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Health Care: Certificates of Need
Maine Health Systems Agency
Delegation of Executive Power
Me. Const Art 4, Pt 3, sec. 1

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The Honorable Harland Goodwin
House Chairman
Health and Institutional Services Committee
Maine House of Representatives
Augusta, Maine 04333

Dear Representative Goodwin:

You have requested an opinion on the permissibility of a non-legislative role as arbiter for the Statewide Health Coordinating Council in the development of procedures and criteria for the certificate of need program. The response of this office to this question follows.

Facts:

The National Health Planning and Resources Development Act of 1974, Public Law 93-641(42 USC 300k, et seq.), was enacted by Congress as a result of its concern over the increasing cost of health care and the lack of effective and evenly distributed health care delivery. It establishes new programs at the state level to provide for the review of all existing and all proposed new institutional health services in the state. It further requires as a pre-condition to certain federal funds the creation of a state certificate of need program which applies to new institutional health services proposed to be offered or developed within the state and which provides for review and determination of need prior to the time such services are developed so that only those services and facilities found to be needed shall be offered or developed in the state. 42 USC §300m-2(a)(4)(B). L.D. 1202 and L.D. 1358 are being developed to implement the required certificate of need program.

P.L. 93-641 also establishes new health agencies. In addition to the State Health Planning and Development Agency, in Maine, the Department of Human Services [hereinafter the Department], there is a Health Systems Agency [MHSA] and the Statewide Health Coordinating Council [SHCC]. The MHSA is a private, non-profit corporation. Its functions include

preparation of health plans for its area, review and approval of each use of federal funds in its area, review and comment to the state agency on new service projects in area institutions, and recommendation of health facilities projects to the state for funding.

The SHCC is composed of representatives appointed by the Governor, approximately 60% of which are from the MHSA and 40% are such other persons as the Governor may deem appropriate. 42 USC § 300m-3 (a), (b)(1). Its functions include advising the Department, preparing a state health plan, approving or disapproving any state health plans and applications for funds under federal health legislation, and reviewing budgets and applications for grants of the MHSA. 42 USC § 300m-3(c).

Under P.L. 93-641, the Department is mandated to administer a certificate of need program. 42 USC § 300m-2(a)(4)(B), and the MHSA is required to review and make recommendations to the Department regarding the need for new institutional health services 42 USC § 300l-2(p). Both the Department and the MHSA are to develop procedures and criteria for the review process. 42 USC § 300n-1(a). There is no substantial review function mandated for the SHCC in the certificate of need program under P.L. 93-641.

Questions posed:

Does Public Law 93-641 or the State of Maine Constitution prohibit the SHCC from assuming the non-legislative role, designated in §§ 306 and 307 of L.D. 1202, as arbiter between MHSA and the Department in the development of procedures and criteria for the Certificate of Need process?

Conclusion:

In view of the totality of the statutory scheme of P.L. 93-641, it is the opinion of this office that the assumption by the SHCC of a role as arbiter between the MHSA and the Department on the development of procedures and criteria for the certificate of need process is in conflict with 42 USC § 300n-1(a) and 42 USC § 300 l-1(b)(1), and thus exposes the state to federal fiscal sanctions for non-compliance under 42 USC § 300m(d). It is, furthermore, the opinion of this office that, if the SHCC were to be assigned the authority of approving or disapproving the regulations developed by the Department and the MHSA, this assignment would be an unconstitutional delegation of power.

In advising on the effect of federal legislation and regulations, however, we would note that such interpretation is primarily the responsibility of the administering federal agency and its counsel. We have made our best efforts to interpret P.L. 93-641, but we caution that our interpretation may be subject to modification by future federal administrative action.

