to have been filed with the Health Facilities Cost Review Board or with a voluntary budget review organization pursuant to the Health Facilities Informa-

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

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

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

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

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

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

form systems.

§395. Hospital reporting; additional requirements

1. Fiscal years. Hospital fiscal years shall be as follows.

A. Unless otherwise approved by the commission, the fiscal year of each hospital subject to this chapter shall be the fiscal year on which it operated as of May 1, 1983. The commission shall approve the conversion to a fiscal year commencing October 1st for those hospitals whose fiscal years, as of May 1, 1983, begin between August 1st and September 19th, provided that the conversion is made prior to July 1, 1984.

B. For purposes of this chapter, a fiscal year which commences between September 20th and September 30th shall be deemed to be a fiscal year commencing October 1st of the same calendar year.

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

3. Modification of systems. The commission may modify the financial and clinical reporting systems to allow for differences in the scope or type of services and in financial structure among the various sizes, categories or types of hospitals subject to this chapter.

4. Medical record abstract data. In addition to the information required to be filed under section 394 and pursuant to rules adopted by the commission for form, medium, content and time of filing, each hospital shall file with the commission such medical record abstract data as the commission may prescribe.

5. Merged data. The commission may require the discharge data submitted pursuant to section 394, subsection 2, and any medical record abstract data required pursuant to subsection 4, to be merged with associated billing data.

6. Authority to obtain information. Nothing in this subchapter may be construed to limit the commission's authority to obtain information from hospitals

which it deems necessary to carry out its duties under subchapter III.

SUBCHAPTER III

HOSPITAL CARE FINANCING SYSTEM

§396. Establishment of revenue limits and apportionment methods

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

2. Criteria. Subject to more specific provisions contained in this subchapter, the revenue limits and apportionment methods established by the commission shall assure that:

A. The financial requirements of a hospital are reasonably related to its total services;

B. A hospital's patient service revenues are reasonably related to its financial requirements; and

C. Rates are set equitably among all payors, purchasers or classes of purchasers of health care services without undue discrimination or preference.

In addition, the commission shall establish revenue limits that will permit the institution to render effective and efficient service in the public interest and that, in the case of a proprietary for-profit hospital subject to this chapter, will suffice to provide a fair return to owners based on the fair value of the institution's investment in hospital resources.

3. Excess charges prohibited. No hospital may charge for services at rates other than those required to achieve the equitable apportionment of the gross patient service revenue limit approved by the commission under this subchapter.

§396-A. Definition of elements of base year financial requirements

The commission shall define by regulation the elements of base year financial requirements of hospitals.

1. Medicare costs. These elements shall consist of acute patient care related costs exclusive of capital costs and shall include those salaries and

wages, fringe benefits, contracted services, supplies and other noncapital expenses which are defined as allowable costs under the Medicare program established pursuant to the United States Social Security Act, Title XVIII, including such offsets of operating revenues as prescribed by Medicare regulations.

2. Other costs. In addition, the following costs shall be included:

A. Costs associated with community education programs;

B. Costs associated with the recruitment of nonhospital-based physicians;

C. Compensation paid to physicians for professional services to the extent that such compensation is included on a hospital's trial balance of expenses as reported in its Medicare cost report; and

D. Such other costs, exclusive of development activity costs, as the commission may deem necessary and appropriate.

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

§396-B. Computation of base year financial requirements

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

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

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

established in accordance with section 396-A. The commission shall make appropriate adjustments to the base year financial requirements to reflect increases or decreases in financial requirements occurring between the base year and the commencement of the hospital's first payment year resulting from the factors specified in section 396-D, subsections 1, 2, 4, 6 to 8 and subsection 9, paragraph B, provided that any rate of increase, on a per case basis, from the base year to the commencement of the hospital's first payment year, shall not exceed the rate of increase for inpatient hospital costs allowed under the Tax Equity and Fiscal Responsibility Act of 1982.

