117th MAINE LEGISLATURE

FIRST REGULAR SESSION-1995

Legislative Document **No. 690**

H.P. 509 House of Representatives, February 28, 1995

An Act to Provide Family Security through Quality, Affordable Health Care.

Reference to the Committee on Human Resources suggested and ordered printed.

JOSEPH W. MAYO, Clerk

Presented by Representative MARTIN of Eagle Lake.
Cosponsored by Representatives: AHEARNE of Madawaska, BENEDIKT of Brunswick, BERRY of Livermore, CHASE of China, HICHBORN of LaGrange, JOHNSON of South Portland, JOSEPH of Waterville, MORRISON of Bangor, O'GARA of Westbrook, ROTONDI of Madison, SHIAH of Bowdoinham, TREAT of Gardiner, TRUMAN of Biddeford, TUFTS of Stockton Springs.

L.D.690

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

PART A

Sec. A-1. 22 MRSA c. 106 is enacted to read:

CHAPTER 106

ACCESS TO AFFORDABLE HEALTH CARE

SUBCHAPTER I

GENERAL PROVISIONS

§371. Definitions

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

1. Agency. "Agency" means the Maine Health Care Agency established by section 375.

2. Council. "Council" means the Maine Health Care Council established by section 375-B.

3. Fund. "Fund" means the Maine Health Care Trust Fund established by section 374, subsection 1.

4. Global budget. "Global budget" means a statewide aggregate amount budgeted for the provision of all health care services or for any sector of health care services.

5. Open plan. "Open plan" means the benefit delivery system for the Maine Health Care Plan that is open to all plan members and all participating providers, as specified in rules adopted pursuant to section 372, subsection 4.

6. Organized delivery system. "Organized delivery system" means an organization that provides or contracts for a complete range of health care services, as specified in the rules adopted pursuant to section 372, subsection 4, paragraph A.

7. Participating provider. "Participating provider" means a provider approved for the delivery of health care services pursuant to section 372, subsection 4.

8. Plan. "Plan" means the Maine Health Care Plan established by section 372.

9. Provider. "Provider" means any person, organization, corporation or association that provides health care services and is authorized to provide those services under the laws of this State. "Provider" includes persons and entities that provide healing, treatment and care for those relying on a recognized religious method of healing as provided for in the federal Social Security Act, Title XVIII and permitted under state law.

10. Resident. "Resident" means a person who resides within the State, as defined by rules adopted by the agency.

11. Small Business Hardship Fund. "Small Business Hardship Fund" means the fund created by section 374, subsection 1, paragraph A as part of the Maine Health Care Trust Fund.

SUBCHAPTER II

ENSURING ACCESS TO HEALTH CARE

§372. Maine Health Care Plan

The Maine Health Care Plan is established to provide family security through quality, affordable health care for the people of the State. The plan must offer health care services beginning July 1, 1996 and be administered and overseen by the agency in accordance with this chapter.

1. Goals of the Maine Health Care Plan. The plan has the following goals:

A. To eliminate income-based disparity in the health care status of citizens of the State;

B. To reduce the rate of growth in the cost of health care services;

C. To reduce waste and inefficiency in the administration of health care services and health insurance;

D. To increase access to primary and preventive health care services;

E. To reduce the number of excessively expensive health care procedures and eliminate unnecessary and harmful procedures;

F. To promote cooperation among communities and providers of health care, to eliminate cost-accelerating practices, to coordinate the delivery of care and use of technology and equipment and to increase quality and cost efficiency;

G. To distribute the costs of health care fairly and equitably;

H. To simplify the health care system for consumers, businesses and providers;

I. To ensure providers clinical freedom to treat patients based on health care needs and criteria; and

J. To ensure accountability in all aspects of the system to promote public confidence and control of costs.

2. Eligibility for the Maine Health Care Plan. In accordance with this subsection, residents and nonresidents are eligible to receive covered health care services from participating providers under the plan within this State if the service is necessary or appropriate for prevention, diagnosis or treatment of, or maintenance or rehabilitation following, injury, disability or disease. The agency shall adopt rules regarding payment of premium, application for a plan card and membership in the plan. The rules must provide for at least the following.

A. Each resident of the State is eligible to receive health care under the plan and may enroll in the plan.

B. A nonresident of the State who maintains significant contact with the State, including employment or self-employment within the State or attendance at a college, university or other institution of higher education in the State, is eligible to receive health care under the plan. Eligibility extends to a person qualifying under this paragraph and to that person's spouse and dependents. The agency shall adopt rules establishing criteria for eligibility for nonresidents and determine the premium to be paid by them and the method of payment.

C. A plan member who ceases to be eligible for the plan may elect, within 60 days of the event that causes ineligibility, to continue participation in the plan for a period of up to 18 months. For the purposes of this paragraph, a plan member is considered to have lost eligibility due to disability if the member could be determined disabled under the federal Social Security Act, Title II or Title XVI. The agency shall ensure that plan members who become ineligible for enrollment in the plan are promptly notified of the provisions of this paragraph. The agency shall adopt rules establishing the premium to be paid by persons eligible under this paragraph and the method of payment.

D. To establish eligibility, each person shall apply for a plan card, pay to the Maine Health Care Trust Fund the premium determined applicable pursuant to section 374, subsection 1, paragraph B and satisfy the application requirements established by the agency.

3. Health care benefits. As provided in this subsection, the plan must provide coverage for health care services from participating providers within this State if those services are necessary or appropriate for the prevention, diagnosis or treatment of, or maintenance or rehabilitation following, injury, disability or disease. The agency shall adopt rules regarding provision of the following covered health care services:

A. Hospital services;

B. Medical and other professional services furnished by participating providers;

C. Laboratory tests and imaging procedures;

D. Home health care for persons requiring services performed by or under the supervision of professional or technical personnel, including but not limited to home care for acute illness, personal care attendant services and the medical component of home care for chronic illness. Notwithstanding any other provision of law, the plan may utilize copayments for permanent care services;

E. Rehabilitative services for persons receiving therapeutic care;

F. Prescription drugs and devices. Unless the prescribing practitioner certifies that a more expensive drug is medically necessary, the plan must cover only part of the cost of a drug dispensed in a package or form of dosage or administration when the agency determines that a less expensive package or form of dosage or administration is available that is pharmaceutically equivalent in its therapeutic effect. If a plan member chooses to purchase a more expensive drug under this paragraph, the plan member is responsible for paying the amount not covered by the plan;

G. Mental health services;

H. Substance abuse treatment;

I. Primary and acute dental services;

J. Vision appliances, including lenses, frames and contact lenses, according to a schedule established by the agency;

K. Medical supplies and durable medical equipment and selected assistance devices;

L. Hospice care; and

M. Health care services payable pursuant to Title 39-A for all employees whose date of injury is on or after July 1, 1996.

4. Benefit delivery. Covered health care services must be provided to plan members by the participating providers of their choice through organized delivery systems or the open plan. The delivery of covered health care services to plan members is subject to the provisions of this subsection. The agency shall adopt rules regarding benefit delivery by the plan that include but are not limited to the following.

A. Organized delivery systems authorized by the agency may provide health care services to plan members.

B. The open plan is available to all plan members and to all participating providers.

C. The plan must pay for health care services provided to plan members while they are out of the State. The plan member must have been out of the State temporarily for reasons other than to obtain the health care services, or the member must have obtained the health care services out of the State for compelling reasons related to the suitability of the services, the nature of the condition and personal circumstances. The agency shall establish and operate a plan to pay for health care services provided to plan members while they are outside the State. The payments must be made at the rates established by the agency for comparable services provided by the plan in the State. Charges in excess of the payment rates established in accordance with this paragraph are the responsibility of the plan member.

D. The plan must pay cash benefits to a provider of health care services or to a plan member for a reasonable amount charged for medically necessary, emergency health care services obtained by a plan member from a provider who is not a participating provider.

