Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Monday, November 17, 2025
10:00 a.m. – 3:00pm

DRAFT MEETING AGENDA

10:00 am Welcome
Chairs, Senator Mike Tipping and Representative Michelle Boyer

10:05 am Commission Discussion of Potential Recommendations
Chairs and Commission Members

Commission will take a break at approx. 12 pm

1:00 pm Continued Commission Discussion of Potential Recommendations (if necessary)
Chairs and Commission Members

2:00 pm Commission Discussion of Whether Additional Meeting is Needed* and Next Steps

2:30 pm Review Outline of Draft Report

3:00 pm Adjourn

*Please bring calendars for scheduling purposes if need for additional meeting to be scheduled

Public access also available through the Maine Legislature's livestream:
https://legislature.maine.gov/Audio/#202

For Review and Consideration at Nov. 17 Meeting
(reflects straw votes taken on Nov. 5)
DRAFT FOR DISCUSSION PURPOSES ONLY

Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Potential Recommendations Suggested by Commission Members for Discussion and Results of Initial Straw Votes Taken on Nov. 5

Note that not all members may have submitted potential recommendations for discussion, that some potential recommendations may have been suggested by more than one member (see asterisk) and that potential recommendations may not be consistent with or directly contradict another potential recommendation.

Certificate of Need Process

Potential Recommendation Suggested	*Results of Straw Vote on Nov. 5*
Increase monetary threshold for establishment of new health care facilities (other than hospitals) by indexing	12 interested in further discussion of this recommendation
Codify existing guidance related to notice of changes or closures of maternity and newborn care* and consider increasing the prior notice requirement to 180 days prior to effective date for a permanent termination of service	12 interested in further discussion of this recommendation with 120-day notice
Require CON review to consider impacts on affordability and accessibility of health care for all consumers (not solely the MaineCare program) as part of review and provide any necessary resources to fulfill the expanded scope of responsibility *	10 interested in further discussion of this recommendation 2 did not indicate interest (Westhoff, Prescott)

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
Changes to Certificate of Need (CON) Requirements for Ambulatory Surgery Centers ("ASC's"): • Exempt ambulatory surgical centers from CON* • Ensure that CON Approval / Denial Process avoids Anti-Competitive and Political Motivations • Increase Capital Thresholds that trigger CON review to Reflect Current Cost of Construction • Increase the capital threshold to $10 million • Define an ambulatory surgical center not subject to review as one with 4 or fewer operating rooms • Require ambulatory surgical centers to accept Medicare and MaineCare at the same rates hospitals receive for similar services as a condition of approval • Require ambulatory surgical centers to provide up to 4% charity care annually as a condition of approval	5 interested in further discussion (Boyer, Foley, Cheff, Ossenfort, Putnoky) 7 did not indicate interest (Tipping, Ende, Garratt-Reed, Maguire, Prescott Vienneau, Westhoff)
Establish a formal review process prior to a hospital discontinuing a service, including providing prior notice to the State and an opportunity for staff and public feedback*	No members interested in further discussion of requiring formal CON review of termination of services generally 5 members interested in requiring prior notice of termination of services by hospitals generally (Tipping, Ende, Garratt-Reed, Ossenfort, Putnoky)

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
Amend CON review to include specific consideration of private equity ownership in a determination by DHHS that an applicant is "fit, willing and able" to provide proposed services at proper standard of care	See straw votes related to regulation of private equity below
Eliminate Certificate of Need (CON) law	No vote taken (indicates Commission does not support exploring this further)
Exempt entities that accept Medicare/Medicaid from CON	No vote taken (indicates Commission does not support exploring this further)
Amend CON review for medical projects (other than long-term care) to require that all patients be served by the facility regardless of ability to pay as a condition of approval	No vote taken (indicates Commission does not support exploring this further)
Include cybersecurity risks in the CON process. Review of technology systems and vulnerabilities of applicants	No vote taken (indicates Commission does not support exploring this further)