B. In computing base year financial requirements for each hospital whose base year is its most recent fiscal year ending on or before June 30, 1983, the commission shall adjust, or require to be adjusted, the hospital's audited Medicare cost report to conform to the definition of base year financial requirements established in accordance with section 396-A. The commission shall make appropriate adjustments to the base year financial requirements to reflect increases or decreases in financial requirements occurring between the base year and the commencement of the hospital's first payment year resulting from the factors specified in section 396-D, subsections 1, 2, 4, 6 to 8 and subsection 9, paragraph B, provided that any rate of increase, on a per case basis, from the base year to the commencement of the hospital's first payment year, shall not exceed the rate of increase for inpatient hospital costs allowed under the Tax Equity and Fiscal Responsibility Act of 1982.

3. New hospitals. The commission shall establish, by regulation, a methodology for computing base year financial requirements for hospitals subject to this chapter which commence operations on or after January 1, 1983. This methodology may include reasonable limits based on the costs approved pursuant to the Maine Certificate of Need Act.

§396-C. Computation of payment year financial requirements

The commission shall determine the payment year financial requirements of each hospital as follows.

1. Payment years. Subject to the provisions of section 395, subsection 1, payment years of each hospital shall coincide with its fiscal years and the first payment year of each hospital shall be its first fiscal year commencing on or after October 1,

1984.

2. First year. The payment year financial requirements for each hospital for the first payment year shall be the base year financial requirements computed in accordance with section 396-B and adjusted by the commission in accordance with section 396-D.

3. Subsequent years. The payment year financial requirements for each hospital for the 2nd payment year and each subsequent payment year shall be the payment year financial requirements determined for the immediately preceding payment year adjusted by the commission in accordance with section 396-D.

§396-D. Adjustments to financial requirements

The commission shall establish, by regulation, methodologies and procedures for consideration and inclusion of the adjustments to hospital financial requirements set forth in this section. In addition to providing for the submission of information required by the commission, these regulations shall addresss the manner in which hospitals will be afforded an opportunity to submit information they wish to be considered in determining adjustments under this section.

1. Economic trend factor. In determining payment year financial requirements, the commission shall include an adjustment for the projected impact of inflation on the prices paid by hospitals for the goods and services required to provide patient care. In order to measure and project the impact of inflation, the commission shall establish and use the following data:

A. Homogeneous classifications of hospital costs for goods and services and of capital costs, which shall be called "cost components;"

B. Estimates or determinations of the proportion of hospital costs in each cost component; and

C. Identification or development of proxies which measure the reasonable increase in prices, by cost component, which the hospitals would be expected to pay for goods and services.

It may also consider the discrepancies, if any, between the projected and actual inflation experience of noncompensation proxies in preceding payment years.

The commission may, from time to time during the

course of a payment year, in accordance with duly promulgated regulations, make further adjustments in the event it obtains substantial evidence that its initial projections for the current payment year will be in error.

2. Case mix. Adjustments may be made for changes in case mix as follows.

A. In determining payment year financial requirements, the commission shall include an adjustment for the projected impact on the hospital's financial requirements of changes in the acuity of illness of the hospital's patients.

In order to measure and project the impact of changes in acuity, the commission shall establish and use the following data:

(1) Classifications of hospital patient admissions, called "patient classification," which are medically meaningful and which have relatively similar resource requirements for their treatment;

(2) Estimates or determinations of the average patient care costs of treating patients, including nursing costs, in each patient classification, which costs shall not include any costs which are fixed or largely independent of the volume of services provided; and

(3) Measurements of the reasonable impact on each hospital's costs of changes in the distribution of the hospital's patients over the patient classifications.

It may also consider discrepancies, if any, between the projected and actual changes in case mix in the preceding payment years.

B. The commission may from time to time during the course of a payment year, in accordance with duly promulgated regulations, make further adjustments, on an interim or final basis, in the event of discrepancies, if any, between projected and actual case mix changes in the preceding payment years or in the event it obtains substantial evidence that its initial projections for the current payment year will be in error. In making such further adjustments, the commission shall consider the special needs and circumstances of small hospitals.

3. Facilities and equipment. In determining

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

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

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

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

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

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

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

A. In determining payment year financial requirements, the commission shall consider the reasonable expected impact on the hospital's financial requirements of changes in the volume of services required to be provided by the hospital.

