CERTIFICATE OF NEED STUDY
OF THE HUMAN RESOURCES COMMITTEE
OF THE 112th LEGISLATURE

APRIL 1986

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* Senator Gauvreau was appointed by the President of the Senate to the committee in January, 1986.

** Senator Berube was reassigned to the Joint Standing Committee on Appropriations and Financial Affairs in January 1986, but remained active on this study until the report was completed.

*** Representative Brodeur was unable to be an active member of this study due to other commitments.

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INTRODUCTION

The Certificate of Need program is a regulatory program, in operation in most states, to provide state review and approval of health care projects involving construction of new facilities, renovation or modernization of existing facilities, expansion of beds or services, or the purchase of major medical equipment. One of the major objectives of a certificate of need program is to constrain the rise in health care costs by preventing unnecessary construction, avoiding unnecessary duplication of services, and restraining inefficient duplication of major medical equipment. This report discusses the origins and development of the certificate of need cost containment program and its effect on the delivery of health care in Maine. A glossary of key terms is included in Appendix A.

Purpose of the Study

The Joint Standing Committee on Human Resources was authorized to study Maine's Certificate of Need program during the interim between the First and Second Regular Sessions of the 112th Legislature. This study was to evaluate the goals and objectives set forth in the original Certificate of Need enabling legislation and the current relevance of those goals and objectives. In addition, the committee was authorized to evaluate whether the Certificate of Need program is the most effective means of achieving those goals which the committee finds relevant. The committee was to evaluate, to the extent possible, the following:

1. the relationship of the Certificate of Need program with the Health Care Finance Commission and the State Health Coordinating Council;

2. the effect of the Certificate of Need Act on competition between various providers of health services;

3. the impact of the Federal rules and requirements on the Certificate of Need program; and

4. the impact of the Certificate of Need program on the following:

   a. the availability of primary care services in rural communities,
   b. distribution of physician specialists,
   c. the access and availability of health services,
   d. timely decisions to make available new health services,
   e. the implementation of new technology in health care services,
   f. the distribution of health services in Maine, and
   g. local community decisions on health services.

Committee Procedure

The Committee met during the Fall of 1985 and the Winter of 1985-86, extending its study into the early days of the Second Regular Session of the 112th Legislature. During the course of its proceedings, it conducted many meetings involving various state and private agencies and organizations, as well as individual health care providers, involved in the delivery or regulation of health care in Maine. In addition to the oral testimony received during its meetings, many written documents were submitted for the committee's evaluation.

The committee heard many issues raised concerning the effectiveness of the Certificate of Need program. We soon realized that the Certificate of Need program is but one part of Maine's broad scheme of health care planning and cost containment. A complete evaluation of the Certificate of Need program in Maine is a topic too broad to contain effectively within the scope of this study. Accordingly, this committee recommends that the Executive and Legislative branches of government coordinate their efforts to constantly monitor the changing health care environment and the effect of Maine's regulation of that environment in a combined effort to maintain accessible quality health care for all Maine citizens at a cost that is reasonably affordable. This report discusses some ways to meet that goal.

In addition, the committee addressed several specific critical areas of the Certificate of Need program and has proposed legislation to provide more flexibility in the process to relieve some of the burdens the Certificate of Need program places on health care providers.

Because of the complex nature of the subject and the time constraints under which this committee had to operate, the impact of the Certificate of Need program on the following areas was not discussed:

1. the availability of primary care services in rural communities,
2. distribution of physician specialists,
3. the access and availability of health services,
4. timely decisions to make available new health services,
5. the implementation of new technology in health care services,
6. the distribution of health services in Maine, and
7. local community decisions on health services.

The committee still believes that these are areas of significant concern and hopes that those agencies and organizations that are evaluating health care in Maine will pursue these items further.

A HISTORY OF MAINE'S CERTIFICATE OF NEED PROGRAM

NOTE: A major portion of this report on the history and development of the Certificate of Need program is taken from a paper prepared by Robert Clarke for this committee, The Background and Development of the Maine Certificate of Need Program, October 1985.

Major Influences on the Health Care System from 1945-1975

Health Insurance:

In the 1930's, public health insurance was virtually non-existent and private health insurance was still rare. During the Depression, hospital revenues decreased drastically. From 1929 to 1930, the average hospital receipts fell from $236.12 per patient to $59.26.[1] Out of this crisis, hospitals, in conjunction with the American Hospital Association, developed Blue Cross plans to provide a stable source of revenue for hospitals. (Blue Cross plans are basically group insurance plans which provide payments to hospitals for covered health services in exchange for a monthly subscription fee.)

During World War II, wage ceilings were imposed by the War Labor Board. The labor force was sparse. The wage ceilings prohibited wage incentives from being used to attract the available labor force. Employers turned to non-wage benefits, such as health insurance, to attract the scarce labor force. By 1950, approximately half of hospital revenues were derived from health insurance. Now, in the 1980's, more than 90% of all hospital revenue comes from health insurance.

The result of this dramatic change in the payment system for health care is that the consumers of health care (the patients), the ultimate payors, have insulated themselves from the direct impact of health care costs in a remarkably short period of time.

Government involvement:

During the post World War II era, we also began to see the beginnings of governmental involvement in health care. President Truman had proposed a national health insurance program. The American Hospital Association (AHA), opposed to this plan, suggested a Federal program of grants to support community hospital construction. In 1947, Congress adopted their version of the AHA proposal and enacted the Hill-Burton Act to encourage the expansion of hospitals and to encourage a more balanced distribution of hospital beds across America.

This program provided grants to any hospital who would make their services available to everyone and who would dedicate a specific amount of free care to those unable to pay. Between 1947 and 1974 four billion dollars was given to almost 6,000 hospitals. By 1973, the program had provided approximately one out of every three beds in community hospitals (358,000 beds).

The Hill-Burton Act marked the Federal government's first entry into health care as a major participant and, indirectly, as a guarantor of health services for the poor. But, this was only part of the story. The Federal government also became involved in health care through:

1. Research: Massive investment in medical research, e.g. through the National Institute of Health, has been responsible for many of the advances in medicine in the last 30 years.

2. Medical education: Substantial funds were invested in medical schools and in the subsidy of medical education more than doubling the number of physicians graduating from American Medical schools in 1980 than graduated in 1960.

3. Medicare and Medicaid: Established in 1966, these two programs gave the elderly and poor access to and financial support for a broad range of health care services. These programs increased the demand for health care services. The method of payment used until 1983, retrospective cost based reimbursement, also provided tremendous incentives to increase the costs of medical care. Payments to providers were based on the actual costs incurred, i.e. the charges the providers made for the services. If a provider became more efficient, the payments from Medicare and Medicaid were reduced. If the costs increased, payments increased. The message that the government was sending by the incentives inherent in this kind of payment system was not to decrease costs.

Results:

Over the last 40 years we have seen many changes in the nature and delivery of health services. These changes include:

1. significant advances in medical technology;

2. increase of access to more advanced health care for those least able to pay and for those in remote areas;

3. a period of rapid and dramatic increase in health costs;

4. insulation of the recipient of health care from the direct impact of increased health costs;

5. a weakening of traditional market forces; and

6. major investments and major policy decisions in the health care field by government.

This dramatic improvement in access to and quality of health services was largely the result, directly or indirectly, of the government's actions in the health care field. In 1966, the Federal government responded to these changes by initiating or authorizing "several efforts intended to bring about an orderly and equitable allocation of the newly available resources, to avoid the costly and unnecessary duplication of new services and to assure sufficient but not excessive growth in the capacity of health care facilities."[2]

Precursors to Certificate of Need

In 1966, the Partnership for Health Act, was enacted to encourage creation of statewide and local health planning agencies, which were expected to engage in comprehensive health planning, to moderate rapidly rising health costs, and to involve consumers in the formulation of health policies. This was to be accomplished by the creation of three agencies:

1. a state comprehensive planning agency to carry out state wide health care planning (Maine's Department of Health and Welfare was the designated agency);

2. a statewide citizens advisory council appointed by the Governor, with a consumer majority, to advise the state planning agency; and

3. local or regional planning agencies (5 were established in Maine), with a consumer majority on their governing boards, to develop local or regional plans.