E. Copayments or deductibles do not apply to health care services provided through the plan, except that to encourage

the use of the most appropriate and cost-effective mode of service, organized delivery systems may require reasonable payments by a plan member if payment is approved by the agency and does not substantially interfere with access to needed health care services.

F. Accountability to the public of the open plan and organized delivery systems must be ensured in order to promote public confidence in the health care delivery system and awareness of the costs of care.

G. Flexible enrollment and transfer processes that preserve plan member confidence and ensure that health care needs are met must be provided.

H. Opportunity for negotiation of fair rates of compensation with participating providers in the open plan and organized delivery systems and negotiation with pharmaceutical companies for similarly classified pharmaceuticals must be provided.

I. A program to expand services to underserved rural and low-income communities must be established.

J. Mechanisms must be developed to provide incentives to participating providers in the open plan and to organized delivery systems for additional savings that do not compromise the quality of health care.

5. Provider requirements. Participating providers, the open plan and organized delivery systems may not charge a plan member or a 3rd party for covered health services and may not charge rates in excess of the reimbursement levels set by the agency. A participating provider of health care services, the open plan and organized delivery systems may not refuse to provide services to a plan member on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, alienage or citizenship status, gender, sexual orientation, disability, marital status or arrest record except as appropriate to the provider's professional specialization or other medically appropriate circumstances.

6. Provision of information by participating providers. A participating provider must make information available to the agency and permit examination of its records by the agency as necessary for the purposes of this section and section 374.

7. Organized delivery system requirements. For fiscal year 1996-97 organized delivery systems must have target loss ratios of 88% and caps on administrative costs of 10%. For fiscal year

1997-98 organized delivery systems must have target loss ratios of 90% and caps on administrative costs of 8%. For each succeeding fiscal year the loss ratio must increase 1% and the administrative cost cap decrease 1% until the agency determines that the greatest efficiency has been reached.

8. Role of other health care programs. Until the agency determines otherwise, the plan is supplemental to all coverage available to a plan member from another health care program, including but not limited to the Medicare program of the federal Social Security Act, Title XVIII; the Medicaid program of the federal Social Security Act, Title XIX; the Civilian Health and Medical Program of the Uniformed Services, 10 United States Code, Sections 1071-1106; the federal Indian Health Care Improvement Act, 25 United States Code, Sections 1601-1682; other 3rd-party payors who may be billable for health care services; and any state and local health programs, including but not limited to workers' compensation and employers' liability insurance, pursuant to former Title 39 and Title 39-A. Health care services billed to 3rd-party payors other than the plan must be paid for by those programs, and coverage under the plan is supplemental to that coverage. A plan member who receives health care services under another health care program or from a 3rd-party payor to which the plan is supplemental shall pay a premium to the fund in proportion to the health care benefits available to the plan member under the plan.

SUBCHAPTER III

ENSURING THE QUALITY, AFFORDABILITY AND EFFICIENCY OF HEALTH CARE

§373. Quality; affordability; efficiency; health planning

The agency shall undertake the following duties to ensure the quality, affordability, efficiency and planning of health care for the citizens of the State.

1. Quality of care. The agency shall establish a quality assurance program and shall adopt rules to implement that program. The program must include but is not limited to the following:

A. Operation of the plan;

B. Utilization of covered health care services of participating and nonparticipating providers;

C. Evaluation of the performance of participating providers;

D. Standards and continuity of care;

E. A plan for increased delivery of preventive and primary care;

F. Access to information and data for the agency;

G. A plan to ensure that the open plan and organized delivery systems address public health needs;

H. Plan member involvement in policy decisions; and

I. An efficient complaint resolution process regarding quality of care and utilization and rate controls.

2. Affordability of care. The agency shall establish an affordability assurance program and shall adopt rules to implement that program. The program must include but is not limited to the following:

A. Rates of compensation for participating providers in organized delivery systems and in the open plan;

B. Operation of the Small Business Hardship Fund to assist employers for which the plan constitutes a hardship;

C. Maintenance of a prescription drug formulary; and

D. Cost containment mechanisms for organized delivery systems and for the open plan. Cost containment mechanisms may include primary care case management, guaranteed provider payment, variable reimbursement rates for providers, review of treatment and services concurrent with the provision of the treatment and services, expenditure targets, practice parameters and treatment norms.

3. Efficiency of care. The agency shall establish an efficiency of care program and shall adopt rules to implement that program. The agency shall review health care malpractice insurance costs and shall work with organized delivery systems, participating providers and insurers to ensure that the resources of the fund are used for maximum service delivery. The agency shall develop claims handling and data collection methods and forms, including but not limited to uniform billing forms and procedures to facilitate the exchange of information and communication between the agency and participating providers.

4. Health planning. The agency shall establish a health planning program and adopt rules to implement that program. Health planning must be considered in light of the programs on

quality, affordability and efficiency established under subsections 1 to 3. The program must include but is not limited to the following:

A. Global budgets for all expenditures of the plan for the base year of the plan and for each following year based on the level of expenditures in the preceding year as increased by the percentage of increase in the average per capita personal income applicable to the State, as developed by the United States Department of Commerce;

B. Global budgets for hospitals and institutional providers with adjustments for case mix, volume and region and separate capital budgets for hospitals and institutional providers;

C. A certificate of need program, pursuant to chapter 103;

D. A health planning program;

E. Data collection regarding health care needs, resources and expenditures; and

F. A hospital financing system, pursuant to chapter 107.

SUBCHAPTER IV

FINANCING OF THE MAINE HEALTH CARE PLAN

§374. Financing of the Maine Health Care Plan

Financing of the plan is accomplished by the fund.

1. Maine Health Care Trust Fund. The Maine Health Care Trust Fund is established to finance the plan. Deposits into the fund and expenditures from the fund must be made pursuant to this section and to rules adopted by the agency to carry out the purposes of this section. All income generated pursuant to this chapter must be deposited in the Maine Health Care Trust Fund, which does not lapse but carries forward from one fiscal year to the next.

A. The Small Business Hardship Fund is established as a part of the fund to assist self-employed persons and employers for which participation in the plan constitutes a hardship.

B. Payments are deposited into the fund from the following sources:

(1) Premium payments made by individuals and employers as follows:

(a) Premium levels for individuals must be based on 2 levels of income: income under $35,000 per year and income over $35,000 per year; and

(b) Assessment levels for employers based on 2 levels of profitability: that measured by a profit margin smaller than 10% and that measured by a profit margin greater than 10%;

(2) Premium payments made by residents and nonresidents based on earned income not included in subparagraph 1 and on unearned income;

(3) Payments made by federal, state and local governmental units;

(4) Payments from the increase in the cigarette tax from 18.5 mills to 21.0 mills levied pursuant to Title 36, section 4365, beginning in fiscal year 1996. Payments from the cigarette tax must be deposited in the Small Business Hardship Fund. Only amounts not required for that fund may be transferred from that fund into the Maine Health Care Trust Fund;

(5) Copayments for permanent care made pursuant to section 372, subsection 3, paragraph D;

(6) Payment of the balance in the account of the Health Care Finance Commission Trust Fund on December 30, 1996; and

(7) Other payments made pursuant to law.

C. Expenditures from the fund are authorized for the following purposes:

(1) One percent of the budget of the fund for health promotion and injury, disease and disability prevention programs;

(2) Payments to participating providers for health care services rendered pursuant to section 372, subsection 4;

(3) Payments to nonparticipating providers for health care services rendered pursuant to section 372, subsection 4;

(4) Payments for capital expenditures approved pursuant to chapters 103 and 107;

(5) Payments to the Small Business Hardship Fund;

(6) Payments for administration of the fund and the plan;

(7) Payments for the operations and expenditures of the agency, the council and any advisory committees authorized by law or appointed by the agency; and

(8) Other payments made pursuant to law.