B. In order to measure the impact of changes in

the volume of service on hospital's costs, the commission shall establish schedules which shall be completed and submitted by each hospital and which shall include:

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

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

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

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

C. The commission shall establish by regulation the methodology by which the volume adjustments calculated subsequent to the close of a payment year are to be included in the payment obligations of payors and purchasers.

D. The commission may, from time to time during the course of a payment year, in accordance with duly promulgated regulations, make such further adjustments as may be necessary in the event of discrepancies, if any, between projected and actual volume changes in preceding payment years or in the event it obtains substantial evidence that its initial projections for the current payment year will be in error. In making such further adjustments, the commission shall consider the special needs and circumstances of small hospitals.

5. Certificate of need projects. Adjustments to financial requirements for the impact on a hospital's costs of projects approved by the department pursuant to the Maine Certificate of Need Act shall be determined as follows.

A. In determining payment year financial requirements, the commission shall include an adjustment to reflect any net increases or decreases in the hospital's costs resulting from projects approved in accordance with the Maine Certificate of Need Act and section 396-K. These adjustments may be made subsequent to the com-

mencement of a fiscal year and shall take effect on the date that expenses associated with the project would be eligible for reimbursement under the Medicare program.

B. In determining payment year financial requirements, the commission shall include an adjustment to reflect any net increases or decreases in the hospital's costs resulting from projects approved by the department pursuant to the Maine Certificate of Need Act prior to the effective date of this chapter, but not reflected in the base year financial requirements; provided that any approved costs shall be adjusted to be consistent with the definition of those costs established under subsection 3 and section 396-A. An adjustment under this paragraph shall not be effective prior to the date on which the expenses associated with the approved project would be eligible for reimbursement under the Medicare program.

6. Productivity. In determining payment year financial requirements for each hospital's fiscal years commencing on or after October 1, 1987, the commission shall consider, and may include, an offsetting adjustment in the event a hospital is not operating efficiently, provided that appropriate consideration shall be given to quality and accessibility of care and to the special needs and circumstances of small hospitals and of hospitals with significant seasonal fluctuations in occupancy.

7. Working capital. In determining payment year financial requirements, the commission shall include an adjustment to provide for financing reasonable increases in the hospital's accounts receivable, net of accounts payable and whatever additional working capital provisions the commission deems appropriate. The commission may, from time to time during the course of a payment year, make such further adjustments with respect to working capital as may be necessary.

8. Change in services. In determining payment year financial requirements, the commission may include an offsetting adjustment to reflect the impact on the hospital's financial requirements of:

A. The termination or significant reduction of health services provided by the hospital;

B. The transfer or assignment to another entity of functions performed by the hospital;

C. A merger or consolidation with another hospital; or

D. A reorganization, as defined pursuant to section 396-L.

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

9. Other adjustments. Other adjustments are determined as follows.

A. In determining payment year financial requirements, the commission may include a positive adjustment for the support of improvements in medical care management and information systems.

B. In determining payment year financial requirements, the commission shall include an adjustment for the reasonable impact on a hospital's costs of events, including events affecting all or a group of hospitals, which were reasonably unforeseen by the hospital and which were beyond the control of the hospital. This adjustment may be made subsequent to the commencement of a fiscal year.

C. New regulatory costs are determined as follows.

(1) In determining payment year financial requirements, the commission shall include an adjustment to reflect the difference between the assessment for the fiscal year imposed pursuant to section 391 and the total amount of dues and fees paid to a voluntary budget review organization in the hospital's base year.

(2) In determining financial requirements, the commission may include a positive adjustment to reflect the reasonable impact, if any, on a hospital's costs which is proven to have resulted from a hospital's conversion to a different fiscal year which has been approved pursuant to section 395, provided that, in the case of a conversion to an October 1st fiscal year which the commission is required to approve pursuant to section 395, subsection 1, the commission shall include an appropriate adjustment.

(3) In determining payment year financial requirements, the commission shall include an adjustment to reflect the impact, if any, on a hospital's costs of changes in hospital reporting requirements imposed by the commission.