These agencies were given limited authority and limited funding. Accordingly, there success was limited.

In 1974, the National Health Policy and Resource Development Act (Public Law 93-641) replaced the Partnership for Health Act. Its purpose was to address the:

1. rising cost of health care;

2. the maldistribution of resources;

3. the lack of uniformly effective methods of delivering health care;

4. the lack of a comprehensive, rational approach to these problems; and

5. consumer ignorance of proper personal health care and of proper ways to use available health resources.

Again, three kinds of agencies were created by the legislation.

Each state was to establish local or regional health systems agencies (HSA). Each agency was to be a non-profit, private entity with a majority of consumers on their governing boards and was to represent their health service area. Governor Longely designated the entire state as a "health service area" and created the Maine Health Systems Agency, Inc. (MHSA) as its only HSA. This had not been anticipated by the Federal legislation and led to a unique implementation of the Federal scheme. Each HSA, in Maine's case the one state-wide MHSA, was responsible for developing annual health systems plans and annual implementation plans for their respective service areas. Other states had several sub-state plans. Maine had only one statewide plan, developed by its MHSA.

The second agency, the state health planning and development agency (SHPDA), was to take the sub-state plans and combine them into a preliminary comprehensive state wide plan. In Maine, this resulted in two agencies preparing a statewide plan, clearly overlapping in responsibility. SHPDA, which was the newly created Bureau of Health Planning and Development in the Department of Human Services (formerly Health and Welfare), was to submit the plan to the third newly created agency.

The third agency was a state wide volunteer health planning body referred to as the "state health coordinating council" (SHCC). Its responsibility was to take the preliminary state health plan submitted by SHPDA, adopt its own version of it (now creating a third statewide plan) and present it to the Governor for his approval or disapproval.

Once approved, SHPDA would be the state agency responsible for implementing those portions of the approved plan which related to state government.

In addition, the MHSA, SHCC and the Department of Human Services were responsible for reviewing proposed use of Federal funds and specific health services.

The last part of Public Law 93-641 required each state to establish a Certificate of Need program and implement the Federal Certificate of Need review (referred to as Section 1122 review.) Failure to comply with the minimum criteria would result in the loss of substantial Federal funds for health related programs.

SHPDA, the Bureau of Health Planning and Development, was designated by the Governor as the state agency responsible for implementing the Maine Certificate of Need Act and the Federal Section 1122 program. SHPDA would review any projects which required a Certificate of Need review and make its recommendation to the Commissioner of the Department of Human Services. The MHSA would also review the Certificate of Need project and make its recommendation to the Commissioner. The MHSA would hold a public hearing on each project as part of its review. The Commissioner, after considering both recommendations, would approve or deny the project.

In 1978, Maine enacted its Certificate of Need program. A description of the current law is contained in the next major section of this report.

Significant Changes to the Certificate of Need Act

In 1979, Congress amended Public Law 93-641. It increased the minimum dollar amount (thresholds) which set the limit on which projects were reviewed. In addition, Federal funding for the HSA's was reduced considerably.

In Maine, this resulted in staff reductions, a cut-back or elimination of many MHSA activities, and, by 1981, no effective review of Certificate of Need projects.

The Legislature began to look at the Certificate of Need program and how the 1979 Federal amendments had affected it. The Joint Standing Committee on Audit and Program Review study recommended the elimination of the MHSA and transfer of their Certificate of Need related functions to the SHCC. Their proposal was withdrawn in deference to a legislatively created special Certificate of Need study committee. Composed of legislators from the Joint Standing Committee on Health and Institutional Services (now called the Joint Standing Committee on Human Resources), it recommended a change in the threshholds for the state Certificate of Need program and the creation of a Certificate of Need Advisory Committee. The Certificate of Need Advisory Committee would take the place of the MHSA whose days were numbered. The study committee chose not to place those Certificate of Need review functions in SHCC, feeling it would be inconsistent with their role as a statewide health planning organization.

These recommendations were enacted in 1982. The Certificate of Need Advisory Committee was established to hold public hearings on Certificate of Need projects, when requested, and make an independent recommendation to the Commissioner. The Committee was composed of 5 consumers and 5 other members representing hospitals, physicians, the nursing home industry, major third party payors, and, as a non-voting member, the Department of Human Services.

THE MAINE CERTIFICATE OF NEED PROGRAM

In enacting the Certificate of Need Act, the Legislature declared "that unnecessary construction or modification of health care facilities and duplication of health services are

substantial factors in the cost of health care and the ability of the public to obtain necessary medical services." (22 MRSA § 302 sub-§ 1). The purposes of the Act are to:

1. promote effective health planning;

2. assist in providing quality health care at the lowest possible cost;

3. avoid unnecessary duplication in health facilities and health services and ensure that only those facilities that are needed will be built or modified;

4. assure that state funds are not used to support unnecessary capital expenditures made by or on behalf of health care facilities;

5. provide an orderly method of resolving questions concerning the need for health care facilities and health services which are proposed to be developed;

6. permit consumers of health services to participate in the process of determining the distribution, quantity, quality and cost of these services; and

7. provide for a Certificate of Need program which meets the requirements of the National Health Planning and Resources Development Act of 1974, Public Law 93-641, and its accompanying regulations.

Hospitals and other designated health care facilities are required to obtain a Certificate of Need approval for projects which are subject to the Certificate of Need review. Those projects which require a Certificate of Need review include:

1. acquisition of major medical equipment costing $300,000 or more if:
   a. owned by a health care facility,
   b. located in a health care facility, or
   c. used to provide services for inpatients of a hospital;

2. capital expenditures of a health care facility of $350,000 or more;

3. development of a new health service by a health care facility:
   a. which will have a capital expenditure cost of $350,000 or more,
   b. which will have an annual operating cost in 3rd fiscal year of $145,000 or more ($155,000 or more after December 31, 1985), or
   c. which qualifies under the SHCC "Category C" rule;

4. termination of a health service if it will involve a capital expenditure of $150,000 or more;

5. changes in bed complement over a 2 year period which involve more than 5 beds or more than 10% of licensed or certified beds;

6. predevelopment activity of $150,000 or more;

7. construction or development of a new health care facility; and

8. other circumstances specified in the law.

A hospital may apply for, and receive, a waiver of the certificate of need review requirements otherwise imposed if:

1. the project is a new health service involving no capital expenditures or a capital expenditure of less than $300,000 and 3rd year annual operating costs are at least $155,000 and not more than $250,000; AND

2. the hospital agrees not to seek or accept any adjustments to its financial requirements under the Health Care Finance Act. (The significance of this will be explained when the relationship of the Certificate of Need program and the Health Care Finance Commission is discussed.)

An overview of the Certificate of Need law with statutory citations, including the requirements and criteria for a Certificate of Need approval, are contained in Appendix B.

THE CREATION OF THE MAINE HEALTH CARE FINANCE COMMISSION

Factors leading to establishment of MHCFC

It soon became apparent that health care costs were continuing to rise, consuming an increasing share of individual, corporate, and governmental budgets. Retrospective cost based reimbursement was feeding not fighting the increase in health costs and was threatening the financial viability of some health care providers. The prominent question to be answered at the state and federal level was "How much of our resources could we, or should, devote to health care?"