2. Requirements for expenditures. The agency shall adopt rules setting the requirements for expenditures from the fund. The agency shall perform quarterly reviews of expenditures within the open plan and organized delivery systems to determine whether expenditures are within the budget of the agency. The requirements include the following:

A. For organized delivery systems, rates that are based on capitation, that utilize risk adjustment and are set to reflect whether a region is underserved or has low income and utilization rates;

B. For participating providers in the open plan, rates that are set to reflect costs, volume and relative value of services and that may be based on contracts and capitation;

C. For institutional providers and hospitals, rates that are based on global budgets; and

D. For rural health centers and the family planning system, rates that reflect their special mission and needs.

SUBCHAPTER V

MAINE HEALTH CARE AGENCY

§375. Establishment

The Maine Health Care Agency is established as an independent executive agency to accomplish the following:

1. Maine Health Care Plan. To administer and oversee the Maine Health Care Plan, established by section 372;

2. Maine Health Care Council. To take action through the direction of the Maine Health Care Council, established by section 375-B; and

3. Maine Health Care Trust Fund. To administer and oversee the Maine Health Care Trust Fund, established by section 374.

§375-A. General powers

In addition to the powers granted to the agency elsewhere in this chapter, the agency is authorized to act as necessary to carry out the purposes of this chapter, including but not limited to the following.

1. Rulemaking. The agency may adopt, amend and repeal rules as necessary for the proper administration and enforcement of this chapter, subject to the Maine Administrative Procedure Act.

2. Executive director and staff. The agency shall employ an executive director, who must have had experience in the organization, financing or delivery of health care and who must perform the duties delegated by the agency. The agency may delegate to the executive director any of its functions and duties except the adoption of rules, the establishment of a global budget for health care for the State under section 373, subsection 4 and the approval of certification of need applications under chapter 103. The executive director is an unclassified employee and serves at the pleasure of the council. The executive director, at the direction of the agency, shall hire personnel to administer this chapter, subject to the Civil Service Law and within the budgetary parameters set by the council.

3. Receipt of gifts, grants and payments; fees. The agency may solicit, receive and accept gifts, grants, payments and other funds and advances from any person and enter into agreements with respect to those grants, gifts, payments and other funds and advances, including agreements that involve the undertaking of studies, plans, demonstrations and projects. The agency may charge and retain fees to recover the reasonable costs incurred in reproducing and distributing reports, studies and other publications and in responding to requests for information.

4. Studies and analyses. The agency may conduct studies and analyses related to the provision of health care, health care costs and matters it considers appropriate.

5. Grants. The agency may make grants to persons to support research or other activities undertaken in furtherance of

the purposes of this chapter. Without the specific written authorization of the agency, a party receiving a grant from the agency may not release, publish or otherwise use results of the research or information made available by the agency.

6. Contracts. The agency may contract with anyone for services necessary to carry out the activities of the agency. Without the specific written authorization of the agency, a party entering into a contract with the agency may not release, publish or otherwise use information made available to it under contracted responsibilities.

7. Audits. To the extent necessary to carry out its responsibilities, the agency, during normal business hours and upon reasonable notification, may audit, examine and inspect any records of any health care provider, organized delivery system or contractor.

8. Data collection. The agency shall institute a data collection system to acquire and analyze information on the provision of health care and health care costs. All data released by the agency must protect the confidentiality of the health care provider and the client and, whenever possible, must be released as aggregate data.

9. Complaint resolution. In cooperation with health care providers and plan members, the agency shall institute a complaint resolution system to handle the complaints of health care providers and plan members.

10. Funding. The agency shall determine the level of funding required to carry out the purposes of this chapter. It shall submit biennially to the Legislature for approval a proposed budget with levels of premiums and assessments and taxes under Title 36, section 4365. Funding for the agency budget approved by the Legislature is paid from the fund.

11. Coordination with federal, state and local health care systems. The agency shall institute a system to coordinate the activities of the agency and the plan with the health care programs of the federal, state and municipal governments.

12. Reports. On or before January 1st of each year the agency shall submit to the Governor and the Legislature an annual report of its operations and activities during the previous year and the funding, tax and budget requirements of subsection 10. This report must include facts, suggestions and policy recommendations that the agency considers necessary. As it determines appropriate, the agency shall publish and disseminate information helpful to the citizens of this State in making

informed choices in obtaining health care, including the results of studies or analyses undertaken by the agency.

13. Advisory committees. The agency may appoint advisory committees to advise and assist the agency. Members of those committees serve without compensation but may be reimbursed by the agency for necessary expenses while on official business of the committee.

14. Headquarters. The agency's central office must be in the Augusta area but the agency may hold hearings and sessions at any place in the State.

15. Seal. The agency may have a seal bearing the words "Maine Health Care Agency."

§375-B. Maine Health Care Council

The Maine Health Care Council is established as the decision-making and directing council for the agency.

1. Membership. The council is composed of 3 members, appointed by the Governor and, within 30 days after authorization, subject to review by the joint standing committees having jurisdiction over banking and insurance matters and over human resource matters and to confirmation by the Legislature.

Persons eligible for appointment to the council must have had experience in the organization, delivery or financing of health care. At least one member of the council must be an individual with experience in the delivery and organization of primary and preventive care and public health services. At least one member of the council must be an individual who is not a health care provider and has not worked for a health care provider or health insurer. Members of the council shall devote full time to their duties.

2. Terms. The terms of the members are staggered. Of the initial appointees, one must be appointed for one year, one for 2 years and one for 3 years. Thereafter, all appointments are for 5-year terms, except that a member appointed to fill a vacancy in an unexpired term serves only for the remainder of that term. Members hold office until the appointment and confirmation of their successors.

3. Chair; voting. The Governor shall designate one member of the council as chair. The chair shall preside at meetings of the council, is responsible for the expedient organization of the agency's work and may vote on all matters before the council.

Two council members constitute a quorum. The council may take action only by an affirmative vote of at least 2 members.

4. Duties. The council shall direct, administer and oversee the agency in the performance of its duties under this chapter. The council shall annually prepare a state health plan in accordance with chapter 103. The council has broad authority to carry out the purposes of this chapter.

Sec. A-2. Working capital advance. The State Controller shall transfer a $400,000 working capital advance to the dedicated account of the Maine Health Care Trust Fund on the effective date of this Part. The Maine Health Care Agency shall repay this working capital advance by June 30, 1997.

Sec. A-3. Effective date. This Part takes effect on January 1, 1996.

PART B

Sec. B-1. Maine Health Care Plan Transition Advisory Committee.

1. Establishment. The Maine Health Care Plan Transition Advisory Committee is established to advise the members of the Maine Health Care Council.

2. Membership. The committee consists of 20 members, who are appointed as specified in this subsection and are subject to confirmation by the Legislature.

Four members must be legislators. Two of those members must be appointed by the President of the Senate, one from each party, and 2 must be appointed by the Speaker of the House of Representatives, one from each party.

Sixteen representatives of the public must be appointed as follows. Eight members must be appointed by the Governor, 4 members must be appointed by the President of the Senate and 4 members must be appointed by the Speaker of the House of Representatives.

The appointing authorities shall notify the Executive Director of the Legislative Council upon making their appointments. All appointments must be made within 30 days of the effective date of this Part. Within the next 30 days the appointments must be reviewed and approved by a joint committee consisting of the members of the joint standing committees on banking and insurance matters and on human resource matters and must be confirmed by the Legislature.

The public members must represent statewide organizations from the following groups: consumers, persons who have not previously had health insurance, providers of maternal and child health services, Medicaid recipients, persons with disabilities, persons who are elderly, organized labor, allopathic and osteopathic physicians, nurses and allied health care professionals, organized delivery systems, hospitals, community health centers, the family planning system and the business community, including a representative of small business.

When appointment of all members of the committee is completed, the chair of the Legislative Council shall call the committee together for its first meeting. The first meeting must be held within 90 days of the effective date of this Part. The members of the committee shall elect a chair from among the members.

3. Responsibilities. The committee shall hold public hearings, solicit public comments and advise the Maine Health Care Agency for the purposes of planning the transition to the Maine Health Care Plan and recommending legislative changes to accomplish the purposes of the Maine Revised Statutes, Title 22, chapter 106.