10. General considerations. General considerations shall be determined as follows.

A. In its consideration of the factors enumerated in this section, the commission shall take into account the special needs and circumstances of small hospitals.

B. In its consideration of the factors enumerated in this section, the commission shall direct its professional staff to develop a data base and a series of analytical techniques to facilitate this consideration and to enhance the predictability and financial stability of hospital financing in the State.

11. Nature and effect of adjustments. The nature and effect of adjustments shall be determined as follows.

A. Unless otherwise specified, adjustments may be positive or negative adjustments.

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

§396-E. Application of available resources; reporting requirements

1. Criteria established. The commission shall establish criteria governing the application of a hospital's available financial resources to satisfy its financial requirements consistent with the following provisions.

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

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

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

D. Donor restricted gifts, grants, devises or restricted income from investment thereof shall be considered available resources only to the extent these funds are applied to the use for which they were donated.

E. If a hospital's actual expenses for a payment year are less than its approved financial requirements, only 50% of the difference shall be excluded from available resources for purposes of computing its gross patient service revenue limit in subsequent years.

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

(1) For a hospital whose base year is its most recent fiscal year ending prior to July 1, 1984, the amount of its budgeted operating margin for the base year, as set forth in its approved base year budget, multiplied by the sum of one and a fraction of which the denominator is 12 and the numerator is the number of months which elapse between the base year and the commencement of its first payment year; or

(2) For a hospital whose base year is its most recent fiscal year ending prior to July 1, 1983, 2% of its expenses allowed under the Medicare program in its base year times the sum of one and a fraction of which the denominator is 12 and the numerator is the number of months which elapse between the base year and the commencement of its first payment year.

G. Financial resources of affiliated interests, as defined in section 396-L, shall be considered as resources available to a hospital to the extent specified in section 396-L.

H. Available financial resources shall not include real estate, facilities, equipment, inventory or tangible personal property, except to the extent that the resources otherwise avail-

able pursuant to paragraphs A to G have been converted into such property.

2. Reporting. Each hospital shall file, on an annual basis and in accordance with regulations duly promulgated by the commission, the following information:

A. The source and amount of all gifts, grants, devises and income from investments; and

B. The amount of funds from gifts, grants, devises and investments expended and the purposes for which such funds were expended.

Notwithstanding the provisions of section 387, the commission shall not publicly disclose the individual identity of sources of gifts and grants.

3. Nothing in this section or in section 396-L may be construed to limit any authority the department may have to require the use of any gifts, grants, devises or income from investments, to finance projects subject to the Maine Certificate of Need Act.

§396-F. Revenue deductions

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

1. Charity care. The commission shall make provision for a reasonable amount of revenue deduction attributable to charity care. For purposes of this section, the amount of revenue deduction attributable to charity care shall be defined as the amount of revenue, net of recoveries, which is expected to be written off as a result of a determination that the patient is unable to pay for the hospital services received, provided that the hospital's determination is made pursuant to a policy which was adopted by the hospital and filed with the commission and which is consistent with reasonable guidelines established by the commission.

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

and which is consistent with reasonable guidelines established by the commission.

3. Differentials. The commission shall provide for revenue deductions which reflect differentials established and approved pursuant to section 396-G.

§396-G. Differentials

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

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

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

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

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

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

determining the differential shall be individually quantified so that the differential shall equal the total of the values assigned to each component.

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

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

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

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

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

A. Any 3rd-party payor or purchaser may apply to the commission for a reduction in the payments it would otherwise be required to make and the commission shall grant a reduction in payments com-

mensurate with one or more components of the differential on a prospective basis if it finds:

(1) That the applicant has implemented activities or programs which, pursuant to the commission's rules, qualify for a reduction; or

(2) That the applicant is willing and able to implement reasonable activities or programs which, pursuant to the commission's rules, qualify for a reduction, but which a hospital will not permit to be implemented.

B. The commission may establish rules under which any 3rd-party payor or purchaser who makes prompt payments, as defined by the commission, will be entitled to a differential without the necessity of making individual application to the commission therefor. The value of such differential shall be established in accordance with subsection 2.

