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132nd MAINE LEGISLATURE

FIRST REGULAR SESSION-2025

Legislative Document **No. 743**

H.P. 485 House of Representatives, February 25, 2025

An Act to Increase the Availability and Affordability of Health Care by Eliminating Certificate of Need Requirements

Reference to the Committee on Health Coverage, Insurance and Financial Services suggested and ordered printed.

ROBERT B. HUNT
Clerk

Presented by Representative LIBBY of Auburn.
Cosponsored by Senator HAGGAN of Penobscot and
Representatives: BOYER of Poland, FOLEY of Wells, NUTTING of Oakland.

Printed on recycled paper

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

Sec. 1. 22 MRSA c. 103-A, as amended, is repealed.

Sec. 2. 22 MRSA §1708, sub-§3, ¶D, as amended by PL 2013, c. 594, §1, is further amended to read:

D. Ensure that any calculation of an occupancy percentage or other basis for adjusting the rate of reimbursement for nursing facility services to reduce the amount paid in response to a decrease in the number of residents in the facility or the percentage of the facility's occupied beds excludes all beds that the facility has removed from service for all or part of the relevant fiscal period ~~in accordance with section 333~~. If the excluded beds are converted to residential care beds or another program for which the department provides reimbursement, nothing in this paragraph precludes the department from including those beds for purposes of any occupancy standard applicable to the residential care or other program pursuant to duly adopted rules of the department;

Sec. 3. 22 MRSA §1714-A, sub-§4, ¶C, as amended by PL 2011, c. 687, §8, is further amended to read:

C. The department shall provide <u>in a letter</u> written notice of the requirements of this section to the transferee in ~~a letter acknowledging receipt of a request for a certificate of need or waiver of the certificate of need for~~ <u>the case of</u> a nursing home or hospital transfer or in response to a request for an application for a license to operate a boarding home or to provide other health care services.

Sec. 4. 22 MRSA §1715, sub-§1, ¶A, as amended by PL 2017, c. 475, Pt. A, §29, is further amended to read:

A. Is ~~either~~ a direct provider of major ambulatory service, as defined in former section 382, subsection 8-A~~, or is or has been required to obtain a certificate of need under section 329 or former section 304 or 304-A~~;

Sec. 5. 22 MRSA §1831, sub-§1, as amended by PL 2013, c. 214, §1, is further amended to read:

1. Provision of information. In order to provide for informed patient or resident decisions, a hospital or nursing facility shall provide a standardized list of licensed providers of care and services and available physicians for all patients or residents prior to discharge for whom home health care, hospice care, acute rehabilitation care~~, a hospital swing bed as defined in section 328, subsection 15~~ or nursing care is needed. The list must include a clear and conspicuous notice of the rights of the patient or resident regarding choice of providers.

A. For all patients or residents requiring home health care or hospice care, the list must include all licensed home health care and hospice providers that request to be listed and any branch offices, including addresses and phone numbers, that serve the area in which the patient or resident resides.

B. For all patients or residents requiring nursing facility care ~~or a hospital swing bed~~, the list must include all appropriate facilities that request to be listed that serve the area in which the patient or resident resides or wishes to reside and the physicians available within those facilities that request to be listed.

C. The hospital or nursing facility shall disclose to the patient or resident any direct or indirect financial interest the hospital or nursing facility has in the nursing facility or home health care provider.

Sec. 6. 22 MRSA §2061, sub-§2, as amended by PL 2011, c. 90, Pt. J, §19, is further amended to read:

2. Review. Each project for a health care facility has been reviewed and approved to the extent required by the agency of the State that serves as the designated planning agency of the State ~~or by the Department of Health and Human Services in accordance with the provisions of the Maine Certificate of Need Act of 2002, as amended~~;

Sec. 7. 24-A MRSA §4203, sub-§1, as amended by PL 2003, c. 510, Pt. A, §19, is further amended to read:

1. ~~Subject to the Maine Certificate of Need Act of 2002, a~~ A person may apply to the superintendent for and obtain a certificate of authority to establish, maintain, own, merge with, organize or operate a health maintenance organization in compliance with this chapter. A person may not establish, maintain, own, merge with, organize or operate a health maintenance organization in this State either directly as a division or a line of business or indirectly through a subsidiary or affiliate, nor sell or offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with, a health maintenance organization without obtaining a certificate of authority under this chapter.