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

Regulatory Oversight of Health Care Transactions

Potential Recommendation Suggested	*Results of Straw Vote on Nov. 5*
Require notice to the Attorney General when a health care entity is required to notify the Federal Trade Commission about a pending merger/acquisition	12 interested in further discussion
Adopt the transparency provisions of LD 1972, which would allow the state to better track a wide range of acquisition types and monitor ownership structures of health care entities	11 interested in further discussion (Tipping, Boyer, Foley, Cheff, Ende, Garratt-Reed, Maguire, Ossenfort, Putnoky, Vienneau, Westhoff) 1 did not indicate interest (Prescott)
Require notice of change of control or significant ownership stake (>49%) by PE, hedge fund, or management services organization (MSO) – potentially broader to include all change of control/ownership for transactions exceeding $X: Disclosure of ultimate parent entity and investment fund Disclosure of names of all entities Disclosure of debt to equity ratio	11 interested in further discussion (Tipping, Boyer, Cheff, Ende, Maguire, Ossenfort, Prescott, Putnoky, Vienneau, Westhoff) 1 did not indicate interest (Garratt-Reed)
Review and possibly revise LD 1972 and ask HCIFS to move forward with this legislation*	8 interested in further discussion (Tipping, Boyer, Cheff, Ende, Foley, Garratt-Reed, *Ossenfort (?)*, Putnoky) 4 did not indicate interest (Maguire, Prescott, Vienneau, Westhoff)
Consider an expanded review and approval process for health care transactions but with a scope limited to acquisition of control by financial entities that pose especially high risks to the stability of the health care system. This could at minimum include private equity firms but could also include management services organizations and real estate investment trusts.	8 interested in further discussion (Tipping, Boyer, Cheff, Ende, Foley, Garratt-Reed, Ossenfort, Putnoky)

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

	4 did not indicate interest (Maguire, Prescott, Vienneau, Westhoff)
Require enhanced review for safety net hospitals and sole providers in a geographic region	No vote taken (indicates Commission does not support exploring this further)
Provide for conditional approval of transactions exceeding $X	No vote taken (indicates Commission does not support exploring this further)

Regulation of Private Equity

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
Prohibit private equity groups and hedge funds from interfering with the professional judgment of physicians in making healthcare decisions:* • Interfering with licensed professionals' clinical judgement • Controlling staffing levels • Dictating coding in medical records • Obtaining legal custody over EHRs and patient data	8 interested in further discussion (Tipping, Boyer, Foley, Cheff, Ende, Garratt-Reed, Prescott, Putnoky) 4 did not indicate interest (Maguire, Ossenfort, Vienneau, Westhoff)
Restrict MSO-affiliated individuals from serving in the same roles within the acquired entity they manage. (They cannot make personnel, staffing/scheduling, clinical, financial/payor, pricing, or asset/equity decisions but does not prohibit MSOs from providing support, advice, or consultation. It prevents them from holding the ultimate authority to make final, binding decisions.)	Combined straw vote below with above

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
Prohibit primary operating real estate sale/leaseback arrangements*	7 interested in further discussion (Tipping, Boyer, Foley, Cheff, Ende, Garratt-Reed, Putnoky) 5 did not indicate interest (Maguire, Ossenfort, Prescott, Vienneau, Westhoff)
Prohibit majority ownership by PE, hedge funds, and MSOs*	7 interested in further discussion (Tipping, Boyer, Foley, Cheff, Ende, Garratt-Reed, Putnoky) 5 did not indicate interest (Maguire, Ossenfort, Prescott, Vienneau, Westhoff)
Prohibit debt financing ratios >X%	7 interested in further discussion (Tipping, Boyer, Foley, Ende, Garratt-Reed, Ossenfort, Putnoky) 5 did not indicate interest (Cheff, Maguire, Prescott, Vienneau, Westhoff)
Prohibit resale before X # of years*	6 interested in further discussion (*Tipping(?)*, Boyer, Foley, Ende, Garratt-Reed, Putnoky, 6 did not indicate interest (Cheff, Maguire, Ossenfort, Prescott, Vienneau, Westhoff)
Limit PE Ownership to 20% Equity Interest	5 interested in further discussion (Tipping, Boyer, Ende, Ossenfort, Putnoky) 7 did not indicate interest (Foley, Cheff, Garratt-Reed, Maguire, Prescott, Vienneau, Westhoff