The Maine Health Care Finance Commission Established

In 1983, Maine established a prospective payment system for hospitals and created the Health Care Finance Commission to implement this system.

The prospective payment system requires the determination of the financial requirements of each health care provider and the aggregate amount the provider must charge to meet those requirements. This is determined in advance by the Health Care Finance Commission. If the provider actually spends less to provide those services, it may keep the extra. The next year's financial requirements are based on the previous year's financial requirements, with adjustments, and not on the actual costs. So, the hospital is not penalized for saving by a reduction in financial requirements. Under the cost based system, the hospital would have received its actual costs, which, if less, would have resulted in less revenues for the hospital.

A prospective payment system has incentives that are just the opposite from those of a cost based system. In a cost based system, the more you spend the more you get reimbursed. There is no incentive to save. As noted above, a prospective payment system provides a benefit, if you save. In addition, you are guaranteed reimbursements for your approved financial requirements, your "budget".

The Relationship between the Health Care Finance Commission Act and the Certificate of Need Program

A hospital's financial requirements are based on the costs of existing equipment and programs, adjusted each year to account for inflation and other items. Expenses for Certificate of Need projects (new services, construction, or equipment) could not automatically be added to the financial requirements of a hospital since they would represent new charges not previously associated with their budgetary needs. Hospitals could not collect the costs for these services.

The legislature, at the same time it enacted the Health Care Finance Commission Act, required that all Certificate of Need projects which were approved be automatically added to a hospital's financial requirements. The costs of these services was automatically passed on to the payors under the payment system established by the Health Care Finance Commission Act. This change to the Certificate of Need program provided the link between the Health Care Finance Commission laws and the Certificate of Need Act. Hospital regulation through the Commission would control the costs of existing services. Certificate of Need approval would be the cost containment tool for control for new services, construction, and equipment. It would help control health care costs by requiring a state agency to review each new service, construction project, or purchase of new equipment and grant approval to only those projects which were actually necessary. Existing programs were held to a budget and any new programs added to that budget had to be found necessary or the system would not allow increases to a hospital's charges to pay for that service or equipment.

The two parts of the system, when combined, cover the whole of health care for those facilities subject to cost regulation and Certificate of Need review.

The Certificate of Need Development Account

Also, in 1983, the Legislature enacted the Certificate of Need Development Account. The Certificate of Need program was required to approve every project that was not duplicative or otherwise unnecessary. Neither the Certificate of Need program nor the Health Care Finance Commission addressed the issue of how much of our resources we should devote to expanding our health services. The cumulative financial impact of Certificate of Need approved projects could not be considered. Its cost would be passed on automatically to the payors of health care. The Certificate of Need Development Account established an affordable limit on growth.

The Certificate of Need Development Account established a limit on the total dollar amount of Certificate of Need projects which may be approved in any one year. This amount is established by statute in the first two years under the Health Care Finance Act at 1% of the total hospital operating expense for the state and is set by the Health Care Finance Commission in subsequent years. Legislation enacted in 1985 (PL 1985, c. 347) amended the method in which debits against the account are determined and allowed projects of unusually high cost to be debited against the account over several years.

The Medicare Prospective Payment System for Hospitals

Established by the Federal government, the Medicare prospective payment system for hospital expenses is different from Maine's prospective payment system. Maine's system includes the goal of assuring the financial viability of Maine's hospitals. The Federal system makes no attempt to determine the financial requirements of a hospital and the aggregate charges to offset those requirements. Medicare pays hospitals a fixed amount for each case. Each case is assigned to a diagnostic related category (DRG) and each DRG is assigned a payment amount. This fixed amount is not adjusted (like the rest of Maine's payors amounts are) to reflect the costs associated with approved Certificate of Need projects. Maine payors will bear those expenses. Medicare payments represent from 35% to more than 50% of the total revenues in some Maine hospitals.

The result of Medicare's prospective payment system approach will significantly increase the financial impact of Certificate of Need related costs to Maine's payors.

THE CHANGING HEALTH CARE ENVIRONMENT

Alvin Toffler, the futurist, recently said that the health care field has seen more changes in the past 5 years than in the previous 50. This rapid rate of change is likely to continue in the near future.

Because of the rapid change in the health care environment, there is a grave danger of solving tomorrow's problems with yesterday's solutions. It is important to focus on the nature of the change and the trends in health care. Some of these recent changes include:

1. The creation of the Health Care Finance Commission;

2. The introduction of DRG's and other changes to the methods of reimbursement, including such actions as the reduction or elimination of discounts;

3. The development and expansion of new service delivery systems including:
   a. HMO's,
   b. PPO's,
   c. walk-in clinics, and
   d. home based care; and

4. Changing hospital utilization patterns.

Some of these changes have altered the nature and characteristics of competition for hospitals and other health care facilities.

It is apparent that in these times, the health care system is characterized by its complexity. It is amorphous. It has experienced extremely significant changes in recent years, changes which are likely to continue to evolve over the next 5-10 years. The committee feels that due to these unpredicted events the legislation regulating the delivery of health services has turned the delivery of health care in Maine into a jungle.

MONITORING THE DELIVERY AND COST OF HEALTH CARE

Todays health care system operates in a dynamic, rapidly changing environment. The next few years of change in the health care system will be crucial years. It is important in the years ahead that Maine seek to improve the organization, financing, and delivery of health care and to assure that those without adequate resources or those with special needs have access to health services. The state needs to ensure the

flexibility and the resources to design health care programs that are tailored to fit the particular health care needs of the people of this state.

The committee did not find any evidence of a systematic, comprehensive effort by the state or any of its agencies to monitor and evaluate the health care delivery systems and the changing health care environment. Current state efforts are fragmented:

1. The Health Care Finance Commission has attempted to examine new trends, but its efforts are hindered by its need to dedicate its resources to the regulation of hospital costs.

2. The Department of Human Services is gathering helpful statistics and is implementing the Certificate of Need program, but has no responsibility to the public or the legislature to conduct any studies of health care trends or evaluations of how Maine's cost containment system is meeting the challenge of a changing health care environment.

3. The State Health Coordinating Council is examining segments of the health care system in Maine to prepare and update its health plan, but is not taking a comprehensive look at the entire health delivery system, especially in the context of cost containment.

This committee believes that it is important for the state to have a method to monitor trends in the health care field, the delivery of health care services, and health care cost containment's effect on delivery of health services and on health care costs, i.e. how health care regulation is interacting with health care delivery.

The study committee finds that it is the responsibility of the Joint Standing Committee on Human Resources to keep informed of the changes/trends in order to better perform its legislative responsibilities. But relevant and timely information in such a complex and rapidly changing arena as health care is not easy to obtain. A systematic way to gather and disseminate this information to the Legislature must be established and nurtured. This committee believes that several existing agencies should focus their attention on these issues and assume significant roles in the growth of quality health care delivery in Maine.

We recommend that the Health Care Finance Commission, which is one of the agencies responsible for regulating the growth of the health care industry, report to the Legislature on the trends it sees in the health care field in Maine. This information should be included in the annual report to the Legislature, which is required to be submitted in January.

The State Health Coordinating Council (SHCC) is in a unique position since it is an independent agency responsible for health planning recommendations. This committee believes the SHCC has a great opportunity to identify and monitor trends in the delivery of health care in Maine, and make objective recommendations to improve the delivery of health care and the regulation of health care costs in an ever changing health care environment. Accordingly, this committee urges the SHCC assume the role of monitoring health trends, reviewing their effect in Maine, evaluating cost containment from the perspective of a changing health care environment and report annually, each February, to the Legislature on its findings and recommendations. The SHCC could utilize the State Planning Office, as well as its own staff, to carry out this role.