Sec. 8. 24-A MRSA §4204, sub-§1, as corrected by RR 2021, c. 1, Pt. B, §342, is repealed.

Sec. 9. 24-A MRSA §4204, sub-§2-A, as amended by PL 2013, c. 588, Pt. A, §29, is further amended to read:

2-A. The superintendent shall issue or deny a certificate of authority to any person filing an application pursuant to section 4203 ~~within 50 business days of receipt of the notice from the Department of Health and Human Services that the applicant has been granted a certificate of need or, if a certificate of need is not required,~~ within 50 business days of receipt of notice from the Department of Health and Human Services that the applicant is in compliance with the requirements of paragraph B. Issuance of a certificate of authority ~~shall~~ must be granted upon payment of the application fee prescribed in section 4220 if the superintendent is satisfied that the following conditions are met~~.~~:

~~A. The Commissioner of Health and Human Services certifies that the health maintenance organization has received a certificate of need or that a certificate of need is not required pursuant to Title 22, chapter 103-A.~~

B. ~~If the~~ The Commissioner of Health and Human Services ~~has determined that a certificate of need is not required, the commissioner~~ makes a determination and provides a certification to the superintendent that the following requirements have been met~~.~~:

(4) The health maintenance organization must establish and maintain procedures to ensure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. These procedures must include mechanisms to ensure availability, accessibility and continuity of care~~.~~;

(5) The health maintenance organization must have an ongoing internal quality assurance program to monitor and evaluate its health care services including primary and specialist physician services, ancillary and preventive health care services across all institutional and noninstitutional settings. The program must include, at a minimum, the following:

(a) A written statement of goals and objectives that emphasizes improved health outcomes in evaluating the quality of care rendered to enrollees;

(b) A written quality assurance plan that describes the following:

(i) The health maintenance organization's scope and purpose in quality assurance;

(ii) The organizational structure responsible for quality assurance activities;

(iii) Contractual arrangements, in appropriate instances, for delegation of quality assurance activities;

(iv) Confidentiality policies and procedures;

(v) A system of ongoing evaluation activities;

(vi) A system of focused evaluation activities;

(vii) A system for reviewing and evaluating provider credentials for acceptance and performing peer review activities; and

(viii) Duties and responsibilities of the designated physician supervising the quality assurance activities;

(c) A written statement describing the system of ongoing quality assurance activities including:

(i) Problem assessment, identification, selection and study;

(ii) Corrective action, monitoring evaluation and reassessment; and

(iii) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(d) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies the method of topic selection, study, data collection, analysis, interpretation and report format; and

(e) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.~~.~~;

(6) The health maintenance organization ~~shall~~ must record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes must be available to the Commissioner of Health and Human Services.~~.~~;

(7) The health maintenance organization ~~shall~~ must ensure the use and maintenance of an adequate patient record system that facilitates documentation and retrieval of clinical information to permit evaluation by the health maintenance organization of the continuity and coordination of patient care and the assessment of the quality of health and medical care provided to enrollees~~.~~;

(8) Enrollee clinical records must be available to the Commissioner of Health and Human Services or an authorized designee for examination and review to ascertain compliance with this section, or as considered necessary by the Commissioner of Health and Human Services~~.~~; and

(9) The health maintenance organization must establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate health maintenance organization staff.

~~The Commissioner of Health and Human Services shall make the certification required by this paragraph within 60 days of the date of the written decision that a certificate of need was not required.~~ If the ~~commissioner~~ Commissioner of Health and Human Services certifies that the health maintenance organization does not meet all of the requirements of this paragraph, the commissioner shall specify in what respects the health maintenance organization is deficient~~.~~;

C. The health maintenance organization conforms to the definition under section 4202-A, subsection 10~~.~~;

D. The health maintenance organization is financially responsible, complies with the minimum surplus requirements of section 4204-A and, among other factors, can reasonably be expected to meet its obligations to enrollees and prospective enrollees.