Reasons:

While it is clear the Congress in enacting P.L. 93-641 has not preempted the field of health planning, the Supremacy Clause of the U.S. Constitution requires that the provisions of P.L. 93-641 as well as federal regulations promulgated thereunder by the Department of Health, Education and Welfare must prevail to the exclusion of conflicting state law or regulation if the state wishes to insure that the federal fiscal sanctions contained in 42 USC §300m(d) are not imposed.

Initially, it is to be reiterated that P.L. 93-641 does not assign any active functions to the SHCC in reviewing application for a certificate of need. This absence of specific provision would not, of course, prevent the SHCC from assuming responsibilities not in conflict with the federal statute. The analysis of the Supremacy Clause issues should not focus merely on the logistics of complying with both state and federal law. Rather one must look at whether the state law stands as an "obstacle to full effectiveness of the federal statute." Head v. New Mexico Board of Examiners, 374 U.S. 424, 432 (1963). See also, Florida Lime and Avocado Growers, Inc. v. Paul, 373 U.S. 132 (1963).

Since the role of arbiter entails decision-making capabilities and the authority to bind the parties to the arbitor's decision, such a scheme presents some conflicts with P.L. 93-641. 42 USC §300n-1(a) requires both the MHSA and the Department to "follow procedures and apply criteria, developed and published by [the respective agencies] in accordance with regulations of [HEW]." The regulations set out more fully the process for adoption of review procedures and criteria. For instance, 42 CFR §122.305(a) states that the health systems agency shall "adopt and review and revise." 42 CFR §122.305(b) further specifies that before adopting the procedures and criteria, the agency must funish certain entities, including the SHCC, with copies of its proposed regulations for the purpose of giving such entities the opportunity to offer written comments on the procedures and criteria. 42 CFR §123.406 specifies a similar course of conduct to be followed by the Department.

Coordination between the MHSA and the Department in establishing their review procedures and criteria is, of course, encouraged. See 42 Federal Register 4018 (Jan. 21, 1977). Nevertheless, in response to suggestions that the Department be required to develop a master set of criteria in order to avoid inconsistent criteria, HEW has indicated that there is no statutory authority for such a regulation and that each agency is required to develop its own. Id. Similarly, the anticipation of the possibility of two diverse sets of procedures is underscored by the provision in 42 CFR §§122.306(d) and 123.407(c) that, in the case of only a few specific procedural requirements,

one agency may consider a requirement satisfied if the other agency has provided for the corresponding procedure.

Overall, then, it is clear that the federal law contemplates the individual development of procedures and criteria by the MHSA and the Department. Moreover, although solicitation of feedback from other agencies such as the SHCC is required, the authority to determine finally the procedures and criteria to be adopted by the two agencies appears to be vested in themselves.

In addition, the exercise of the contemplated authority by the SHCC would distort the scheme set out in P.L. 93-641 because of the peculiarities involved in the establishment of the health planning entities in Maine. Most states, because of significantly larger populations, have several HSAs. From these several HSAs, then, are drawn the HSA representatives who compose approximately 60% of the SHCC. In Maine, however, there is only one HSA so that approximately 60% of the SHCC is made up of MHSA representatives. In effect, then, to give the SHCC final say over the criteria and procedures to be adopted by both the MHSA and the Department would be to give the MHSA the authority to develop the Department's criteria in contravention of 42 USC §300n-1(a) and the regulations thereunder.

The role of the SHCC as arbiter also presents a potential conflict with 42 USC §300 l-1(b)(1). That section provides that if the health systems agency is a non-profit private corporation, which the MHSA is, then it may not be a subsidiary or "otherwise controlled by" any other legal entity. 42 CFR §122.102(a) defines control as "where such other corporation or entity is legally empowered to exercise authority over the HSA's performance of its health planning and development functions."

The only case that has construed this "control" provision narrowed somewhat the broad definition of control. In Mid-America Regional Council v. Mathews, 416 F.Supp. 896, 905 (W.D. Mo. 1976), where the court did not find the HSA to be controlled by another agency, legislative intent was deemed to be that an HSA should be an "autonomous entity" devoid of any relationship that would allow another entity to "direct or exercise" the HSA's functions. In addition, the court noted that the fact that two entitles had common directors did not itself evidence control.