4. Differentials established. Notwithstanding any other provisions of this section, the commission shall establish such differentials for payments under the United States Social Security Act, Title XVIII, as may be required pursuant to contractual limitations imposed on these payments. The differential established for payments by the department under the United States Social Security Act, Titles V and XIX, shall be the greater of the differential approved in accordance with subsection 3 or such amount as may be required for the department to remain in compliance with the requirements of the United States Social Security Act, Titles V and XIX.

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

In accordance with the procedures under section 398, the commission shall establish a gross patient service revenue limit for each hospital for each payment year commencing on and after October 1, 1984. This limit shall be established by adding:

A. The payment year financial requirements of the hospital, offset by the hospital's available resources in accordance with section 396-E; and

B. The revenue deductions determined pursuant to section 396-F.

§396-I. Payments to hospitals

1. Components of revenue limits. The commission

shall, for each payment year, apportion each hospital's approved gross patient service revenue limit into the following components, as applicable.

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

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

2. Apportionment among payors and purchasers. Based on historical or projected utilization data, the commission shall apportion, for each revenue center specified by the hospital subject to subsection 5, and for the hospital as a whole, the hospital's approved gross patient service revenue among the following categories:

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

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

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

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

(1) The commission shall require major 3rd-party payors to make biweekly periodic interim payments to hospitals, provided that any such payor may, on its own initiative, make more frequent payments. Payments to hospitals shall be calculated by applying any approved differential for a payor to the gross patient service revenue apportioned to the payor and dividing the amount by 26.

(2) After the close of each payment year, the commission shall adjust the apportionment of payments among major 3rd-party payors based on actual utilization data for that year. Final settlement shall be made within 30 days of that determination.

B. Payments made by payors, other than major

3rd-party payors, and by purchasers, shall be made in accordance with the following procedures.

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

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

C. In addition to any reductions in payments to hospitals under paragraphs A and B, if a hospital exceeds its gross patient service revenue limit by an amount in excess of a margin equal to 5% for small hospitals and 3% for all other hospitals, the commission may impose a penalty equal to 120% of the amount in excess of the margin times the rate of inflation. The amount of any penalty imposed shall be applied prospectively, and in accordance with methods prescribed by the commission, to reduce charges applicable to the class or classes of payors or purchasers which were overcharged. In determining whether to impose a penalty, the commission shall consider

whether the revenues received by a hospital met its approved financial requirements.

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

5. Review of allocations. Notwithstanding the provisions of subsection 2, the commission shall review the allocation of revenues to revenue centers specified by each hospital and shall assure that such allocation, to the extent it results in internal departmental subsidies, is reasonable and does not result in undue price discrimination.

§396-J. Establishment and administration of Management Support Fund; disbursements from fund

1. Establishment. There is established a statewide Management Support Fund administered by the commission. The assets of this fund shall be derived from the portion of the approved gross patient service revenue of each hospital, if any, in a fiscal year designated as management fund revenue and transmitted to the Management Support Fund pursuant to section 396-I, subsections 1 and 4.

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

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

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

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

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

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

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

Disbursements under this section shall not be offset against payment year financial requirements in computing a hospital's gross patient service revenue limit under section 396-H.

§396-K. Establishment of Certificate of Need Development Account

The commission shall establish, on a statewide basis, a Certificate of Need Development Account as follows.

1. Amount established. Subject to the requirements of paragraphs A and B, for each payment year cycle, as defined in subsection 4, the commission shall consider the need for, and may credit the Certificate of Need Development Account with, an amount to support the development and undertaking of projects which are subject to review pursuant to the Maine Certificate of Need Act. This amount shall be established by rule after consideration of the State Health Plan, the ability of the citizens of the State to underwrite the additional costs and the limitations imposed on these payments by the Federal Government pursuant to the United States Social Security Act, Titles XVIII and XIX. For the first 2 payment year cycles, the commission shall establish the amounts as follows:

A. For the first payment year cycle, 1% of the sum of:

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

(2) The total actual expenses, including capital costs, which were incurred, in its

most recent fiscal year ending prior to July 1, 1983, by any hospital which did not secure approval, prior to July 1, 1983, of its budget for its most recent fiscal year ending prior to July 1, 1984; and

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

2. Approval of adjustments. The commission shall approve an adjustment to a hospital's financial requirements under section 396-D, subsection 5, paragraph A, for a proposal if:

A. The proposal was subject to review and was approved by the department under the Maine Certificate of Need Act; and

B. The associated annual capital and operating costs would not exceed the amount which the commission has determined will have been credited to the Certificate of Need Development Account by the date of implementation of the project, after account for previously approved projects.

3. Debits and carry overs. The commission shall debit against the Certificate of Need Development Account the total capital and operating costs associated with each proposal for which an adjustment is approved under subsection 2. Amounts credited to this account for which there are no debits shall be carried forward to subsequent payment year cycles.

4. Payment year cycles. For the purposes of this section, a payment year cycle is each annual period of October 1st through September 30th beginning with the first payment year cycle of October 1, 1984, through September 30, 1985.

§396-L. Affiliated interests

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

A. "Affiliated interest" means:

(1) Any person which is a subsidiary of a hospital;

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

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

(4) Any person, other than an individual, which a hospital, or any of its affiliates as defined in subparagraphs (1) to (3), controls through common governing board members, contracts or other legal documents that give the hospital or its affiliates the authority to direct the person's activities, management and policies, but not including control exercised only through canonical or similar religious control;

(5) Any person to whom a hospital has transferred some of its resources and substantially all of whose resources are held for the benefit of the hospital or any of its affiliated interests;

(6) Any person to whom a hospital has assigned certain of its functions and who is operating primarily for the benefit of the hospital or any of its affiliated interests;

(7) Any person, other than an individual, and other than an auxiliary, which has solicited funds in the name of and with expressed or implied approval of the hospital or any of its affiliated interests, and substantially all the funds solicited by that person were intended by the contributor or were otherwise required to be transferred to the hospital or any of its affiliated interests or used at their discretion or direction; and

(8) Notwithstanding subparagraphs (1) to (7), any person which would be considered a person related to the hospital, as defined under the Medicare program established pursuant to the United States Social Security Act, Title XVIII.

B. "Reorganization" means any creation, organization, extension, consolidation, merger, transfer of ownership or control, liquidation, dissolution or termination, direct or indirect, in whole or in part, of an affiliated interest, as defined in paragraph A, subparagraphs (1) to (7), accomplished by the issue, sale, acquisition, lease, exchange, distribution or transfer of control or property.

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

account of the transactions is $10,000 or more for the fiscal year.

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

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

B. In determining base year financial requirements pursuant to section 396-B or in establishing adjustments for productivity or other factors pursuant to section 396-D, the commission may disregard unreasonable or unnecessary costs under significant transactions between a hospital and the persons specified in paragraph A.

C. Each hospital which has or will have affiliated interests, as defined in subsection 1, paragraph A, subparagraphs (1) to (7), shall file, either as part of its filing under section 396-D or as part of its application for approval of a reorganization pursuant to subsection 4, whichever is earlier, a 5-year corporate plan containing information as specified by the commission. At a minimum, the plan shall set forth the manner in which financial resources of the affiliated interests will be applied to offset financial requirements of the hospital in accordance with subsection 5 and section 396-E, subsection 1, paragraph G. The commission shall review and approve or disapprove each corporate plan taking into account, at a minimum, the following factors as the commission deems appropriate in the interest of the people of the State:

(1) Long-term capital and operating needs of the affiliated interests to meet market conditions and achieve reasonable growth;

(2) Federal reimbursement and burdens imposed on other payors;

(3) The effect which the services of the affiliated interests would have on the quality and efficiency of health services; and

(4) Requirements associated with maintaining tax-exempt status.

The hospital shall submit annual updates of its corporate plan which shall not require approval unless significant modifications are made to the plan. Notwithstanding the provisions of section 387, confidential commercial information submitted by a hospital or its affiliates under this paragraph or under subsection 4 shall not be subject to public disclosure. The commission shall adopt rules establishing criteria for determining the confidentiality of such information and establishing procedures to afford hospitals and affiliated interests notice and opportunity to comment in response to requests for information which may be considered confidential.