(1) In a determination of minimum surplus requirements, the following terms have the following meanings.

(a) "Admitted assets" means assets recognized by the superintendent pursuant to section 901-A. For purposes of this chapter, the asset value is that contained in the annual statement of the corporation as of December 31st of the year preceding the making of the investment or contained in any audited financial report, as defined in section 221-A, of more current origin.

(b) "Reserves" means those reserves held by corporations subject to this chapter for the protection of subscribers. For purposes of this chapter, the reserve value is that contained in the annual statement of the corporation as of December 31st of the preceding year or any audited financial report, as defined in section 221-A, of more current origin.

(2) In making the determination whether the health maintenance organization is financially responsible, the superintendent may also consider:

(a) The financial soundness of the health maintenance organization's arrangements for health care services and the schedule of charges used;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a nonprofit hospital or medical service corporation, a government or any other organization for insuring or providing the payment of the cost of health care services or the provision for automatic

applicability of an alternative coverage in the event of discontinuance of the plan;

(d) Any agreement with providers for the provision of health care services that contains a covenant consistent with subsection 6; and

(e) Any arrangements for insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care services~~.~~;

E. The enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to section 4206~~.~~;

F. Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 4203 or by independent investigation, is contrary to the public interest~~.~~;

G. Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of that organization ~~shall be~~ is responsible for those funds in a fiduciary relationship to the organization~~.~~;

H. The health maintenance organization ~~shall maintain~~ maintains in force a fidelity bond or fidelity insurance on those employees and officers of the health maintenance organization who have duties as described in paragraph G, in an amount not less than $250,000 for each health maintenance organization or a maximum of $5,000,000 in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the superintendent~~.~~;

I. If any agreement, as set forth in paragraph D, subparagraph (2), division (c), is made by the health maintenance organization, the entity executing the agreement with the health maintenance organization ~~must demonstrate~~ demonstrates to the superintendent's satisfaction that the entity has sufficient unencumbered surplus funds to cover the assured payments under the agreement, otherwise the superintendent ~~shall disallow~~ may not allow the agreement. In considering approval of such an agreement, the superintendent shall consider the entity's record of earnings for the most recent 3 years, the risk characteristics of its investments and whether its investments and other assets are reasonably liquid and available to make payments for health care services~~.~~;

K. The health maintenance organization provides a spectrum of providers and services that meet patient demand~~.~~;

L. The health maintenance organization meets the requirements of section 4303, subsection 1~~.~~;

M. The health maintenance organization demonstrates a plan for providing services for rural and underserved populations and for developing relationships with essential community providers within the area of the proposed certificate. The health maintenance organization must make an annual report to the superintendent regarding the plan~~.~~; and

O. ~~Each~~ The health maintenance organization ~~shall provide~~ provides basic health care services.

The applicant shall furnish, upon request of the superintendent, any information necessary to make any determination required pursuant to this subsection.

Sec. 10. 24-A MRSA §4225, as corrected by RR 2021, c. 2, Pt. A, §79, is amended to read:

§4225. Commissioner of Health and Human Services' authority to contract

The Commissioner of Health and Human Services, in carrying out the commissioner's obligations under ~~section 4204, subsection 1, paragraph B,~~ section 4215~~;~~ and section 4216, subsection 1, may contract with qualified persons to make recommendations concerning the determinations required to be made by the commissioner. Such recommendations may be accepted in full or in part by the commissioner.

Sec. 11. 24-A MRSA §4303-F, sub-§1, ¶E, as amended by PL 2023, c. 591, §3, is further amended to read:

E. A carrier may not require a ground ambulance service provider to obtain prior authorization before transporting an enrollee to a hospital, between hospitals or from a hospital to a nursing home, hospice care facility or other health care facility~~, as defined in Title 22, section 328, subsection 8~~. A carrier may not require an air ambulance service provider to obtain prior authorization before transporting an enrollee to a hospital or between hospitals for urgent care. For the purposes of this paragraph, the following terms have the following meanings.

(1) "Ambulatory surgical facility" means a facility, not part of a hospital, that provides surgical treatment to patients not requiring hospitalization. "Ambulatory surgical facility" does not include the offices of private physicians or dentists, whether in individual or group practice.