Mid-America is inapplicable to the situation proposed here. In that case, the second entity was the agency being superceded by the HSA. Thus even though there had been a sharing of directors between the two agencies and the second agency had provided technical assistance to the HSA, there was to be no binding authority of the second entity over the HSA as there would be here.

In contrast, to give authority to the SHCC to decide as arbiter the criteria and procedures to be adopted by the MHSA would permit the SHCC to "direct and exercise" some of its health planning functions.

While the power to approve or disapprove regulations to be used in the certificate of need review process is not extensive control, it is clear from a review of P.L. 93-641 that no binding authority of the SHCC over the MHSA is contemplated. Pursuant to 42 USC §300m-3 the SHCC merely reviews and comments on the MHSAs grant applications and budget. The SHCC's only approval functions are to state plans and applications for federal funds and to approve a state health plan which is a synthesis and revision by the SHCC of the HSP developed by the MHSA and the preliminary state health plan developed by the department.

Delegation of Power

An assignment to the SHCC of the authority as arbiter to approve or disapprove the regulations promulgated by the Department or by the MHSA would be the delegation of a rule-making function and thus a delegation of legislative power. See Corum v. Beth Israel Medical Center, 373 F.Supp. 550 (S.D. N.Y. 1974). The issue, then, is whether such a provision constitutes an unconstitutional delegation since the SHCC is a quasi-public body not subject to the control of the Governor or the Legislature; its actions and decisions are reviewable instead by the Secretary of HEW. Moreover, although the Governor appoints 40% of the Council, the remaining 60% of the membership is composed of representatives of the MHSA, a private corporation.

Delegation of power by the Legislature to non-public agents is not inherently unconstitutional. See City of Biddeford v. Biddeford Teacher's Assoc., 304 A.2d 287 (Me. 1973). Indeed in an opinion issued by this office on this date to Senator Snowe regarding certificate of need legislation, it was found that, pursuant to the factors enunciated in Biddeford, the provision for MHSA review of certificate of need applications was not an unconstitutional delegation of power. (Attachment A).

The distinctions between the two delegations lie, first of all, in the nature of the authority to be exercised. Unlike the mere review function of the MHSA, the SHCC here would be making final determinations as to the procedures and criteria to be adopted and used in the final-decision making process of the Department. Particularly through this control over the criteria to be utilized in deciding what new institutional health services are needed, the SHCC would be exercising ultimate authority in policy areas. The delegation, then, lies outside the limits permissible under Biddeford.

A second major consideration is the adequacy of procedural safeguards. Finks v. Maine State Highway comm., 328 A.2d 791 (Me. 1974); City of Biddeford v. Biddeford Teachers Assoc., supra. While the recommendations of the MHSA are subject to review, there would be no state mechanism to review the decision of approbation or non-approbation by the SHCC. Indeed, even in a federal case unholding the delegation to a private council of the authority to approve regulations promulgated by the Secretary of HEW, the court emphasized that a delegation is proper so long as the private body to whom the powers are delegated functions subordinately to a public official or agency. Corum v. Beth Israel Medical Center, supra.

The SHCC functions subordinately only to the Secretary of HEW and not to any state official. In addition, P.L. 93-641 does not provide for any review by the Secretary over the SHCC's functions in the certificate of need program, since the Act does not contemplate the SHCC assuming any significant review functions under the certificate of need program.

In view, then, of the influence the SHCC would have over health planning policy and in view of the absence of any significant state controls over the SHCC's actions, the delegation to the SHCC of authority to approve or disapprove regulations promulgated by the department would be in derogation of the State of Maine Constitution, Art, IV, Pt. 3, §1.

Very truly yours,

Joseph E. Brennan,
Attorney General