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
For non-hospital transactions, require that private equity firms invest at least 10% of equity internally	5 interested in further discussion (Tipping, Boyer, Ende, Garratt-Reed, Putnoky,) 7 did not indicate interest (Foley, Cheff, Maguire, Ossenfort, Prescott, Vienneau, Westhoff)
Prohibit PE ownership of hospitals*	3 interested in further discussion (Tipping, Cheff, Ende) 9 did not indicate interest (Boyer, Foley, Garratt-Reed, Maguire, Ossenfort, Prescott, Putnoky, Vienneau, Westhoff)
Make the moratorium on hospital ownership by private equity firms and real estate trusts passed with LD 985 permanent, adding coverage of hospital-affiliated entities (similar to those described in Connecticut SB 1507)	See straw votes above
Ensure PE, hedge fund or MSO are liable for financial damages if an acquired, highly leveraged facility fails or files for bankruptcy within a given time frame (5 years?) due to underfunding or asset stripping (modeled on Federal proposal: Corporate Crimes Against Health Care Act of 2024, which proposed to grant the Department of Justice (DOJ) and State Attorneys General the power to claw back all compensation (including salaries, fees, and dividends) paid to PE executives and portfolio company executives within a 10-year period before or after a facility experiences serious financial difficulties due to "looting.")	6 interested in further discussion (Tipping, Boyer, Ende, Garratt-Reed, Putnoky, Vienneau) 6 did not indicate interest (Foley, Cheff, Maguire, Ossenfort, Prescott, Westhoff)
Limit management fees to private equity and address taxation of these entities *(added during discussion)*	6 interested in further discussion (Tipping, Boyer, Ende, Garratt-Reed, Putnoky, Westhoff) 6 did not indicate interest (Foley, Cheff, Maguire, Ossenfort, Prescott, Westhoff)

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
Prohibit certain activities associated with failures of health care entities following private equity acquisition (consider exemption for nursing facilities)	No vote taken (indicates Commission supports consideration of other related suggestions)
Require private equity firms to directly contribute to a "Maine health care quality fund" (similar to Oregon model)	No vote taken (indicates Commission does not support exploring this further)

Suggestions with Broader Scope

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
Reestablish statewide health care services planning*	12 interested in further discussion
Provide more time for the Commission to consider these issues	10 interested in further discussion 2 additional members absent (Garratt-Reed, Ossenfort)
Enact the Uniform Law Commission's Uniform Antitrust Pre-Merger Notification Act to help strengthen the AG's ability to review Antitrust issues*	10 interested in further discussion (Tipping, Boyer, Cheff, Ende, Garratt-Reed, Maguire, Ossenfort, Prescott, Vienneau, Westhoff) 2 did not indicate interest (Foley, Putnoky)

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
Recommend use of federal grant funding through Rural Health Transformation Program to provide financial assistance to struggling rural hospitals *(as amended during discussion)*	9 interested in further discussion (Tipping, Boyer, Foley, Cheff, Ende, Maguire, Prescott, Vienneau, Westhoff) 2 did not indicate interest (Ossenfort, Putnoky) 1 additional member absent (Garratt-Reed)
Support cooperation among hospitals to extent possible under federal law and consider re-enacting laws to allow state-issued approval of mergers and joint activities that achieve specific public health benefits determined by the State to outweigh potential harm from reduced competition (revisit repeal of Certificate of Public Accommodation law)	8 interested in further discussion (Tipping, Boyer, Cheff, Ende, Maguire, Prescott, Vienneau, Westhoff) 4 did not indicate interest (Foley, Garratt-Reed, Ossenfort, Putnoky)
Prohibit provider non-compete clauses and non-disparagement limits in contracts *(also add non-solicitation clauses as amended during discussion)*	7 interested in further discussion (Tipping, Boyer, Cheff, Foley, Ende, Garratt-Reed, Putnoky, 5 did not indicate interest (Maguire, Ossenfort, Prescott, Vienneau, Westhoff)

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

Potential Recommendation Suggested	***Results of Straw Vote on Nov. 5***
Create a task force to study the demand for long-term care to determine the appropriate number of long-term care beds and to increase nursing home bed capacity statewide*. Allocate the necessary funding to address the bed capacity and workforce needs projected by the task force. *(also include discharge planning as amended during discussion)*	7 interested in further discussion (Tipping, Foley, Cheff, Ende, Maguire, Vienneau, Westhoff) 3 did not indicate interest (Boyer, Prescott, Putnoky) 2 additional members absent (Garratt-Reed, Ossenfort)
Establish a State fund for temporary financial support for long-term care facilities (nursing homes/ residential care facilities) to bridge emergency financial situation and to prevent immediate closures. Explore government backed bond programs (e.g. Maine Health & Higher Educational Facilities Authority (MHHEFA) as a lending resource for long term care like it once was.	5 interested in further discussion (Tipping, Boyer, Maguire, Vienneau, Westhoff) 6 did not indicate interest (Foley, Cheff, Ende, Ossenfort, Prescott, Putnoky) 1 additional member absent (Garratt-Reed)
Require MaineCare rate adequacy studies and notable investment by the Legislature	2 interested in further discussion (Tipping, Westhoff) 10 did not indicate interest (Boyer, Foley, Cheff, Ende, Garratt-Reed, Maguire, Ossenfort, Prescott, Putnoky, Vienneau)
Enhance monitoring and tracking of maternity/obstetrics services in the State (although work is underway, how are we tracking this as a state? Do we want to make a specific recommendation to HCIFS on this focus area?)	See discussion of certificate of need; no vote taken