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

4. Reorganization. Unless exempt by rule or order of the commission, no reorganization may take place without the approval of the commission. No reorganization may be approved by the commission unless it is established by the applicant for approval that the reorganization is consistent with the interests of the people of the State. The commission shall rule upon all requests for approval of a reorganization within 60 days of the filing date. The filing date shall be the date when the commission notifies the applicant that the filing is complete. If the commission deems that the necessary investigation cannot be concluded within 60 days after the filing date, the commission may extend the period for a further period of no more than 120 days. Reviews of reorganizations which are also subject to review under the Maine Certificate of Need Act shall be conducted simultaneously with the department's review under the Act.

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

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

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

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

D. The ability of the hospital to provide reasonable and adequate care is not impaired.

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

F. The hospital's credit is not impaired or adversely affected.

G. The requirements of subsection 5 will be met.

5. Determination of available resources. After review of corporate plans submitted in accordance with subsection 2, the commission shall, consistent with the following provisions, determine the amount of financial resources of an affiliated interest, as defined in subsection 1, paragraph A, subparagraphs (1) to (7), to be applied to hospital financial requirements pursuant to section 396-E.

A. Gifts, grants and income from investments thereof received by affiliated interests shall not be considered available resources.

B. Excess revenues of nonprofit affiliated interests and profits of for-profit affiliated interests shall be offset, except to the extent that the retention of such funds by the affiliated interest is required to meet its capital and operating needs as defined in the plan submitted to and approved by the commission pursuant to subsection 2. The amount of these excess revenues or profits shall be determined without regard to any gifts, grants or other transfers of funds by the affiliated interest to the hospital or to other affiliates but shall otherwise be determined on a consolidated after-tax basis.

C. Of the amounts determined under paragraph B, 50% shall be offset generally against hospital financial requirements and 50% may be designated

by the hospital for a particular use by the hospital.

§396-M. Medicare waiver

The commission shall exercise its best efforts to design a program which qualifies for a waiver of hospital reimbursement requirements under the United States Social Security Act, Title XVIII, as authorized by Section 1886 of that Act, and shall apply to the Secretary for such a waiver. Notwithstanding any other provisions of this chapter, the commission is further authorized to enter into such agreements with the Secretary as may be required to secure the waiver, provided that nothing in this section may be construed to require that such a waiver be obtained in order for this subchapter to be implemented and provided further that the acceptance of any conditions under such a waiver would not be detrimental to the interests of the people of the State.

§396-N. Coordination with department

The commission and the department shall jointly undertake a study of the likely effects of the hospital care financing system established under this subchapter on hospitals which are also licensed to provide skilled nursing facility services or intermediate care facility services and shall make such modifications to the rules implementing either the hospital care financing system or the prospective payment system for long-term care facilities administered by the department or both as may be necessary to assure that the revenue limits established for such hospitals will permit them to render effective and efficient services in the public interest. In carrying out the requirements of this section, the commission and the department shall consult with the affected hospitals.

§396-O. Experimental and demonstration projects

The commission may, with the written agreement of any directly affected hospital, 3rd-party payor or purchaser, implement experimental or demonstration projects designed to assess methods of establishing revenue limits or payment methodologies other than those established generally under this chapter. The commission shall consult with appropriate advisory committees prior to initiating any experimental or demonstration project and shall include the results of any project as part of its annual report. These experimental or demonstration projects may include, but need not be limited to, the following:

1. Regional hospital corporations. Establish-

ment of regional hospital corporations;

2. Diagnostic related groups. Payment on the basis of diagnostic related groups;

3. Capitation. Payment on a capitation basis; and

4. Preferred provider relationships. Preferred provider relationships.

§396-P. Advisory committees

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

A. The commission shall establish a Professional Advisory Committee consisting of 2 allopathic physicians, 2 osteopathic physicians, 2 nurses and one hospital employee, other than a nurse or physician, directly involved in the provision of patient care. This committee shall advise the commission and its staff with respect to the effects of the health care financing system established under this subchapter on the quality of care provided by hospitals.