Furthermore, we recommend that the Joint Standing Committee on Human Resources study the relationship of the SHCC to the Executive and Legislative branches of state government and its role in developing a state health plan that is responsive to the rapidly changing health care system. This study should include an evaluation of what the best staffing arrangement is to ensure the SHCC's independence.

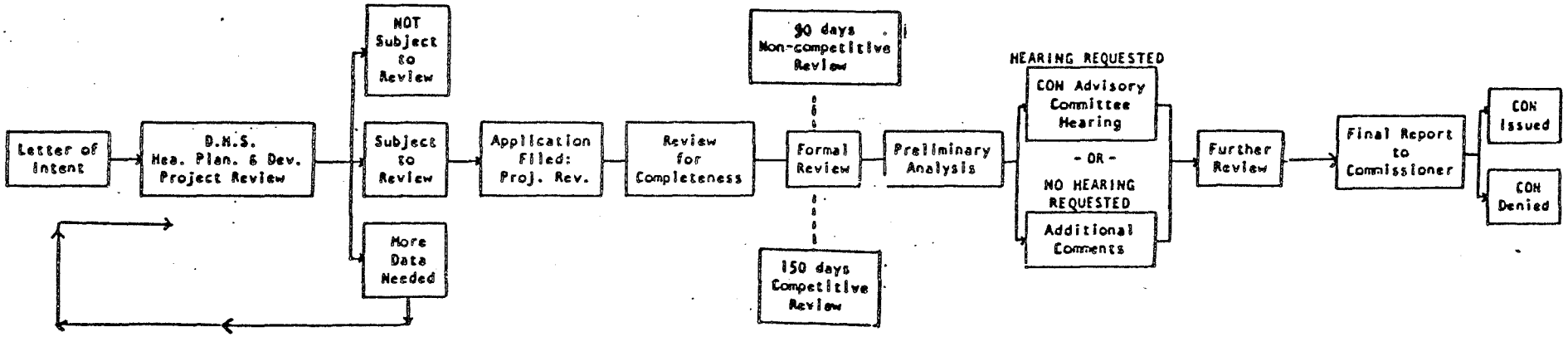
CERTIFICATE OF NEED PROCEDURE

The procedure for approval of a Certificate of Need application has been described as complex and time-consuming. Hospitals deplore the amount of information that must be filed. Many applications are incomplete when initially filed and incur delays caused by the need to prepare and submit additional information. It is alleged that some of the delays are caused by the lack of clear, concise guidelines for the initial application.

The application process starts by filing of a letter of intent with the Department of Human Services. The project review staff make an initial determination that an application is not subject to Certificate of Need review, is subject to Certificate of Need review, or that insufficient data was submitted to make that determination, in which case more data must be submitted. Once it has been determined that a project is subject to Certificate of Need review a formal application is filed which receives a review for completeness. The next step is a formal review, with a 90 day or 150 day deadline, depending upon the nature of the project. The results of this formal review, the preliminary analysis, may give rise to a hearing by the Certificate of Need Advisory Committee. Once the hearing is complete, or in cases without a hearing as soon as the preliminary analysis is complete, the entire application, with comments is submitted to the commissioner for his approval or denial. This process is presented graphically on the next page.

CERTIFICATE OF NEED REVIEW PROCESS

BASIC OUTLINE



This committee makes the following recommendations for improving the Certificate of Need application process.

1. We recommend that the applicant and the department meet, in person, at or prior to the time a determination is made whether or not a project is subject to review. This would provide an opportunity for the department to advise the applicant what information will be needed for a completed application to avoid delays caused by repeated requests for more information during the process.

2. The department should establish and publish criteria for Certificate of Need applications to better inform potential applicants what information is necessary for a fully complete application.

3. The number of staff available to review Certificate of Need applications is inadequate to accomplish the responsibilities given to them. We understand that the Governor will request an additional position in his budget. We support that request and urge its inclusion in the budget.

This committee also received testimony concerning an anonymous letter which was submitted to the Department of Human Services in a recent application for Certificate of Need approval. This committee does not approve of the use of anonymous letters in Certificate of Need applications. This committee does not want to prohibit independently verified data which can be documented. The committee will introduce legislation to express that intent.

SELECTED TOPICS

Recognizing Regional Differences in Health Care.

Maine is a diverse state with sparsely populated rural areas, thriving urban centers, and a little bit of everything in between. Because of this, Maine's health care needs vary throughout the state. The Federal health planning laws have all recognized the need for regional health planning and provided for initial health planning at the regional level . Maine's unique structural organization of its planning body has established one state-wide agency, the SHCC, to prepare a state health plan.

The SHCC, in an effort to address the diverse regional variations in health care services, holds regional hearings on the proposed state health plan. This committee believes that it is important to address Maine's health care needs and health care services on a regional basis and and encourages the SHCC to increase their sensitivity to these regional differences, needs and opportunities.

The committee considered the desirability of requiring regional representation for membership on the SHCC but realized the impracticality of that suggestion.

The Effect of the Certificate of Need Process on Health Care Facilities which are Subject to Review and Health Care Facilities which are Not Subject to Review

Not all health care facilities or health care providers are required to receive Certificate of Need approval for health care projects, e.g. a group of doctors in the Bangor area was not required to obtain Certificate of Need approval when they recently purchased a Nuclear Magnetic Resonator. Should a hospital in that same area desire to make a similar purchase, it would require Certificate of Need approval before making that purchase. Some hospitals have indicated that this hinders their ability to compete effectively with those facilities or providers who are not required to seek Certificate of Need approval.

This disparate treatment has been the source of concern in the health care community. The committee heard testimony that it would be more equitable to either require everyone to obtain certificate of need approval or to require no one to obtain certificate of need approval.

The committee discussed that issue and recognized that there are many variations of the current system which could address that concern. Many of the committee members felt that a less restrictive regulatory environment may be the most appropriate action to take. A minority of the committee members felt that a more appropriate course of action would be to extend the regulatory system to all health care facilities and providers.

This is not an easy issue to address. The types of competition and the effects of competition in the health care field are not the same as in other parts of the business world. The unique nature of the commodity, health services, and the rapidly changing health care environment prescribe a more complex analysis. This committee recognizes the seriousness of this issue and urges those agencies responsible for health care planning, particularly the SHCC, to take the lead in evaluating the scope of the current health care regulatory scheme, the effects of current health care regulation on the timely and cost-effective delivery of quality health services, and the role of competition in the quality, availability, and cost of health services.

Removal of the Certificate of Need Program from the Department of Human Services and Transfer of that Function to the Health Care Finance Commission.

It was suggested, during the course of this study, that it might be more appropriate to have all the health care regulation administered by one agency, specifically the Health Care Finance Commission. This committee was impressed with the fact that the health care environment and regulation of health services was in a period of rapid change. In view of this, the committee did not make any recommendations concerning this issue.

COMMITTEE PROPOSAL

Based on the observations of this committee indicating the rapid and continued changes in the health care field and the problems identified with the Certificate of Need process, the committee makes the following recommendation to revise the Certificate of Need process to make it more flexible and more responsive to the dynamics of the health care delivery system in Maine.

Currently, the amount of new money available for capital expenditures and new services is limited by the Certificate of Need Development Account. Only projects which have received a Certificate of Need approval may adjust their financial requirements and acquire the additional revenue to fund these projects. We recommend that 20% of the Certificate of Need Development Account be set aside and made available to hospitals for certain projects without Certificate of Need review. Unlike current projects which a hospital undertakes without Certificate of Need approval, projects which are included in that 20% special account will be added to a hospital's financial requirements (their budgets) and will become expenses recoverable in hospital revenues.

This special account would be divided among all hospitals based on their respective proportionate share of the aggregate of all hospitals' financial requirements.A hospital would have access to this funding authorization for use as the hospital sees fit for projects with an annual financial impact of $150,000 or less. Unused amounts in each hospital's account will be carried forward to subsequent years.