4. Staffing and funding. The Maine Health Care Agency shall provide staffing and funding for the committee.

5. Compensation. Members of the committee serve without compensation. They are entitled to reimbursement from the Maine Health Care Agency for travel and other necessary expenses incurred in the performance of their duties on the committee.

6. Reports. As it determines appropriate, the committee shall report to the Maine Health Care Agency. The committee shall report to the Governor and to the Legislature on July 1, 1996, January 1, 1997, July 1, 1997 and December 31, 1997.

7. Completion of duties. The committee shall complete its duties on December 31, 1997, when all terms of membership on the committee expire.

Sec. B-2. Effective date. This Part takes effect on January 1, 1996.

PART C

Sec. C-1. 5 MRSA §12004-I, sub-§38, as enacted by PL 1987, c. 786, §5, is amended to read:

38. ~~Human Services, Health Facilities~~ Maine Health Care Agency	Certificate of Need Advisory Committee	$25/Day	22 MRSA §307

Sec. C-2. 22 MRSA §303, sub-§3-A, as enacted by PL 1983, c. 579, §6, is amended to read:

3-A. Commission. "Commission" means the Maine Health Care Finance Commission established pursuant to chapter 107. This subsection is repealed on January 1, 1997.

Sec. C-3. 22 MRSA §303, sub§4-A is enacted to read:

4-A. Council. "Council" means the Maine Health Care Council established pursuant to chapter 106.

Sec. C-4. 22 MRSA §303, sub-§5, as amended by PL 1981, c. 705, Pt. V, §3, is further amended to read:

5. Department. "Department" means the ~~Department of Human Services, but does not include the Certificate of Need Advisory Committee within the department~~ Maine Health Care Agency established pursuant to chapter 106.

Sec. C-5. 22 MRSA §303, sub-§20, as enacted by PL 1977, c. 687, §1, is repealed.

Sec. C-6. 22 MRSA §303, sub-§21, as amended by PL 1985, c. 418, §3, is further amended to read:

21. State health plan. "State health plan" means the plan that must be prepared annually by the ~~State Health Coordinating Council after consideration of the preliminary state health plan prepared by the Office of Health Planning and Development, within the Bureau of Medical Services~~ council.

Sec. C-7. 22 MRSA §304-A, sub-§4, ¶C, as enacted by PL 1981, c. 705, Pt. V, §16, is amended to read:

C. The addition of a health service ~~which~~ that falls within a category of health services ~~which~~ that are subject to review regardless of capital expenditure or operating cost and ~~which category~~ that the department has defined through regulations ~~promulgated~~ adopted pursuant to section 312, ~~based on recommendations from the State Health Coordinating Council~~;

Sec. C-8. 22 MRSA §304-D, sub-§5, as enacted by PL 1985, c. 661, §2, is amended to read:

5. Treatment of project by the Maine Health Care Agency. 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 section 396-K.

Sec. C-9. 22 MRSA §307, sub-§2-A, as amended by PL 1989, c. 503, Pt. B, §79, is further amended to read:

2-A. Certificate of Need Advisory Committee. The Certificate of Need Advisory Committee, established by Title 5, section 12004-I, subsection 38, and created within the ~~Department of Human Services~~ Maine Health Care Agency, ~~shall participate~~ participates with the ~~department~~ agency in the public hearing process.

A. The committee ~~shall be~~ is composed of 10 members, 9 of whom ~~shall be~~ are appointed by the Governor. The ~~Commissioner of Human Services~~ council shall name a designee to serve as an ex officio nonvoting member of the committee. The 9 members appointed by the Governor ~~shall~~ must be selected in accordance with the following requirements.

(1) Four members ~~shall~~ must be appointed to represent the following.

(a) One member ~~shall represent~~ represents the hospitals.

(b) One member ~~shall represent~~ represents the nursing home industry.

(c) One member ~~shall represent~~ represents major 3rd-party payors.

(d) One member ~~shall represent~~ represents physicians.

In appointing these representatives, the Governor shall consider recommendations made by the Maine Hospital Association, the Maine Health Care Association, the Maine Medical Association, the Maine Osteopathic Association and other representative organizations.

(2) Five public members ~~shall~~ must be appointed as consumers of health care. One of these members ~~shall~~ must be designated on an annual basis by the Governor as chair of the committee. Neither the public members nor their spouses or children may, within 12 months preceding the appointment, have been affiliated with, employed by, or have had any professional affiliation with any health care facility or institution, health product manufacturer or corporation or insurer providing coverage for hospital or medical care~~,--and provided-that~~; neither membership in or subscription to a service plan maintained by a nonprofit hospital and medical service organization, nor enrollment in a health maintenance organization, nor membership as a policyholder in a mutual insurer or coverage under such a policy, nor the purchase of or coverage under a policy issued by a stock insurer may disqualify a person from serving as a public member.

B. Appointed members of the committee ~~shall~~ serve for terms of 4 years. Members ~~shall~~ hold office until the appointment and confirmation of their successors. Of the members first appointed by the Governor, the member representing hospitals and 2 public members ~~shall~~ hold office for 4 years, the member from the nursing home industry and one public member ~~shall~~ hold office for 3 years, the member from the insurance field and one public member ~~shall~~ hold office for 2 years and the physician and one public member ~~shall~~ hold office for one year.

C. Vacancies among appointed members ~~shall~~ must be filled by appointment by the Governor for the unexpired term. A vacancy in the office of the chair ~~shall~~ must be filled by the Governor, who shall designate a new chair for the balance of the member's term as chair. The Governor may remove any appointed member who becomes disqualified by virtue of the requirements of paragraph A, or for neglect of any duty required by law, or for incompetency or dishonorable conduct.

D. Each appointed member of the committee ~~shall--be compensated~~ is entitled to compensation according to Title 5, chapter 379.

E. Five members of the committee ~~shall~~ constitute a quorum. Actions of the committee ~~shall~~ must be by majority vote.

Sec. C-10. 22 MRSA §307, sub-§2-B, ¶¶H and I, as enacted by PL 1981, c. 705, Pt. V, §25, are amended to read:

H. At its next meeting following the receipt of comments pursuant to paragraph F or G, or in the case of a public hearing pursuant to paragraph G, the committee shall make a recommendation of approval or disapproval with respect to the application or applications under consideration. The recommendation ~~shall~~ must be determined by majority vote of the appointed members present and voting. Members of the committee may make additional oral comments or submit written comments, as they ~~deem~~ determine appropriate, with respect to the basis for their recommendations or their individual views. The committee recommendation and any accompanying comments ~~shall~~ must be forwarded to the ~~commissioner~~ council.

I. At the time the staff submits its final report to the ~~commissioner~~ council, a copy of the report ~~shall~~ must be sent to the applicant and a notification ~~shall~~ must be sent to all registered affected persons. No further comments may be accepted.

Sec. C-11. 22 MRSA §307, sub-§5-A, as amended by PL 1985, c. 661, §3, is further amended to read:

5-A. Decision by the council. Decisions by the ~~commissioner shall~~ council must 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~~ council 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~~ council must be based on the informational record developed in the course of review as specified in paragraph C. Notice of the decision ~~shall~~ must be sent to the applicant and the committee. This notice ~~shall~~ must incorporate written findings ~~which~~ that 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~~ council 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~~ may not rely on the contents of any documents relating to the application when those documents are submitted to the department anonymously.

Sec. C-12. 22 MRSA §307, sub-§6-A, as amended by PL 1993, c. 410, Pt. FF, §2, is further amended to read:

6-A. Review cycles. The department shall establish review cycles for the review of applications. There must be at least one review cycle for each type or category of project each calendar year, the dates for which must be published at least 3 months in advance. An application must be reviewed during the next scheduled review cycle following the date on which the application is either declared complete or submitted for review pursuant to section 306-A, subsection 4, paragraph B. Hospital projects that must be considered within the constraints

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

Sec. C-13. 22 MRSA §309, sub-§5, as enacted by PL 1981, c. 705, Pt. V, §33, is amended to read:

5. Standards applied in certificate of need. The ~~commissioner~~ council shall, in issuing a certificate of need, make ~~his~~ a decision, to the maximum extent practicable, directly related to criteria established under federal laws and standards or criteria prescribed in ~~regulations promulgated by the department~~ rules adopted by the Maine Health Care Agency pursuant to subsections 1 to 4 and section 312.