^ Commission members Haggan and Poitras absent from straw votes; Commission member Montejo abstained from straw votes

For Commission Review Nov. 17
Re: CON Discussion

State of Maine Regulatory Thresholds for Certificate of Need Projects Covered Projects, Threshold Amounts, Statutory Citations			
Covered Projects	**Base Statutory Threshold Amount**	**Applicable Threshold as of 1/1/2025**	**Citation**
Capital Expenditures – new or existing hospitals; other existing healthcare facilities, excluding nursing facilities	$10,000,000	$14,304,312	22 M.R.S.A. §329 (3)
Nursing Facility: capital expenditures – new or existing nursing facility; expenditures related to nursing services	$5,000,000	$7,152,156	22 M.R.S.A. §329 (6)
New Nursing Facility - new nursing facility	$5,000,000	$5,000,000	22 M.R.S.A. §329 (4-A) (A)(1)
New Healthcare 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 (excludes hospitals or nursing facilities)	$3,000,000	$3,000,000	22 M.R.S.A. §329 (4-A) (B)(1)
Major Medical Equipment	$3,200,000	$4,577,380	22 M.R.S.A §328 (16)
New Health Service - capital expenditures	$3,000,000	$4,291,294	22 M.R.S.A. §328 (17-A) (A)
New Health Service – 3rd-year incremental annual operating costs	$1,000,000	$1,430,432	22 M.R.S.A.§328 (17-A) (B)
New Technology in private office of healthcare practitioner is a new health service	$3,200,000	$4,577,380	22 M.R.S.A. §328 (17-A) (C)
Indexed Threshold: Except for "new healthcare facility" thresholds, 22 M.R.S.A. §329 (4-A), the baseline threshold amounts shall be updated annually beginning January 1, 2013, as determined by United States Department of Labor, Bureau of Labor Statistics Consumer Price Index, medical care services index. See 22 M.R.S.A. §328 (16), (17-A), and §329 (3), (6).			

State of Maine
Office of Affordable Health Care

For Commission Review Nov. 17
Re: Regulatory Oversight discussion

LD 1972: An Act to Enhance Transparency and Value in Health Care Transactions

Who does LD 1972 apply to?

The Material Change Transaction (MCT) review process applies to any transaction involving a health care provider, provider organization, or health care facility within the state that has total assets or annual revenues, or anticipated annual revenues for new entities, of at least **$10,000,000.**

How the MCT review process will improve oversight

Current CON Process for Acquisitions		Proposed MCT Process
Only facility-level transactions reviewed	→	Includes small practices, real estate sales, closure of services, etc.
Limited language on variables included in review/determination	→	Includes affordability, equity, workforce, access, and quality assessments
Post-transaction oversight focused on clinical outcomes	→	Broader post-transaction review authority

How CON and MCT will interact

CON still covers:

- Changes to control of nursing homes
- Introduction of new health services
- Construction of new health facilities
- Changes in bed complement
- Capital expenditures >$10M and by nursing homes
- Major medical equipment purchases

Merger & Acquisition Review Moves from CON to MCT Process

LD 1972, An Act to Enhance Transparency and Value in Health Care Transactions

Section by Section Walk Through

Part A

- Limits the existing Certificate of Need review process for "Transfer of ownership; acquisition by lease, donation, transfer; acquisition of control" to only apply to nursing homes, since there are specific federal requirements for state review of the impact of transactions on nursing homes, in light of their heavy financing by Medicaid.
- CON will continue to be required for acquisitions of major medical equipment, capital expenditures over $10M, introduction of new health services, construction of new health facilities, changes in bed complement, and other capital expenditures by nursing homes.