No Certificate of Need review will be required. A hospital's financial requirements will be adjusted to reflect the additional income needed to fund this project. While not increasing or decreasing the total funds available to hospitals through the Development Account, this proposal will:

1. expedite the process for minor projects,

2. eliminate Department determination and approval of need for these projects, and

3. provide hospitals with additional flexibility to support projects which formerly required a Certificate of Need or which have not previously been subject to review and therefor not included in a hospital's adjustments to its financial requirements.

This will, in essence, create two separate accounts, the Statewide Development Account and the Individual Hospital Component, which will replace the Certificate of Need Development Account as follows:

STATEWIDE DEVELOPMENT ACCOUNT	INDIVIDUAL HOSPITAL COMPONENT
80% of total: available for traditional Certificate of Need approved projects. (Same rules as previous Certificate of Need Development Account.)	20% of total: available for minor projects (under $150,000 for 3rd yr expenses) which are either: 1. not subject to CON review, or 2. reviewable, but hospital chooses not to have it reviewed.

To illustrate the difference this can make to a hospital, we can examine the hypothetical implementation of a hospital SCAN team in Hospital "A", first under current law and then as it could be implemented under this proposal.

CURRENT LAW	STUDY PROPOSAL
1. Not subject to Certificate of Need review	1. Not subject to Certificate of Need review
2. No adjustment to fin. req.	2. Adjustment to fin. req.
3. No adjustment to rates	3. Adjustment to rates
4. No new $ to pay for project Money to pay for project must come from:	4. New $ pay for project Money to pay for project will come from the special account.
a. savings, or	a. savings not used,
b. other programs (whose funding would be reduced or eliminated.)	b. no effect on money for other programs.

COMMITTEE RECOMMENDATIONS

1. MONITORING HEALTH CARE TRENDS AND EFFECTS OF REGULATION.

a. The Executive and Legislative branches of government should coordinate their efforts to constantly monitor the changing health care environment and the effect of Maine's regulation of that environment in a combined effort to maintain accessible quality health care for all Maine citizens at a cost that is reasonably affordable.

b. The Health Care Finance Commission should include information on trends in the health care system to the Legislature as a part of its annual report.

c. The State Health Coordinating Committee should take the lead in identifying and monitoring the trends in the delivery of health care in Maine and evaluating the effects of regulation on the quality, accessibility, and cost of health services. The Legislature should be advised annually in February regarding these matters.

2. IMPROVING THE CERTIFICATE OF NEED PROCEDURE.

a. The Department of Human Services and the applicant should meet, in person, at or prior to the time a determination is made whether or not a project is subject to review in order to provide an opportunity to delineate precisely what information is necessary for a completed application to avoid unnecessary delays.

b. The Department of Human Services should establish and publish criteria for Certificate of Need applications in order to better inform potential applicants what information is necessary for a complete application.

c. The number of staff available for Certificate of Need application review is insufficient. We support the Governor's request in this year's budget for additional staff.

d. The Department of Human Services should be prohibited from using anonymous letters for any part of its review or evaluation of a Certificate of Need application.

3. INCREASED EMPHASIS ON REGIONAL PLANNING.

This committee urges a greater sensitivity to regional differences in health care planning.

4. INCREASE THE FLEXIBILITY OF THE REGULATORY SYSTEM TO ALLOW HOSPITALS TO ADAPT TO A RAPIDLY CHANGING HEALTH CARE ENVIRONMENT.

Establish a fund which each hospital can use for minor projects without requiring a Certificate of Need approval and which will be added to a hospital's financial requirements.

EPILOGUE

Recommendation number 4 was introduced into the Second Regular Session as LD 2018. At the time this report was sent to the printers, LD 2018, as amended by the Joint Standing Committee on Human Resources, had been enacted in both bodies of the Legislature and was on the Governor's desk awaiting his action. An engrossed copy of the amended bill is attached as Appendix E. The committee amendment made the following changes in the original bill:

1. Provided a one time adjustment to the financial requirements for hospitals whose fiscal year begins near or before implementation of this Act to assure that all hospitals would be able to benefit from the special 20% account in their third payment year;

2. Gave special consideration to the needs of small hospitals by distributing the individual hospital components of the Hospital Development Account based on a formula which provides a minimum base allocation to small hospitals before the remainder of the account is allocated on a pro rata basis to each hospital; and

3. Added new provisions to the bill to:
   a. require CON review to consider the gains that may be anticipated, for projects proposed by facilities within 30 miles of the state border, from the ability to attract health care consumers from out of state and the ability to retain Maine health care consumers in Maine facilities; and
   b. requires the Health Care Finance Commission to consider additional criteria in establishing the amount to be credited to the Hospital Development Account and to report their rationale in setting that amount to the Human Resources Committee.

Prior to publication of this report, the Director of the Bureau of Medical Services, Trish Riley, informed this committee of the Bureau's efforts which would be made to improve the Certificate of Need program, especially to streamline the procedure and increase its utility and efficiency. This committee welcomes that effort by the Bureau. A copy of that letter is contained in Appendix D.

4763

FOOTNOTES

1. Blue Cross, What Went Wrong?, Sylvia Law, Health Law Project, U.of Pa., Yale University Press, 1974, p.6.

2. The Background and Development of the Maine Certificate of Need Act, Robert Clarke, October, 1985, p.3.

GLOSSARY OF TERMS

Cost based payment system (or retrospective cost based payment system:

A method of payment used until 1983 by Medicaid, Medicare and Blue Cross/Blue Shield of Maine to pay for hospital services. The payments made are based on the costs incurred by the health care provider, not on the prices charged by the health care provider.

Department of Human Services (formerly the Department of Health and Welfare):

The agency of Maine state government assigned the duty of administering the CON program and the Section 1122 reviews.

Diagnostic related group (DRG):

The term refers to a specific method of classifying a hospital's cases. Each case is assigned to one of nearly 500 DRG's. Each DRG is designed to represent a grouping of cases that is medically meaningful and has similar resource requirements. Values are assigned to each of these DRG's and, as a result, changes in the hospital's case-mix (the relative proportions of the hospital's different kinds of cases) can be measured.

Health systems agency (HSA):

The private non-profit agencies required under Public Law 93-641. These agencies were expected to carry out health planning, reviews of Federal funds expenditures, and reviews of institutional health services under the CON program.

Medicaid (or Title XIX of the Social Security Act):

Health care program for low income persons. It is administered by the states and funded jointly by the state and Federal government.

Medicare (or Title XVIII of the Social Security Act):

Nation-wide health insurance program for individuals eligible for Social Security benefits. The program is funded entirely by the Federal government.

Appendix A

Prospective payment systems:

Method of reimbursement for health services on the basis of rates or amounts established in advance of the delivery of services and not affected by the amount of cost actually incurred.

Public Law 93-641:

The National Health Planning and Resources Development Act of 1974.

Section 1122 reviews:

The reviews of certain capital expenditures by institutional health care providers as required by Section 1122 of the Social Security Act. In Maine these reviews are conducted by the Department of Human Services.

State Health Coordinating Council (SHCC):

Voluntary statewide advisory group required under Public Law 93-641. It is required to develop and adopt the State Health Plan.

State Health Plan (SHP):

The statewide plan adopted by the SHCC and approved by the Governor. It is a requirement of Public Law 93-641.

State health planning and development agency (SHPDA):

Agency required under Public Law 93-641 to carry out health planning and to implement state CON programs. In Maine, this agency is the Division of Health Planning and Development of the Department of Human Services.