The ~~commissioner shall~~ council may not deny issuance of a certificate of need, or make ~~his~~ a decision subject to fulfillment of a condition on the part of the applicant, except ~~where~~ when the denial or condition directly relates to criteria established under federal laws and standards or criteria prescribed in ~~regulations promulgated by the department~~ rules adopted by the Maine Health Care Agency in accordance with subsections 1 to 4 and section 312, ~~which~~ that are pertinent to the application.

Sec. C-14. 22 MRSA §309, sub-§6, as amended by PL 1989, c. 502, Pt. A, §65, is further amended to read:

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

Sec. C-15. 22 MRSA §310, as amended by PL 1985, c. 443, §2, is further amended to read:

§310. Reconsideration

Any person directly affected by a review may, for good cause shown, request in writing a hearing for the purposes of reconsideration of the decision of the ~~department~~ council to issue or to deny a certificate of need. The ~~department~~ council, if it determines that good cause has been demonstrated, shall hold a hearing to reconsider its decision. To be effective, a request for the hearing ~~shall~~ must be received within 30 days of the ~~department's~~ council's decision. If the ~~Department--of--Human Services~~ council determines that good cause for a hearing has been demonstrated, the hearing ~~shall~~ must commence within 30 days of receipt of the request. A decision ~~shall~~ must be rendered within 60 days of the commencement of the hearing. The decision may be rendered beyond this time period by mutual consent of the parties. For purposes of this section, a request for a hearing ~~shall-be-deemed~~ is determined to have shown good cause if it:

1. New information. Presents significant, relevant information not previously considered by the ~~department~~ council;

2. Changes in circumstances. Demonstrates that there have been significant changes in factors or circumstances relied upon by the ~~department~~ council in reaching its decision;

3. Failure to follow procedures. Demonstrates that the ~~department~~ council has materially failed to follow its adopted procedures in reaching its decision; or

4. Other bases. Provides other bases for a hearing that the ~~department~~ council has determined ~~constitutes~~ constitute good cause.

Sec. C-16. 22 MRSA §312, as amended by PL 1981, c. 705, Pt. V, §34, is repealed and the following enacted in its place;

§312. Rules

The Maine Health Care Agency shall adopt rules necessary to carry out the provisions and purposes of this chapter in accordance with Title 5, chapter 375. The Maine Health Care Agency, to the extent applicable, shall adopt rules that are consistent with the state health plan. The Maine Health Care Agency is authorized to accept federal funds to be used for carrying out this chapter.

Sec. C-17. 22 MRSA §314, as amended by PL 1985, c. 418, §16, is further amended to read:

§314. Conflict of interest

In addition to the limitations of Title 5, section 18, a member or employee of the ~~Department of Human Services~~ Maine Health Care Agency or Certificate of Need Advisory Committee who has a substantial economic or fiduciary interest ~~which~~ that would be affected by a recommendation or decision to issue or deny a certificate of need, or who has a close relative or economic associate whose interest would be ~~so~~ affected ~~shall be~~, is ineligible to participate in the review, recommendation or decision making process with respect to any application for which the conflict of interest exists.

Sec. C-18. 22 MRSA §396-K, as amended by PL 1991, c. 771, §1, is further amended by repealing and replacing the headnote to read:

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

Sec. C-19. 22 MRSA §396-K, sub-§2, ¶C, as enacted by PL 1985, c. 661, §10, is amended to read:

C. Debits and carry-overs ~~shall be~~ are 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~~ are 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~~ that 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~~ are 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 immediately 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~~ Certificate of Need 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~~ are 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~~ are carried forward to the 3rd payment cycle as a credit to the statewide component of the ~~Hospital~~ Certificate of Need Development Account established in accordance with subsection 3.

Sec. C-20. 22 MRSA §396-K, sub-§3, as amended by PL 1991, c. 771, §1, is further amended to read:

3. Certificate of Need Development Account. For the 3rd and subsequent payment year cycles, the ~~commission~~ council shall establish a ~~Hospital~~ Certificate of Need Development Account to support the development of hospital facilities and services and nonhospital facilities using major medical equipment that receive certificates of need pursuant to section 304-A. This account ~~shall be~~ is administered as follows.

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

(1) The ~~State--Health--Plan~~ state health plan, as defined in section 303, subsection 21;

(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~~ federal Social Security Act, ~~Title~~ Titles XVIII and XIX;

(4) The special needs of small hospitals;

(5) The historic needs and experience of hospitals and other facilities subject to this account 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.;

(10) The needs of each particular region of the State; and

(11) The recommendations of any advisory committee created by the Maine Health Care Agency pursuant to section 375-A, subsection 13.

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

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

B-1. On the basis of additional information received after an annual credit is established pursuant to paragraph A, including information ~~provided by the department~~ concerning the ~~State Health Plan~~ state health plan or projects then under review, the ~~commission~~ council may increase or decrease the amount of the annual credit by the adoption of a rule change proposed during the course of the payment year cycle to which it applies. ~~The commission may not act under this paragraph to decrease the credit below the amount that would, in combination with any amounts carried over from prior years, equal the total of any debits associated with projects approved on or before the date that the commission notifies the department of a proposed rule that would decrease the credit.~~ For any payment year cycle in which the annual credit is apportioned to "statewide" and "individual hospital" components, the increase or decrease authorized by this paragraph applies solely to the "statewide" component of the credit.

C. The ~~commission~~ council 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 or the council 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 ~~Hospital~~ Certificate of Need Development Account as of the date of approval of the project by the department or the council, after accounting for previously approved projects.

F. Debits and carry-overs ~~are~~ must be determined as follows.

(1) Except as provided in subparagraph (2), the ~~commission~~ council shall debit against the ~~Hospital~~

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 C and with each project for which certificate of need approval has been granted pursuant to section 304-A, subsection 2. Incremental annual capital and operating costs ~~are~~ must be determined in the same manner as adjustments to financial requirements are determined under section 396-D, subsection 5, for the 3rd year of implementation of the ~~project~~ projects subject to such adjustments. For acquisitions of equipment by persons other than hospitals, incremental annual capital and operating costs must be determined in a manner consistent with the manner in which project costs are determined for hospitals.

(2) In the case of a project ~~which~~ that is approved under paragraph C and ~~which~~ that involves extraordinary incremental annual capital and operating costs, the ~~commission~~ council may, in accordance with duly ~~promulgated~~ adopted rules, defer the debiting of a portion of the annual costs associated with the project until a subsequent payment year cycle or cycles.

(3) Amounts credited to the ~~Hospital~~ Certificate of Need Development Account for which there are no debits ~~are~~ must be carried forward to subsequent payment year cycles as a credit.

Sec. C-21. 22 MRSA §396-K, sub-§5, as enacted by PL 1987, c. 835, §1, is amended to read:

5. Temporary adjustment. For the 4th payment year, an adjustment of $7,800,000 ~~shall~~ must be made to the ~~Hospital~~ Certificate of Need Development Account. For purposes of this adjustment, the provisions of subsection 3, paragraph B, ~~shall only~~ apply only to the credits in the account as of October 1, 1987. This adjustment ~~shall be~~ is in addition to any amount remaining in the Certificate of Need Development Account.

Sec. C-22. Transition. The following provisions apply to the transfer of the certificate of need program and related programs from the Department of Human Services to the Maine Health Care Agency.

1. The Maine Health Care Agency is the successor in every way to the Department of Human Services, Office of Health Planning and Development. All responsibilities, power and authority that were formerly vested in the Department of Human

Services, Office of Health Planning and Development are transferred to the Maine Health Care Agency.