This section is intended to avoid duplication of processes, effectively exempting mergers and acquisitions from CON, since they would instead be reviewed as Material Change Transactions.

Part B

- Establishes a Material Change Transaction review process in the Division of Licensing and Certification within DHHS to review a wide range of transactions involving health care provider entities.
- Material Change Transaction (MCT) review is different from the existing CON process in two primary ways:
  - **A wider range of transactions are subject to review.** CON only reviews the transfer of ownership or change of control of an entire health care facility. MCT would apply to health care "entities" including physician practices, which are frequently a target of private equity acquisition, particularly high-margin specialty practices. MCT would also apply to transactions below the entity level, e.g. major real estate sales, closure of essential services.
  - MCT also allows the Department to consider a much **wider range of factors** in making a decision on approval of a transaction. When deemed necessary by DLC, some MCTs may warrant a more in-depth Cost and Market Impact Review, which will include review of impacts on multiple dimensions of patient experience (cost, quality, accessibility), health equity, workforce conditions, and prior history of transactions by parties involved.

Part C

- Requires health care entities (except small practices with 5 or fewer physicians) to annually submit information to the Maine Health Data Organization about ownership/control and organizational structure.
- This data will allow OAHC and other stakeholders to better monitor and analyze transactions over time, as well as improving transparency into the organizational structures of health systems.

Proposed Statutory Provisions Requiring Reporting of Information Related to Ownership and Control of Health Care Entities

Sec. __. 22 MRSA §8710-A is enacted to read:

§8710-A. Ownership and control of health care entities

1. Definitions. For the purposes of this section, unless the context otherwise indicates, all terms have the same meanings as under section 371.

[NOTE: "Health care entity" defined for these purposes to mean a health care provider, a health care facility or a provider organization. "Health care entity" does not include a nursing facility as defined by section 328, subsection 18.]

2. Reporting of ownership and control of health care entities. A health care entity shall report to the organization on an annual basis and upon the completion of a material change transaction involving the health care entity in a form and manner required by the organization the following information:

A. Legal name of health care entity;

B. Business address of health care entity;

C. Locations of operations;

D. Business identification numbers of the health care entity, as applicable, including:

(1) Taxpayer identification number;

(2) National provider identifier;

(3) Employer identification number; and

(4) United States Department of Health and Human Services, Centers for Medicare and Medicaid Services certification number;

E. Name and contact information of a representative of the health care entity;

F. The name, business address, business identification numbers listed in paragraph D and federal tax classification for each person or entity that, with respect to the relevant health care entity:

(1) Has an ownership or investment interest;

(2) Has a controlling interest;

(3) Is a management services organization; or

(4) Is a significant equity investor;

G. A current organizational chart showing the business structure of the health care entity, including:

(1) Any entity listed in paragraph F;

(2) Affiliates, including entities that control or are under common control as the health care entity; and

(3) Subsidiaries;

H. For a health care entity that is a health care provider or a health care facility:

(1) The affiliated health care providers identified by name, license type, specialty, national provider identifier and other applicable identification number described in paragraph D; the address of the principal practice location; and whether the health care provider is employed or contracted by the health care entity; and

(2) The name and address of affiliated health care facilities by license number, license type and capacity in each major service area;

I. The names, national provider identifiers, if applicable, and compensation of the members of the governing board or board of directors or similar governance body for the health care entity; any entity that is owned or controlled by, affiliated with or under common control with the health care entity; and any entity described in paragraph F; and

J. Payor mix information for the reporting year by:

(1) The number of services provided and percent of total services provided by payor category; and

(2) The percent of total patient service revenue by payor category.

3. Exceptions. The following health care entities are exempt from the reporting requirements under subsection 2:

A. A health care entity that is an independent provider organization, without any ownership or control entities, consisting of 5 or fewer physicians, except that if such a health care entity experiences a material change transaction under chapter 106, the health care entity is subject to reporting pursuant to chapter 106; and

B. A health care provider or provider organization that is owned or controlled by another health care entity, if the health care provider or provider organization is shown in the organizational chart submitted under subsection 2, paragraph G and the controlling health care entity reports all the information required under subsection 2 on behalf of the controlled or owned entity, except that health care facilities are not subject to this exception.

4. Sharing of ownership information to improve transparency. This subsection governs the sharing of ownership information to improve transparency.