(2) "Health care facility" means a hospital, psychiatric hospital, nursing facility, kidney disease treatment center including a freestanding hemodialysis facility, rehabilitation facility, ambulatory surgical facility, independent radiological service center, independent cardiac catheterization center or cancer treatment center. "Health care facility" does not include the office of a private health care practitioner, as defined in Title 24, section 2502, subsection 1-A, whether in individual or group practice. In an ambulatory surgical facility that functions also as the office of a health care practitioner, the following portions of the ambulatory surgical facility are considered to be a health care facility:

(a) Operating rooms;

(b) Recovery rooms;

(c) Waiting areas for ambulatory surgical facility patients;

(d) Any space with major medical equipment; and

(e) Any other space used primarily to support the activities of the ambulatory surgical facility.

(3) "Health services" means clinically related services that are diagnostic, treatment, rehabilitative services or nursing services provided by a nursing facility. "Health services" includes alcohol or drug dependence, substance use disorder and mental health services.

(4) "Hospital" means an institution that primarily provides to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of persons who are injured, disabled or sick or rehabilitation services for the rehabilitation of persons who are injured, disabled or sick. "Hospital" also includes psychiatric and tuberculosis hospitals.

(5) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions used to provide medical and other health services that costs $3,200,000 or more. "Major medical equipment" does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and has been determined to meet the requirements of the United States Social Security Act, Title XVIII, Section 1861(s)(10 and 11). In determining whether medical equipment costs more than the threshold provided in this subparagraph, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquiring the equipment must be included. If the equipment is acquired for less than fair market value, the cost includes the fair market value. The threshold amount for review must be updated by the commissioner to reflect the change in the Consumer Price Index for medical care services as reported by the United States Department of Labor, Bureau of Labor Statistics, with an effective date of January 1st each year.

(6) "Nursing facility" means any facility defined under section 1812-A.

(7) "Rehabilitation facility" means an inpatient facility that is operated for the primary purpose of assisting in the rehabilitation of persons who are disabled through an integrated program of medical services and other services that are provided under competent professional supervision.

Sec. 12. 24-A MRSA §6203, sub-§1, ¶A, as amended by PL 2003, c. 510, Pt. A, §22, is further amended to read:

A. The provider has ~~submitted to the department an application for a certificate of need, if required under Title 22, section 329, and the department has submitted a preliminary report of a recommendation for approval of a certificate of need and the provider has~~ applied for any ~~other~~ licenses or permits required prior to operation.

Sec. 13. 24-A MRSA §6203, sub-§1, ¶G, as enacted by PL 1995, c. 452, §11, is amended to read:

G. The department has approved the adequacy of all services proposed under the continuing care agreement ~~not otherwise reviewed under the certificate of need process~~.

Sec. 14. 24-A MRSA §6203, sub-§2, as amended by PL 1995, c. 452, §§12 to 16, is further amended to read:

2. Final certificate of authority. The superintendent shall issue a final certificate of authority, subject to annual renewal, when:

A. The provider has obtained any required ~~certificate of need or other~~ permits or licenses ~~required~~ prior to construction of the facility;

C. The superintendent is satisfied that the provider has demonstrated that it is financially responsible and ~~shall~~ may reasonably be expected to meet its obligations to subscribers or prospective subscribers;

D. The superintendent has determined that the provider's continuing care agreement meets the requirements of section 6206, subsection 3~~,~~ and the rules ~~promulgated in~~ adopted under this chapter; and

G. The provider certifies to the superintendent either:

(1) That preliminary continuing care agreements have been entered and deposits of not less than 10% of the entrance fee have been received either:

(a) From subscribers with respect to 70% of the residential units, including names and addresses of the subscribers, for which entrance fees will be charged; or

(b) From subscribers with respect to 70% of the total entrance fees due or expected at full occupancy of the community; or

(2) That preliminary continuing care agreements have been entered and deposits of not less than 25% of the entrance fee received from either:

(a) Subscribers with respect to 60% of the residential units, including names and addresses of the subscribers, for which entrance fees will be charged; or

(b) Subscribers with respect to 60% of the total entrance fees due or expected at full occupancy of the community.