MAINE'S CERTIFICATE OF NEED ACT : AN OVERVIEW

LEGISLATIVE FINDINGS:

"The Legislature finds that unnecessary construction or modification of health care facilities and duplication of health services are substantial factors in the cost of health care and the ability of the public to obtain necessary medical services." (22 MRSA § 302 sub-§ 1)

PURPOSES OF THE ACT:

1. Promote effective health planning;

2. Assist in providing quality health care at the lowest possible cost;

3. Avoid unnecessary duplication in health facilities and health services and ensure that only those facilities that are needed will be built or modified;

4. Assure that state funds are not used to support unnecessary capital expenditures made by or on behalf of health care facilities;

5. Provide an orderly method of resolving questions concerning the need for health care facilities and health services which are proposed to be developed;

6. Permit consumers of health services to participate in the process of determining the distribution, quantity, quality and cost of these services; and

7. Provide for a certificate of need program which meets the requirements of the National Health Planning and Resources Development Act of 1974, Public Law 93-641 and its accompanying regulations.

(22 MRSA § 302, sub-§ 2)

APPENDIX B

PROJECTS REQUIRING A CERTIFICATE OF NEED:

1. Acquisition of major medical equipment costing $300,000 or more if:
   a. owned by a health care facility,
   b. located in a health care facility, or
   c. used to provide services for inpatients of a hospital;

2. Capital expenditures of a health care facility of $350,000 or more;

3. Development of a new health service by a health care facility:
   a. which will have a capital expenditure cost of $350,000 or more,
   b. which will have an annual operating cost in 3rd fiscal year of $145,000 or more ($155,000 or more after December 31, 1985), or
   c. which qualifies under the SHCC "Category C" rule;

4. Termination of a health service if it will involve a capital expenditure of $150,000 or more;

5. Changes in bed complement over a 2 year period which involve more than 5 beds or more than 10% of licensed or certified beds;

6. Predevelopment activity of $150,000 or more;

7. Construction or development of a new health care facility; and

8. Other circumstances as specified in sub-§ 9.

(22 MRSA § 304-A)

WAIVER OF CERTIFICATE OF NEED REVIEW:

A hospital may apply for, and receive, a waiver of the certificate of need review requirements otherwise imposed if:

1. the project is a new health service involving no capital expenditures or a capital expenditure of less than $300,000 and 3rd year annual operating costs are at least $145,000 ($155,000 after December 31, 1985) and not more than $250,000; AND

2. the hospital agrees not to seek or accept any adjustments to its financial requirements under the Health Care Finance ACT (22 MRSA § 396-D).

(22 MRSA § 304-C)

CERTIFICATE OF NEED DEVELOPMENT ACCOUNT:

The Certificate of Need Development Account establishes a limit on the total dollar amount of Certificate of Need projects which may be approved in any one year. This amount is eatablished by statute in the first two years under the Health Care Finance Act at 1% of the total hospital operating expense for the state and is set by the Health Care Finance Commission after that. Legislation enacted this year (PL 1985, c. 347) amended the method in which debits against the account are determined and allowed projects of unusually high cost to be debited against the account over several years.
(22 MRSA § 396-K)

REQUIREMENTS FOR CON:

A. That the applicant is fit, willing and able to provide the proposed services at the proper standard of care;

B. That economic feasibility of the proposed services is demonstrated in terms of: Effect on the existing and projected operating budget of the applicant; the applicant's ability to establish and operate the facility or services in accordance with licensure regulations promulgated under pertinent state laws; and the projected impact on the facility's costs and rates and the total health care expenditures in the community and the State;

C. That there is a public need for the proposed services; and

D. That the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State and are in accordance with standards, criteria or plans adopted and approved pursuant to the state health plan developed by the department.

(22 MRSA § 309, sub§ 1)

CRITERIA FOR CON:

In the determination to issue or deny a certificate of need, the department shall, among other criteria, consider the following:

1. The relationship of the health services being reviewed to the state health plan;

2. The relationship of the health services being reviewed to the health services and capital requirements' plans, if any, of the applicant;

3. The current and projected needs that the population served or to be served has for the proposed services;

4. The availability of less costly alternatives or more effective methods of providing the proposed services;

5. The relationship of the proposed services to the existing health care systems;

6. The availability of resources, including health personnel, management personnel and funds for capital and operating needs, for the provision of the proposed services and the availability of alternative uses of the resources for the provision of other health services;

7. The relationship, including the organizational relationship, of the proposed services to ancillary or support services;

8. The special needs and circumstances of health maintenance organizations;

9. The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in health service areas in which the entities are located or in adjacent health service areas;

10. The importance of recognizing the public choice of allopathic or osteopathic health services by considering the unique needs and circumstances of providers of allopathic and osteopathic health care;

11. The costs and methods of any proposed construction or modification of a facility, including the costs and methods of energy provisions;

12. The probable impact of the proposal being reviewed on the costs of providing health services;

13. The need for utilizing new techological developments on a limited experimental basis in the absence of sufficient data to establish the need for the services;

14. The gains that may be anticipated from innovative measures in the organization, financing and delivery of health care and the development of comprehensive services for the community to be served; and

15. The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

(22 MRSA §309, sub§ 2)

SECOND REGULAR SESSION

ONE HUNDRED AND TWELFTH LEGISLATURE

Legislative Document **No.**

S.P. In Senate,

JOY J. O'BRIEN, Secretary of the Senate

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-SIX

AN ACT to Authorize Additional Facilities for Long-term Care.

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

Legislative intent. It is the intent of the Legislature to authorize the Department of Human Services to include the cost of 270 new intermediate care facility beds in its current services budget in the next biennium. It is further the intent of this Legislature that the Department of Human Services solicit proposals for new beds and complete the certificate of need approval for those 270 new beds as soon as possible, but, in any case, not later than July 1, 1989.

FISCAL NOTE

The addition of 270 new beds will add $5,400,000 in annual expenditures to the Medicaid program: $1,700,000 from the General Fund and $3,700,000 federal Medicaid matching funds. These funds, and consequently the additional appropriations, will not be needed until fiscal year 1988 because of the lead time required to approve and construct intermediate care facilities.

STATEMENT OF FACT

The Joint Select Committee on Nursing Home Needs studied the long-term care needs for Maine's citizens. That study determined that Maine's population in need of long-term care will increase considerably over the next 25 years. The committee identified a severe shortage in intermediate care facility beds and skilled nursing facility beds in Maine. This shortage was exacerbated by the fact that no new beds have been funded during the last fiscal year. There is a 2-year to 3-year delay in constructing new beds from the time they are authorized because of the competitive certificate of need process to determine who will receive the new beds and because of the time required for construction. Unless immediate action is taken, the shortage of beds will increase and access to care will be denied an ever increasing number of Maine citizens.

This bill provides authorization for 270 new beds. This will authorize the 180 beds which should have been authorized during the last biennium and an additional 90 beds for the following year. While this number will not meet the total need for new long-term care beds, it will allow an affordable beginning to reduce the bed deficit.

6968032586

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

February 26, 1986

JOSEPH E. BRENNAN
GOVERNOR

MICHAEL R. PETIT
COMMISSIONER

Senator Paul Gauvreau
Rep. Merle Nelson
Committee on Human Resources
State House
Augusta, Maine 04333

Dear Senator Gauvreau and Representative Nelson:

I am pleased to provide the additional information you requested concerning the CON Advisory Council and the Department's plans regarding improvements in the certificate of need program. I have enclosed the legislative and regulatory language describing the CON Advisory Committee as well as a list of its members.