A. Information provided under this subsection is public information and may not be considered confidential, proprietary or a trade secret, except that any individual health care provider's taxpayer identification number that is also their social security number is confidential.

B. Not later than July 1, 2027 and annually thereafter, the organization shall post on a publicly accessible website a report with respect to the previous one-year period, including:

(1) The number of health care entities reporting for that previous one-year period, disaggregated by the business structure of each specified health care entity;

(2) The name, address and business structure of any entity with an ownership or controlling interest in a health care entity;

(3) Any change in ownership or control for each health care entity;

(4) Any change in the tax identification number of a health care entity; and

(5) As applicable, the name, address, tax identification number and business structure of other affiliates that are under common control with, subsidiaries of or management services entities of the health care entity, including the business type and the tax identification number of each.

C. The organization may share information reported under this section with the Office of Affordable Health Care, Attorney General, other state agencies and other state officials to reduce or avoid duplication in reporting requirements or to facilitate oversight or enforcement pursuant to the laws of the State, except that any tax identification numbers that are individual social security numbers may be shared only with other state agencies or other state officials that agree to maintain the confidentiality of such information.

RE: Statewide Healthcare Services Planning

Maine Revised Statutes Annotated
Title 2. Executive
Chapter 5. State Health Planning [Repealed] (Refs & Annos)

This section has been updated. Click here for the updated version.

2 M.R.S.A. § 101

§ 101. Duties of Governor

1. Governor. The Governor or the Governor's designee shall:

A. Develop and issue the biennial State Health Plan, referred to in this chapter as "the plan," pursuant to section 103 by December 1, 2005 and every 2 years thereafter;

B. Make an annual report to the public assessing the progress toward meeting goals of the plan and provide any needed updates to the plan;

C. Issue an annual statewide health expenditure budget report that must serve as the basis for establishing priorities within the plan; and

D. Establish a limit for allocating resources under the certificate of need program described in Title 22, chapter 103-A [1], called the capital investment fund, for each year of the plan pursuant to section 102.

The Governor shall provide the reports specified in paragraphs B and C to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs, the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters.

Credits
2003, c. 469, § B-1; 2005, c. 369, § 1; 2005, c. 397, § C-1, eff. Sept. 17, 2005.

Footnotes

1 22 M.R.S.A. § 326 et seq.

2 M. R. S. A. § 101, ME ST T. 2 § 101
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed

(1)

Maine Revised Statutes Annotated
Title 2. Executive
Chapter 5. State Health Planning [Repealed] (Refs & Annos)

This section has been updated. Click here for the updated version.

2 M.R.S.A. § 102

§ 102. Capital investment fund

1. Purpose. The capital investment fund is a limit for resources allocated annually under the certificate of need program described in Title 22, chapter 103-A.

2. Process; criteria. The process for determining the capital investment fund amount must be set forth in rules and may include the formation of an ad hoc expert panel to advise the Governor. The process must include the division of the total capital investment fund amount into nonhospital and hospital components, must establish large and small capital investment fund amounts within each component and must be based on 3rd-year capital and operating expenses of projects under the certificate of need program. The process must take into account the following:

A. The plan;

B. The opportunity for improved operational efficiencies in the State's health care system;

C. The average age of the infrastructure of the State's health care system; and

D. Technological developments and the dissemination of technology in health care.

3. Nonhospital capital expenditures. The nonhospital component of the capital investment fund must be at least 12.5% of the total.

Credits
2003, c. 469, § B-1; 2005, c. 227, § 1; 2007, c. 94, § 1; 2009, c. 194, § 1, eff. May 22, 2009.

2 M. R. S. A. § 102, ME ST T. 2 § 102
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

End of Document

(2)

Maine Revised Statutes Annotated
Title 2. Executive
Chapter 5. State Health Planning [Repealed] (Refs & Annos)

This section has been updated. Click here for the updated version.

2 M.R.S.A. § 103

§ 103. State Health Plan

1. Purpose. The plan issued pursuant to section 101, subsection 1, paragraph A must set forth a comprehensive, coordinated approach to the development of health care facilities and resources in the State based on statewide cost, quality and access goals and strategies to ensure access to affordable health care, maintain a rational system of health care and promote the development of the health care workforce.