2. Notwithstanding the provisions of the Maine Revised Statutes, Title 5, all accrued expenditures, assets, liabilities, balances or appropriations, allocations, transfers, revenues or other available funds in an account or subdivision of an account of the Department of Human Services, Office of Health Planning and Development must be transferred to the proper accounts of the Maine Health Care Agency by the State Controller upon the request of the State Budget Officer and with the approval of the Governor.

3. All rules and procedures in effect, in operation or adopted on the effective date of this Part by the Department of Human Services regarding certificate of need, health planning or rural health remain in effect until rescinded, revised or amended by the Maine Health Care Agency.

4. All contracts, agreements and compacts in effect on the effective date of this Part in the former Office of Health Planning and Development within the Department of Human Services remain in effect until rescinded, revised or amended by the Maine Health Care Agency.

5. All positions within the Department of Human Services, Office of Health Planning and Development are transferred to the Maine Health Care Agency. The Bureau of Human Resources shall assist with the orderly implementation of these provisions.

6. All records, property and equipment previously belonging to or allocated for the use of the Department of Human Services, Office of Health Planning and Development are transferred to the Maine Health Care Agency.

Sec. C-23. Statutory revisions. By January 1, 1997, the Maine Health Care Agency shall submit to the Legislature legislation recommended to clarify the reorganization of services affected by this Part.

Sec. C-24. Effective date. Sections C-1 to C-6 of this Part take effect July 1, 1996. Sections C-8, C-9, C-14 and C-19 to C-22 of this Part takes effect January 1, 1997.

PART D

Sec. D-1. 2 MRSA §6-B, as enacted by PL 1983, c. 579, §1, is repealed.

Sec. D-2. 3 MRSA §927, sub-§9, ¶B, as repealed and replaced by PL 1991, c. 376, §11, is further amended to read:

B. Independent agencies:

(1) Maine Conservation School;

(2) Office of State Historian;

(3) Maine Arts Commission;

(4) Maine State Museum Commission;

(5) Maine Historic Preservation Commission;

~~(6) Maine Health Care Finance Commission;~~

(7) Board of Occupational Therapy Practice;

(8) Board of Respiratory Care Practitioners;

(9) Radiologic Technology Board of Examiners;

(10) Maine Library Commission;

(11) Maine Waste Management Agency; and

(12) Maine Court Facilities Authority.

Sec. D-3. 5 MRSA §931, sub-§1, ¶L, as amended by PL 1991, c. 376, §17, is repealed.

Sec. D-4. 22 MRSA §382, sub-§1-B is enacted to read:

1-B. Agency. "Agency" means the Maine Health Care Agency established pursuant to chapter 106.

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

Sec. D-6. 22 MRSA §382, sub-§3-A is enacted to read:

3-A. Council. "Council" means the Maine Health Care Council established pursuant to chapter 106.

Sec. D-7. 22 MRSA §383, sub-§1, as amended by PL 1989, c. 503, Pt. B, §80, is repealed.

Sec. D-8. 22 MRSA §383, sub-§2, as enacted by PL 1983, c. 579, §10, is amended to read:

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

A. ~~The commission~~ In addition to meetings the council may hold to fulfill other responsibilities, the council shall meet from time to time as required to fulfill its responsibilities under this chapter. Meetings ~~shall~~ may be called by the ~~chairman~~ chair or by any ~~3~~ 2 members and, except in the event of an emergency meeting, ~~shall~~ must be called by written notice. Meetings ~~shall~~ must be announced in advance and open to the public, to the extent required by Title 1, chapter 13, subchapter I.

B. ~~Three~~ Two members of the ~~commission shall~~ council constitute a quorum. No action of the ~~commission may be~~ council is effective without the concurrence of at least ~~3~~ 2 members.

Sec. D-9. 22 MRSA §384, as amended by PL 1985, c. 785, Pt. B, §84, is repealed.

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

Sec. D-11. 22 MRSA §386, first ¶, as enacted by PL 1983, c. 579, §10, is amended to read:

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

Sec. D-12. 22 MRSA §386, sub-§3, as enacted by PL 1983, c. 579, §10, is amended to read:

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

Sec. D-13. 22 MRSA §391, as amended by PL 1993, c. 410, Pt. UUU, §1, is repealed.

Sec. D-14. 22 MRSA §392, as enacted by PL 1983, c. 579, §10, is repealed.

Sec. D-15. 22 MRSA §396-D, sub-§5, as amended by PL 1985, c. 661, §8, is further amended to read:

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

A. Except as provided in paragraph C, in determining payment year financial requirements, the ~~commission~~ council 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~~ council 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.

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

C. In determining payment year financial requirements, if a project approved in accordance with the Maine Certificate of Need Act and section 396-K subsequent to October 1, 1985, involves an activity specified in subsection 8, the ~~commission~~ council may elect to determine an adjustment to reflect any net decrease resulting from that project in a manner consistent with its determination of adjustments under subsection 8.

Sec. D-16. 22 MRSA §396-D, sub-§9, ¶C, as enacted by PL 1983, c. 579, §10, is amended to read:

C. New regulatory costs are determined as follows.

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

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

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

Sec. D-17. 22 MRSA §396-K, sub-§2, ¶B, as repealed and replaced by PL 1985, c. 661, §10, is amended to read:

B. The ~~commission~~ council 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~~ council 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~~ council, after accounting for previously approved projects.

Sec. D-18. 22 MRSA §396-L, sub-§4, ¶A, as repealed and replaced by PL 1985, c. 778, §5, is amended to read:

A. The following procedures ~~shall~~ apply to an application for approval of a hospital restructuring.

(1) Except as provided in subparagraph (2), the ~~commission~~ council shall rule upon all requests for approval of a hospital restructuring within 90 days of the filing date. The filing date ~~shall be~~ is the date when the ~~commission~~ council notifies the applicant that the filing is complete.

(2) If the ~~commission deems~~ council determines that the necessary investigation ~~cannot~~ can not be concluded within 90 days after the filing date, the ~~commission~~ council may extend the period for a further period of no more than 90 days. If the ~~commission~~ council fails to make a final ruling on or before the end of the 2nd 90-day period or such later date as may be fixed by agreement of all parties, the application ~~shall be~~ is deemed disapproved.

(3) Review of hospital restructurings that are also subject to review under the Maine Certificate of Need Act ~~shall~~ must, to the maximum extent practicable, be conducted simultaneously with the ~~department's~~ council's review under the Act.

Sec. D-19. 22 MRSA §396-P, sub-§1, as corrected by RR 1991, c. 2, §73, is amended to read:

1. Establishment. The ~~commission shall~~ council may, after consultation with representative groups, appoint the following advisory committees to assist in its duties under this chapter. In addition to the specific tasks of each committee in paragraphs A to D, each committee must report to the agency on the performance of the agency in the delivery of quality, affordable health care for the people of this State.

A. The ~~commission shall~~ council may appoint a Professional Advisory Committee, authorized by Title 5, section 12004-I, subsection 47, consisting of 2 allopathic physicians, 2 osteopathic physicians, 2 nurses and one hospital employee, other than a nurse or physician, directly involved in the provision of patient care. This committee shall advise the ~~commission~~ council and its staff with respect to the effects of the health care financing system established under this subchapter on the quality of care provided by hospitals.

B. The ~~commission shall~~ council may appoint a Hospital Advisory Committee, authorized by Title 5, section 12004-I, subsection 45, consisting of 2 representatives of hospitals ~~which~~ that have 55 or fewer beds, 2 representatives of hospitals ~~which~~ that have 56 to 110 beds and 2

representatives of hospitals ~~which~~ that have more than 110 beds. This committee shall advise the ~~commission~~ council and its staff with respect to analytical techniques, data requirements, financial and other requirements of hospitals, and the effects of the health care financing system established under this subchapter on the hospitals of the State.

C. The ~~commission--shall~~ council may appoint a Payor Advisory Committee, authorized by Title 5, section 12004-I, subsection 46, consisting of one representative of nonprofit hospital and medical service corporations, one representative of commercial insurance companies, one representative of self-insured groups and one representative of the department. This committee shall advise the ~~commission~~ council and its staff with respect to analytical techniques, data requirements and other technical matters involved in implementing and administering the health care financing system established under this subchapter.