Within 120 days after determining that the application to the superintendent ~~and the department~~ is complete, the superintendent shall issue or deny a final certificate of authority to the provider~~, unless a certificate of need is required, in which case the final certificate of authority shall be issued or denied in accordance with the certificate of need schedule~~.

Sec. 15. 24-A MRSA §6203, sub-§6, as amended by PL 2003, c. 155, §1, is further amended to read:

6. Provision of services to nonresidents. The final certificate of authority must state whether any skilled nursing facility that is part of a life-care community or a continuing care retirement community may provide services to persons who have not been bona fide residents of the community prior to admission to the skilled nursing facility. If the life-care community or the continuing care retirement community admits to its skilled nursing facility only persons who have been bona fide residents of the community prior to admission to the skilled nursing facility, then the community is ~~exempt from the provisions of Title 22, chapter 103-A, but is~~ subject to the licensing provisions of Title 22, chapter 405~~,~~ and is entitled to only one skilled nursing facility bed for every 4 residential units in the community. Any community exempted under ~~Title 22, chapter 103-A~~ rules adopted by the department may admit nonresidents of the community to its skilled nursing facility only during the first 3 years of operation. For purposes of this subsection, ~~a~~ "bona fide resident" means a person who has been a resident of the community for a period of not less than 180 consecutive days immediately preceding admission to the nursing facility or has been a resident of the community for less than 180 consecutive days but who has been medically admitted to the nursing facility resulting from an illness or accident that occurred subsequent to residence in the community. Any community exempted under ~~Title 22,~~

~~chapter 103-A~~ rules adopted by the department is not entitled to and may not seek any reimbursement or financial assistance under the MaineCare program from any state or federal agency and, as a consequence, that community must continue to provide nursing facility services to any person who has been admitted to the facility.

Notwithstanding this subsection, a life-care community that holds a final certificate of authority from the superintendent and that was operational on November 18, 2002 and that is barred from seeking reimbursement or financial assistance under the MaineCare program from a state or federal agency may continue to admit nonresidents of the community to its skilled nursing facility after its first 3 years of operation with the approval of the superintendent. A life-care community that admits nonresidents to its skilled nursing facility as permitted under this subsection may continue to admit nonresidents after its first 3 years of operation only for such period as approved by the superintendent after the superintendent's consideration of the financial impact on the life-care community and the impact on the contractual rights of subscribers of the community.

Sec. 16. 24-A MRSA §6226, as amended by PL 2003, c. 510, Pt. A, §23 is repealed.

Sec. 17. 24-A MRSA §6951, sub-§6, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

6. Technology assessment. The forum shall conduct technology assessment reviews to guide the use and distribution of new technologies in this State. ~~The forum shall make recommendations to the certificate of need program under Title 22, chapter 103-A.~~

Sec. 18. 35-A MRSA §10122, as enacted by PL 2011, c. 424, Pt. A, §6 and affected by Pt. E, §1, is amended to read:

§10122. Health care facility program

The trust shall develop and implement a process to review projects undertaken by health care facilities that are directed solely at reducing energy costs through energy efficiency, renewable energy technology or smart grid technology and to certify those projects that are likely to be cost-effective. ~~If a project is certified as likely to be cost-effective by the trust, the review process serves as an alternative to the certificate of need process established pursuant to Title 22, section 329, subsection 3.~~

Sec. 19. 38 MRSA §1310-X, sub-§4, ¶A, as amended by PL 2003, c. 551, §17, is further amended to read:

A. A commercial biomedical waste disposal or treatment facility, if at least 51% of the facility is owned by a licensed hospital or hospitals ~~as defined in Title 22, section 328, subsection 14~~ or a group of hospitals that are licensed under Title 22 acting through a statewide association of Maine hospitals or a wholly owned affiliate of the association; and

SUMMARY

Under current law, before introducing additional health care services and procedures in a market area, a person must apply for and receive a certificate of need from the Department of Health and Human Services. This bill eliminates that requirement by repealing the Maine Revised Statutes, Title 22, chapter 103-A, which includes sections 326

to 350-C, and making statutory changes to other provisions of law for consistency with the repeal of chapter 103-A.