As I explained in our January 27, 1986 background paper on CON, the Department is anxious to streamline the CON review process and to further increase its utility and efficiency. We remain committed to a strong CON program which assures the orderly and cost effective development of a quality health care system and which best represents consumers. Our project review staff is anxious to improve the process and to take a lead in creating appropriate responses to legitimate concerns about problems in that process. Too often the staff who day to day operate the program are left to react to mandates and respond to complaints about problems which have not been clearly enough defined. Therefore, I plan to launch an effort to engage our project review staff and providers in a thoughful analysis of the process itself. While I want those representatives to define the agenda for action, among the concerns I am certain we will consider are:

1. How can the process be more timely?
2. What are the costs a provider incurs to complete a CON? Are they reasonable? Are they any more or less reasonable for small hospitals?
3. Are the criteria used to judge a CON application clear, understandable and measurable? Can the state health plan be a more effective tool? If so, how?
4. Would a simplified application format and/or more technical assistance from staff be useful?
5. Can the minor review cycle be more timely?
6. Should the thresholds be increased?

Appendix D

To complete this process as quickly as possible and to assure that the entire staff is not inappropriately taken from their day to day responsibilities of timely project review, I plan to take two specific actions.

1. Convene an ad-hoc work group of 6 to 10 members who will be hospital and other providers. It will also include a consumer representative from the State Health Coordinating Council, a member of the CON Advisory Council, a representative of payors other than Medicaid and staff from Project Review.

   I am pleased that Sheila Hanley, Director of Planning at Mercy Hospital, has agreed to co-chair this committee with me and I will today ask the Maine Hospital Association to appoint two additional members.

2. With advice from this committee, hire an independent consultant to assist in reviewing the process of CON and recommending revisions to make that process more efficient, effective and better understood.

We can only understand and appreciate the problems of the CON process by discussing them openly and honestly with the providers affected. While the MHA has made it abundantly clear that their goal is to repeal the CON program and we have made a very different goal clear. I believe providers will offer us valuable guidance in improving the system. We are anxious to work with them and begin to identify problems and implement appropriate action to solve them.

I do not anticipate a formal study report but rather specific procedural changes which will be implemented over the coming year through regulatory and procedural reforms. Like you, we are anxious to make changes as soon as possible where legitimate problems are identified and the process can be improved. Thanks.

Sincerely,

Trish

Trish Riley
Director
Bureau of Medical Services

TR/cd

STATE OF MAINE

APR 01 1986

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY-SIX

H.P. 1428 - L.D. 2018

AN ACT to Revise the Certificate of Need Process.

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

Sec. 1. 22 MRSA §304-C, as enacted by PL 1985, c. 338, §2, is repealed.

Sec. 2. 22 MRSA §304-D is enacted to read:

§304-D. Waiver of certificate of need review for certain minor projects and for projects for which hospitals do not seek positive adjustment to financial requirements established by the Maine Health Care Finance Commission

1. Categories of projects eligible for waiver. A hospital may apply for a waiver of the certificate of need review requirements otherwise imposed by this chapter with respect to the following projects:

A. The offering or development of any new health services involving:

(1) No capital expenditure or a capital expenditure of less than $300,000; and

(2) Third-year annual operating costs of at least the expenditure minimum for operating costs, but less than $250,000; or

B. Any project that is a minor project, as defined in section 396-K, subsection 1, paragraph

B, and that meets the requirements of section 396-K, subsection 3, paragraph E, subparagraph (2).

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

3. Waiver process for certain new health services. Any hospital may file a request for waiver under subsection 1, paragraph A, with the department describing the proposed project and its projected associated capital costs and projected operating costs, as appropriate. Within 15 days following receipt of the hospital's waiver request and other information, if requested, the department shall issue its waiver determination.

The department shall waive certificate of need review in all cases where the request demonstrates that:

A. The project meets the criteria of subsection 1, paragraph A; and

B. The hospital agrees to be bound by the conditions of subsection 2.

4. Waiver process for certain minor projects. Any hospital may file a request for waiver under subsection 1, paragraph B, with the department describing the proposed project and its associated capital and operating costs. Within 15 days following receipt of the commission's determination under section 396-K, subsection 3, paragraph E, the department shall issue its waiver determination. The department shall waive certificate of need review in all cases where the request demonstrates that the project meets the criteria of subsection 1, paragraph B.

5. Treatment of project by the Maine Health Care Finance Commission. The total capital costs and operating costs associated with a project described in subsection 1, paragraph A, shall not be debited against the Certificate of Need Development Account or the Hospital Development Account pursuant to sec-

tion 396-K.

Sec. 3. 22 MRSA §307, sub-§5-A, as amended by PL 1985, c. 418, §9, is further amended to read:

5-A. Decision by the department. Decisions by the commissioner shall be made in accordance with the following procedures.

A. The department shall prepare its final staff report based solely on the record developed to date, as defined in paragraph C, subparagraphs (1) to (6).

B. After reviewing each application, the commissioner shall make a decision either to issue a certificate of need or to deny the application for a certificate of need. The decision of the commissioner shall be based on the informational record developed in the course of review as specified in paragraph C. Notice of the decision shall be sent to the applicant and the committee. This notice shall incorporate written findings which state the basis of the decision, including the findings required by section 309, subsection 1. If the decision is not consistent with the recommendations of the Certificate of Need Advisory Committee, the commissioner shall provide a detailed statement of the reasons for the inconsistency.

C. For purposes of this subsection, "informational record developed in the course of review" includes the following:

(1) All applications, filings, correspondence and documentary material submitted by applicants and interested or affected persons prior to the termination of the public comment period under subsection 2-B, paragraph F or, if no hearing is held, prior to the 80th day of a 90-day review cycle and prior to the 140th day of a 150-day review cycle;

(2) All documentary material reflecting information generated by the department prior

to termination of the public comment period or, if no hearing is held, prior to the 80th day of a 90-day review cycle and prior to the 140th day of a 150-day review cycle;

(3) Stenographic or electronic recording of any public hearing or meeting held during the course of review, whether or not transcribed;

(4) All material submitted or obtained in accordance with the procedures in subsection 2-B, paragraph G;

(5) The staff report of the agency, the preliminary staff report of the department and the recommendations of the committee;

(6) Officially noticed facts; and

(7) The final staff report of the department.

Documentary materials may be incorporated in the record by reference, provided that registered affected persons are afforded the opportunity to examine the materials.

In making a determination on any pending application under the certificate of need program, the department shall not rely on the contents of any documents relating to the application when those documents are submitted to the department anonymously.

Sec. 4. 22 MRSA §309, sub-§2, ¶¶N and O, as enacted by PL 1977, c. 687, §1, are amended to read:

N. The gains that may be anticipated from innovative measures in the organization, financing and delivery of health care and the development of comprehensive services for the community to be served; ~~and~~

O. The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages~~.~~;

and

Sec. 5. 22 MRSA §309, sub-§2, ¶P is enacted to read:

P. For any facility located within 30 miles of the state border, the gains that may be anticipated from the ability to attract health care consumers from out-of-state and the ability to provide health care for Maine citizens who formerly had to obtain that care out-of-state.

Sec. 6. 22 MRSA §309, sub-§6, as amended by PL 1985, c. 338, §3, is further amended to read:

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

Sec. 7. 22 MRSA §396-D, sub-§3, ¶A, as enacted by PL 1983, c. 579, §10, is amended to read:

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~~ for which an adjustment is required to be made under subsection 5 or subsection 9, paragraph D. Any positive adjustments made to reflect such increases in capital costs shall not be effective until the facilities or fixed equipment have been put into use and the associated expenses would be eligible for reimbursement under the Medicare program.

Sec. 8. 22 MRSA §396-D, sub-§5, ¶A, as amended by PL 1985, c. 339, §1, is further amended to read:

A. Except as provided in paragraph C, 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 that have been approved by the department in accordance with the Maine Certificate of Need Act and that otherwise meet the requirements of section 396-K, subsection 2, paragraph B, or subsection 3, paragraph C. These adjustments may be made subsequent to the commencement 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.