B. The commission shall establish a Hospital Advisory Committee consisting of 2 representatives of hospitals which have 55 or fewer beds, 2 representatives of hospitals which have 56 to 110 beds and 2 representatives of hospitals which have more than 110 beds. This committee shall advise the commission and its staff with respect to analytical techniques, data requirements, financial and other requirements of hospitals, and the effects of the health care financing system established under this subchapter on the hospitals of the State.

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

2. Chairman. The chairman of each committee

shall be appointed by the chairman of the commission and shall be rotated on an annual basis.

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

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

SUBCHAPTER IV

PROCEDURES

§397. Proceedings generally

1. Proceedings. Proceedings before the commission shall be subject to the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter IV, and such additional rules of practice as the commission may promulgate consistent with that Act.

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

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

4. Appeals. Any person aggrieved by a final determination of the commission may appeal therefrom to the Superior Court in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter VII.

§398. Procedures for establishment of revenue limits and interim adjustments

In establishing procedures for the determination of revenue limits and interim adjustments, the com-

mission shall provide for the following.

1. Revenue limits. At least 90 days prior to the start of each payment year of each hospital subject to this chapter, the executive director shall propose a gross patient service revenue limit and the apportionment thereof for approval by the commission. If no notice of contest is filed within the period of time specified by the commission by an affected hospital, affiliated interest, 3rd-party payor or group of purchasers, and if the commission does not disapprove or modify the proposed limit or apportionment, the limit and apportionment shall take effect on the first day of the applicable payment year; otherwise, the commission shall, after opportunity for hearing before the commission, an individual member of the commission or a duly appointed and sworn hearing examiner, issue a final order no later than the first day of the applicable payment year, except that, if the proposed limit or apportionment for a hospital's first payment year is timely contested, and the commission, after due diligence, is unable to issue a final order by the first day of the payment year, it shall issue a provisional order by that date which shall be superseded by a final order no later than 90 days after the start of the payment year.

2. Interim adjustments. Upon application by a hospital, affiliated interest, payor or group of purchasers, for an interim adjustment to financial requirements permitted under section 396-D, or upon application by a payor or group of purchasers for a modification of its approved differential or of the apportionment of the gross patient service revenue, and after opportunity for hearing, a final order shall be promulgated within 120 days from the date a completed application was filed. Any proposed change shall take effect upon the date specified in the order. At any time during the period between the filing date and the commission's final decision on the request, the commission may extend provisional approval to any part of the request. This provisional approval shall be superseded by the commission's final decision on the request. The commission may establish reasonable limits on the frequency of requests filed under this subsection.

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

§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, reorganizations and significant transactions, and other matters regulated by the commission pursuant to subchapter III.

Sec. 11. 22 MRSA §2061, sub-§2, as amended by PL 1981, c. 455, is further amended to read:

2. Review. Each project for a hospital or nursing home has been reviewed and approved to the extent required by the agency of the State which serves as the Designated Planning Agency of the State in accordance with the provisions of section 1122 of the ~~Federal~~ United States Social Security Act, as amended, 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. 12. Advisory committees established. The Maine Health Care Finance Commission shall establish the advisory committees required pursuant to Title 22, section 396-P, as soon as possible. Upon establishment, and until September 30, 1984, the chairman of each of the 3 advisory committees shall be entitled to participate, in the manner of an ex officio nonvoting member, solely with respect to deliberations and actions of the commission directly related to the formulation and adoption of rules, but not including, deliberations and actions which are properly conducted in executive session. After September 30, 1984, the commission may, in its sole discretion, permit such participation to continue. This section may not be construed to authorize participation in deliberations and actions of the commission related to the application or enforcement of rules.

Sec. 13. Transfer of property. All reports, files, records, books, periodicals, supplies, equipment and other property of the Health Facilities Cost Review Board shall be transferred to the Maine Health Care Finance Commission upon the effective date of this Act.

Effective September 23, 1983.