D. The ~~commission-shall~~ council may appoint the Consumer Advisory Committee, authorized by Title 5, section 12004-I, subsection 44-A, consisting of 2 representatives of organizations or agencies concerned with the health care needs of the elderly, 2 representatives of employers who purchase hospital care benefits for their employees and 3 representatives of organizations representing the interests of consumers or individual purchasers of hospital care. This committee shall advise the ~~commission~~ council and its staff concerning the effects of the health care financing system on consumers of health care services and the views of consumers concerning the quality, cost and accessibility of the hospital care that consumers receive.

Sec. D-20. 22 MRSA §396-P, sub-§3, as enacted by PL 1983, c. 579, §10, is amended to read:

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

Sec. D-21. 22 MRSA §397, sub-§3, as amended by PL 1991, c. 771, §2, is further amended to read:

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

~~commission~~ council is sought or a proposed revenue limit is contested, the burden of proof is on the person seeking the approval or contesting the revenue limit if, in the case of a proposed revenue limit, the ~~executive director~~ council staff has furnished, reasonably in advance of the deadline established for notices of contest, a written explanation of the differences between the information timely filed with the ~~commission~~ council by the hospital for the purpose of computing a revenue limit and the information relied upon in computing the proposed revenue limit.

Sec. D-22. 22 MRSA §398, sub-§1, as amended by PL 1985, c. 109, §2, is further amended to read:

1. Revenue limits. At least 90 days prior to the start of each payment year of each hospital subject to this chapter, ~~the executive director~~ a staff person designated by the council shall propose a gross patient service revenue limit and the apportionment thereof for approval by the ~~commission~~ council. If no notice of contest is filed within the period of time specified by the ~~commission~~ council by an affected hospital, affiliated interest, 3rd-party payor or group of purchasers, and if the ~~commission~~ council does not disapprove or modify the proposed limit or apportionment, the limit and apportionment ~~shall~~ take effect on the first day of the applicable payment year; otherwise, the ~~commission~~ council shall, after opportunity for hearing before the ~~commission~~ council, an individual member of the ~~commission~~ council or a duly appointed and sworn hearing examiner, issue a final order no later than the first day of the applicable payment year, except that, if the proposed limit or apportionment is timely contested, and the ~~commission~~ council, after due diligence, is unable to issue a final order by the first day of the payment year, it shall issue a provisional order by that date, which ~~shall~~ must be superseded by a final order no later than 150 days after the start of the payment year.

Sec. D-23. Transition. The following provisions apply to the abolition of the Maine Health Care Finance Commission and the transfer of its responsibilities and authority to the Maine Health Care Agency.

1. The Maine Health Care Agency is the successor in every way to the Maine Health Care Finance Commission. All responsibilities, power and authority that were formerly vested in the Maine Health Care Finance Commission are transferred to the Maine Health Care Agency.

2. Notwithstanding the provisions of the Maine Revised Statutes, Title 5, all accrued expenditures, assets, liabilities, balances, appropriations, allocations, transfers, revenues and

other available funds in an account or subdivision of an account of the Maine Health Care Finance Commission must be transferred to the proper accounts of the Maine Health Care Agency by the State Controller upon the request of the State Budget Officer and with the approval of the Governor.

3. All rules and procedures in effect or adopted on the effective date of this Part by the Maine Health Care Finance Commission remain in effect until rescinded, revised or amended by the Maine Health Care Agency.

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

5. All positions within the Maine Health Care Finance Commission are transferred to the Maine Health Care Agency. The Bureau of Human Resources shall assist with the orderly implementation of this provision.

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

7. The Maine Health Care Finance Commission may not levy an assessment pursuant to Title 22, section 391 for any period of time lasting beyond December 30, 1996.

8. The Health Care Finance Commission Fund is abolished on January 1, 1997. All funds remaining in the account of the Health Care Finance Commission Fund on December 30, 1996 must be transferred on January 1, 1997 to the Maine Health Care Trust Fund. All outstanding obligations of the Health Care Finance Commission for fiscal year 1997 are payable from the Maine Health Care Trust Fund.

Sec. D-24. Statutory revisions. By March 1, 1997, the Maine Health Care Agency shall submit to the Legislature legislation recommended to clarify the reorganization of services affected by this Part.

Sec. D-25. Maine Revised Statutes amended; revision clause. Wherever in the Maine Revised Statutes the words "Health Care Finance Commission" appear or reference is made to those words, they are amended to read and mean "Maine Health Care Agency" and the Revisor of Statutes shall implement this revision when updating, publishing or republishing the statutes.

Sec. D-26. Effective date. This Part takes effect January 1, 1997.

PART E

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

§6-F. Salaries of members of the Maine Health Care Council and of the executive director of the Maine Health Care Agency

Notwithstanding any other provisions of law, the salaries of members of the Maine Health Care Council and of certain employees of the Maine Health Care Agency are as follows.

1. Members, Maine Health Care Council. The salaries of the members of the Maine Health Care Council are within salary range 91.

2. Executive director, Maine Health Care Agency. The salary of the executive director of the Maine Health Care Agency is within salary range 91.

Sec. E-2. Effective date. This Part takes effect on January 1, 1996.

PART F

Sec. F-1. 24-A MRSA §2185 is enacted to read:

§2185. Benefits that duplicate the health care benefits of the Maine Health Care Plan

Health insurance policies and contracts and health care contracts and plans are subject to the following provisions.

1. Prohibited conduct. A person, insurer, health maintenance organization or nonprofit hospital or medical service organization may not sell or offer for sale in this State a health insurance policy or contract or a health care contract or plan that offers benefits that duplicate the health care benefits offered by the Maine Health Care Plan under Title 22, section 372, subsection 3 unless that person, insurer, health maintenance organization or nonprofit hospital or medical service organization has been authorized as an organized delivery system by the Maine Health Care Agency pursuant to section 372, subsection 4, paragraph A. A violation of this section constitutes an unfair and deceptive trade practice under section 2152.

2. Allowed conduct. A person, insurer, health maintenance organization or nonprofit hospital or medical service organization may sell or offer for sale in the State a health insurance policy or contract or a health care contract or plan that offers coverage and benefits that are supplemental to and do not duplicate covered health care benefits offered by the Maine Health Care Plan under Title 22, section 372, subsection 3.

Sec. F-2. Effective date. This Part takes effect on July 1, 1996 and applies to all policies, contracts and plans delivered or issued for delivery on or after July 1, 1996. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

PART G

Sec. G-1. 36 MRSA §4365, first ¶, as amended by PL 1989, c. 588, Pt. D, §1, is further amended to read:

A tax is imposed on all cigarettes held in this State by any person for sale, the tax to be at the rate of 15.5 mills for each cigarette beginning October 1, 1989; 16.5 mills for each cigarette beginning January 1, 1991; ~~and~~ 18.5 mills for each cigarette beginning July 1, 1991; and 21.0 mills for each cigarette beginning December 1, 1995. Payment of the tax ~~shall~~ must be evidenced by the affixing of stamps to the packages containing the cigarettes. If a federal program similar to that provided in Title 22, section 3185, becomes effective, this tax is reduced by one mill for each cigarette. The Governor shall determine by proclamation when the federal program has become effective. Nothing contained in this chapter ~~shall~~ may be construed to impose a tax on any transaction, the taxation of which by this State is prohibited by the Constitution of the United States.

Sec. G-2. 36 MRSA §4365-D is enacted to read:

§4365-D. Rate of tax after November 30, 1995

Cigarettes stamped at the rate of 18.5 mills per cigarette and held for resale after November 30, 1995 are subject to tax at the rate of 21.0 mills per cigarette.

A person holding cigarettes for resale is liable for the difference between the tax rate of 21.0 mills per cigarette and the tax rate of 18.5 mills per cigarette in effect before December 1, 1995. Stamps indicating payment of the tax imposed by this section must be affixed to all packages of cigarettes held for resale as of December 1, 1995, except that cigarettes held in vending machines as of that date do not require that stamp.