Sec. 9. 22 MRSA §396-D, sub-§9, ¶D is enacted to read:

D. 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 that meet the requirements of section 396-K, subsection 3, paragraph E.

(1) Except as provided in subparagraph (2), the adjustment under this paragraph shall only be made as part of the annual revenue limit determination and not as an interim adjustment.

(2) Once during the course of its 3rd payment year, a hospital whose fiscal year commences on or after October 1, 1986, and before March 1, 1987, may seek an adjustment under this paragraph, if it has not sought such an adjustment as part of its 3rd payment year revenue limit filing.

Sec. 10. 22 MRSA §396-K, as amended by PL 1985, c. 347, §§1 to 3, is repealed and the following enacted in its place:

§396-K. Establishment of Hospital Development Account

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

A. "Major project" means a hospital project subject to review under the Maine Certificate of Need Act that has incremental annual capital and operating costs in its 3rd year of implementation, including a partial first fiscal year, of $150,000 or more.

B. "Minor project" means a hospital project subject to review under the Maine Certificate of Need Act that has incremental annual capital and operating costs in its 3rd fiscal year of implementation, including a partial first fiscal year, of less than $150,000.

C. "Payment year cycle" means each annual period of October 1st to September 30th beginning with the first payment year cycle of October 1, 1984, to September 30, 1985.

2. Certificate of Need Development Account. For the first and 2nd payment year cycles, as defined in subsection 1, the commission shall establish a statewide Certificate of Need Development Account to support the development and undertaking of projects which are subject to review pursuant to the Maine Certificate of Need Act. This account shall be administered as follows.

A. The commission shall credit the Certificate of Need Account with the following amounts:

(1) For the first payment year cycle, 1% of the sum of:

(a) 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

(b) 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

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

The amount to be credited in a particular payment year cycle will be deemed credited to the Certificate of Need Account as of the first day of that payment year cycle.

B. The commission shall approve an adjustment to a hospital's financial requirements under section 396-D, subsection 5, paragraph A, for a project if:

(1) The project was subject to review and was approved by the department under the Maine Certificate of Need Act; and

(2) The associated incremental annual capital and operating costs do not exceed the amount remaining in the Certificate of Need Development Account as of the date of approval of the project by the department, after accounting for previously approved projects.

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

(1) Except as provided in subparagraph (2), the commission shall debit against the Certificate of Need Development Account the full amount of the incremental annual capital and operating costs associated with each project for which an adjustment is approved under paragraph B. Incremental annual capital and operating costs shall be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 5, for the 3rd fiscal year of implementation of the project.

(2) In the case of a project which is approved in the first or 2nd payment year cycle and whose associated incremental annual capital and operating costs are determined to exceed $2,000,000, debits shall be made as follows:

(a) In the payment year cycle in which the project is approved, the commission shall debit against the Certificate of Need Development Account an amount equal to $2,000,000; and

(b) In the payment year cycle immedi-

ately following the cycle in which the project is approved, the commission shall debit against the Certificate of Need Development Account established under this subsection or the statewide component of the Hospital Development Account established under subsection 3 an amount equal to the difference between the incremental annual capital and operating costs associated with the project and the amount debited under division (a) in the previous payment year cycle.

(3) Amounts credited to the Certificate of Need Development Account for the first payment year cycle for which there are no debits shall be carried forward to the 2nd payment year cycle. Amounts credited to the Certificate of Need Development Account for the 2nd payment year cycle for which there are no debits shall be carried forward to the 3rd payment cycle as a credit to the statewide component of the Hospital Development Account established in accordance with subsection 3.

3. Hospital Development Account. For the 3rd and subsequent payment year cycles, the commission shall establish a Hospital Development Account to support the development of hospital facilities and services. This account shall be administered as follows.

A. The commission shall annually establish, by rule, the amount to be credited to the Hospital Development Account. In establishing the amount of the credit, the commission shall, at a minimum, consider:

(1) The State Health Plan;

(2) The ability of the citizens of the State to underwrite the additional costs;

(3) The limitations imposed on payments for new facilities and services by the Federal

Government pursuant to the United States Social Security Act, Title XVIII and XIX;

(4) The special needs of small hospitals;

(5) The historic needs and experience of hospitals over the past 5 years;

(6) The amount in the account for the previous years and the level of utilization by hospitals in those years;

(7) Obsolescence of physical plants;

(8) Technological developments; and

(9) Management services or other improvements in the quality of care.

The commission shall report, no later than January 15th of each year, to the joint standing committee of the Legislature having jurisdiction over human resources regarding the rationale the commission used in establishing the amount credited to the Hospital Development Account in the previous year.

The amount to be credited in a particular payment year cycle will be deemed credited to the Hospital Development Account as of the first day of that payment year cycle.

B. The annual credit to the Hospital Development Account shall be apportioned into the following 2 components.

(1) One component, equal to 80% of the annual credit, shall be designated as the "statewide component" and shall be used on a statewide basis for the support of major projects and those minor projects that meet the requirements of paragraph C.

(2) One component, equal to 20% of the annual credit, shall be designated as the "individual hospital component" and shall be further allocated and administered in ac-

cordance with paragraphs D and E.

C. The commission shall approve an adjustment to a hospital's financial requirements under section 396-D, subsection 5, paragraph A, for a major or minor project if:

(1) The project was approved by the department under the Maine Certificate of Need Act; and

(2) The associated incremental annual capital and operating costs do not exceed the amount remaining in the statewide component of the Hospital Development Account as of the date of approval of the project by the department, after accounting for previously approved projects.

D. The component specified in paragraph B, subparagraph (2), shall be allocated to individual hospitals. The amount allocated to each hospital shall be considered the hospital's individual development account and shall be determined as follows:

(1) 0.5% of the individual hospital component specified in paragraph B, subparagraph (2), shall first be allocated to each hospital; and

(2) The remainder of the individual hospital component shall then be allocated to each hospital by dividing the hospital's payment year financial requirements by the total payment year financial requirements of all hospitals and multiplying that quotient by the amount of the remainder. For purposes of this calculation, the payment year financial requirements of a hospital are the most recent payment year financial requirements determined as of the first day of each payment year cycle, regardless of whether those financial requirements are determined pursuant to a proposed revenue limit, a provisional revenue limit or a final revenue limit as of that date.

E. The commission shall approve an adjustment to a hospital's financial requirements under section 396-D, subsection 9, paragraph D, for a proposal:

(1) If the proposal is either:

(a) A minor project that has not been approved by the department under the Maine Certificate of Need Act; or

(b) A proposal that is not subject to review under the Maine Certificate of Need Act; and

(2) To the extent that the associated incremental annual capital and operating costs as determined by the commission do not exceed the amount remaining in the hospital's individual development account, after accounting for previous projects debited against the account. The commission need not make a determination under this subparagraph nor an adjustment under this paragraph unless the person seeking the adjustment has submitted all information reasonably required by the commission to calculate these costs.

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

(1) Except as provided in subparagraph (2), the commission shall debit against the statewide component of the Hospital Development Account the full amount of the incremental annual capital and operating costs associated with each project for which an adjustment is approved under paragraph C. Incremental annual capital and operating costs shall be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 5, for the 3rd fiscal year of implementation of the project.

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

extraordinary incremental annual capital and operating costs, the commission may, in accordance with duly promulgated rules, defer the debiting of a portion of the annual costs associated with the project until a subsequent payment year cycle or cycles.

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

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

4. Determinations by department. For purposes of implementing, subsection 3, paragraph E, the department shall determine whether a project is subject to review under the Maine Certificate of Need Act and, if so, whether it is a minor or major project.

In House of Representatives, ... 1986

Read twice and passed to be enacted.

..... Speaker

In Senate, ... 1986

Read twice and passed to be enacted.

..... President

Approved 1986

..... Governor