Notwithstanding any other provision of this chapter, it is presumed that all cigarette vending machines are filled to capacity on December 1, 1995, and the tax imposed by this section must be reported on that basis. A credit against this inventory tax must be allowed for cigarettes stamped at the 21.0 mill rate placed in vending machines before December 1, 1995.

Payment of the tax imposed by this section must be made to the State Tax Assessor before February 15, 1996, accompanied by forms prescribed by the State Tax Assessor, and credited to the Maine Health Care Trust Fund.

PART H

Sec. H-1. Employment retraining. The Maine Health Care Agency shall coordinate with the Department of Economic and Community Development, the Department of Labor and the private industry councils to ensure that employment retraining services are available for administrative workers employed by insurers and providers who are displaced due to the transition to the Maine Health Care Plan.

Sec. H-2. Delivery of long-term health care services. The Maine Health Care Agency shall study the delivery of long-term health care services to plan members. The study must address the best and most efficient manner of delivery of health services to individuals needing long-term care and funding sources for long-term care. In undertaking the study, the agency shall consult with the Maine Health Care Plan Transition Advisory Committee, representatives of consumers and potential consumers of long-term care services, representatives of providers of long-term care services and representatives of employers, employees and the public. The agency shall report to the Legislature on or before January 1, 1998 and shall include suggested legislation in the report.

Sec. H-3. Provision of health care services. The Maine Health Care Agency shall study the provision of health care services under the Medicaid and Medicare programs. The study must consider the waivers necessary to coordinate the Medicaid and Medicare programs with the Maine Health Care Plan, the method of coordination of benefit delivery and compensation, reorganization of State Government necessary to achieve the objectives of the agency and any other changes in law needed to carry out the purposes of the Maine Revised Statutes, Title 22, chapter 106. The agency shall apply for all waivers required to coordinate the benefits of the Maine Health Care Plan and the Medicaid and Medicare programs. The agency shall report to the Legislature on or before March 1, 1997 and shall include suggested legislation in the report.

PART I

Sec. I-1. Agency transfer. It is the intent of the Legislature that by January 1, 1997, the Bureau of Health and the Bureau of Medical Services within the Department of Human Services be abolished and the functions, programs, staff and resources of those bureaus be transferred to the Maine Health Care Agency.

Sec. I-2. Agency report. By December 1, 1996, the Maine Health Care Agency, with the advice and assistance of the Commissioner of Human Services, shall submit to the Legislature all legislation needed to implement the reorganization of services in accordance with this Part, including amendments to the statutes, reallocation of funds and transitional language as needed.

STATEMENT OF FACT

This bill establishes a universal access health care system that offers choice of coverage through organized delivery systems or through a managed care system operated by the Maine Health Care Agency and channels all health care dollars through a dedicated trust fund. It reorganizes State Government as required for the delivery of a unified health care system.

1. Part A of the bill does the following.

It establishes the Maine Health Care Plan to provide family security through quality, affordable health care for the people of the State. All residents and nonresidents who maintain significant contacts with the State are eligible for covered health care services through the Maine Health Care Plan. The plan is funded by the Maine Health Care Trust Fund, a dedicated fund receiving payments from employers, individuals, plan members and, after fiscal year 1997, from the 5¢ per package increase in the cigarette tax. The Maine Health Care Plan provides a range of benefits, including hospital services, health care services from participating providers, laboratories and imaging procedures, home health services, rehabilitative services, prescription drugs and devices, mental health services, substance abuse treatment services, dental services, vision appliances, medical supplies and equipment and hospice care. Health care services through the Maine Health Care Plan are provided by participating providers in organized delivery systems and through the open plan, which is available to all providers. The plan is supplemental to other health care programs that may be available to plan members, such as Medicare, Medicaid, the federal Civilian

Health and Medical Program of the Uniformed Services, the federal Indian Health Care Improvement Act and workers' compensation.

It establishes the Maine Health Care Agency to administer and oversee the Maine Health Care Plan, to act under the direction of the Maine Health Care Council and to administer and oversee the Maine Health Care Trust Fund. The Maine Health Care Council is the decision-making and directing council for the agency and is composed of 3 full-time appointees.

It directs the Maine Health Care Agency to establish programs to ensure quality, affordability, efficiency of care and health planning. The agency health planning program includes the establishment of global budgets for health care expenditures for the State and for institutions and hospitals. The health planning program also encompasses the certificate of need responsibilities of the agency, the health planning responsibilities pursuant to the Maine Revised Statutes, Title 22, chapter 103, data collection and the hospital financing system pursuant to Title 22, chapter 107.

It contains a directive to the State Controller to advance $400,000 to the Maine Health Care Trust Fund on the effective date of that Part. This amount must be repaid from the fund by June 30, 1997.

It contains the effective date of the Part, January 1, 1996.

2. Part B of the bill establishes the Maine Health Care Plan Transition Advisory Committee. Composed of 20 members, appointed and subject to confirmation, the committee is charged with holding public hearings, soliciting public comments and advising the Maine Health Care Agency on the transition from the current health care system to the Maine Health Care Plan. Members of the committee serve without compensation but may be reimbursed for their expenses. The committee is directed to report to the Governor and to the Legislature on July 1, 1996, January 1, 1997, July 1, 1997 and December 31, 1997. The committee completes its work on December 31, 1997.

3. Part C of the bill transfers the certificate of need and related health planning programs from the Department of Human Services to the Maine Health Care Agency as of July 1, 1996. Authority to make certificate of need decisions is transferred from the department to the agency. The Office of Health Planning and Development is abolished and its staff, resources and responsibilities are transferred to the agency. This Part changes the Hospital Development Account into the Certificate of Need Development Account.

4. Part D of the bill consolidates the staff, powers and responsibilities of the Maine Health Care Finance Commission into the newly created Maine Health Care Agency as of January 1, 1997. On that date, the commission is abolished and the Maine Health Care Agency and Maine Health Care Council assume all of the former commission's powers and duties. The hospital assessment formerly collected to fund the commission is abolished.

5. Part E of the bill establishes the salaries of the members of the Maine Health Care Council and the executive director of the Maine Health Care Agency.

6. Part F of the bill prohibits the sale on the commercial market of health insurance policies and contracts that duplicate the coverage provided by the Maine Health Care Plan. It allows the sale of health care policies and contracts that do not duplicate and are supplemental to the coverage of the Maine Health Care Plan.

7. Part G of the bill imposes a 5¢ per package increase in the cigarette tax beginning December 1, 1995. Proceeds from the cigarette tax increase are paid to the Maine Health Care Trust Fund.

8. Part H of the bill directs the Maine Health Care Agency to ensure employment retraining for administrative workers employed by insurers and providers who are displaced by the transition to the Maine Health Care Plan. It directs the Maine Health Care Agency to study the delivery and financing of long-term care services to plan members. Consultation is required with the Maine Health Care Plan Transition Advisory Committee, representatives of consumers and potential consumers of long-term care services and representatives of providers of long-term care services, employers, employees and the public. A report to the Legislature is due January 1, 1998.

The Maine Health Care Agency is directed to study the provision of health care services under the Medicaid and Medicare programs, waivers, coordination of benefit delivery and compensation, reorganization of State Government necessary to accomplish the objectives of the Maine Health Care Agency and legislation needed to carry out the purposes of the bill. The agency is directed to apply for all waivers required to coordinate the benefits of the Maine Health Care Plan and the Medicaid and Medicare programs. A report is due to the Legislature by March 1, 1997.

9. Part I of the bill declares the Legislature's intent to abolish the Bureau of Health and the Bureau of Medical Services and to transfer their powers, responsibilities, programs, staff

and resources to the Maine Health Care Agency by January 1, 1997. The agency is directed to work with the Commissioner of Human Services to prepare all necessary legislation and submit it to the Legislature by December 1, 1996.