2. Input. In developing the plan, the Governor shall, at a minimum, review the process for the development of the plan with the joint standing committee of the Legislature having jurisdiction over health and human services matters and seek input from the Advisory Council on Health Systems Development, pursuant to section 104; the Maine Quality Forum and the Maine Quality Forum Advisory Council, pursuant to Title 24-A, chapter 87, subchapter 2 [1]; a statewide health performance council; and other agencies and organizations.

3. Requirements. The plan must:

A. Assess health care cost, quality and access in the State based on, but not limited to, demographic, health care service and health care cost data;

B. Develop benchmarks to measure cost, quality and access goals and report on progress toward meeting those goals;

C. Establish and set annual priorities among health care cost, quality and access goals;

D. Prioritize the capital investment needs of the health care system in the State within the capital investment fund, established under section 102;

E. Outline strategies to:

(1) Promote health systems change;

(2) Address the factors influencing health care cost increases; and

(3)

(3) Address the major threats to public health and safety in the State, including, but not limited to, lung disease, diabetes, cancer and heart disease;

F. Provide recommendations to help purchasers and providers make decisions that improve public health and build an affordable, high-quality health care system;

G. Be consistent with the requirements of the certificate of need program described in Title 22, chapter 103-A; and

H. Include the report cards on health status by district issued by the Department of Health and Human Services, Maine Center for Disease Control and Prevention and the Statewide Coordinating Council for Public Health pursuant to Title 22, section 413, subsection 3 to monitor progress in improving health. The plan must also use survey and other health tracking systems available in or to the Maine Center for Disease Control and Prevention to monitor rates of preventive risk factors and diseases among the uninsured.

3-A. Review. The plan must be reviewed by the joint standing committee of the Legislature having jurisdiction over health and human services matters prior to being finalized and issued by the Governor.

4. Uses of plan. The plan must be used in determining the capital investment fund amount pursuant to section 102 and must guide the issuance of certificates of need by the State and the health care lending decisions of the Maine Health and Higher Education Facilities Authority. A certificate of need or public financing that affects health care costs may not be provided unless it meets goals and budgets explicitly outlined in the plan.

Credits

2003, c. 469, § B-1; 2005, c. 369, §§ 2 to 6; 2009, c. 355, §§ 1 to 3.

Footnotes

1 24-A M.R.S.A. § 6951 et seq.

2 M. R. S. A. § 103, ME ST T. 2 § 103

Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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Maine Revised Statutes Annotated
Title 2. Executive
Chapter 5. State Health Planning [Repealed] (Refs & Annos)

This section has been updated. Click here for the updated version.

2 M.R.S.A. § 104

§ 104. Advisory Council on Health Systems Development

1. Deleted. Laws 2007, c. 441, § 1, eff. June 27, 2007.

1-A. Appointment; composition. The Advisory Council on Health Systems Development, established in Title 5, section 12004-I, subsection 31-A and referred to in this section as "the council," consists of 20 members appointed pursuant to this subsection.

A. The Governor shall appoint 15 members with the approval of the joint standing committee of the Legislature having jurisdiction over health and human services matters:

(1) Two individuals with expertise in health care delivery, one of whom represents hospitals;

(2) One individual with expertise in long-term care;

(3) One individual with expertise in mental health;

(4) One individual with expertise in public health care financing;

(5) One individual with expertise in private health care financing;

(6) One individual with expertise in health care quality;

(7) One individual with expertise in public health;

(8) Two representatives of consumers;

(9) One individual with expertise in the insurance industry;

(10) Two individuals with expertise in business, one representing a business or businesses with fewer than 50 employees;

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(11) One representative of the Department of Health and Human Services, Maine Center for Disease Control and Prevention that works collaboratively with other organizations to improve the health of the citizens of this State; and

(12) One individual with expertise in health disparities and representing the State's racial and ethnic minority communities.

Prior to making appointments to the council, the Governor shall seek nominations from the public, from statewide associations representing hospitals, physicians and consumers and from individuals and organizations with expertise in health care delivery systems, health care financing, health care quality and public health.

B. Five members of the council must be members of the Legislature who serve on the joint standing committee of the Legislature having jurisdiction over health and human services matters or the joint standing committee of the Legislature having jurisdiction over insurance and financial services matters:

(1) Two members of the Senate, appointed by the President of the Senate, including one member recommended by the Senate Minority Leader; and

(2) Three members of the House of Representatives appointed by the Speaker of the House, including one member recommended by the House Minority Leader.

2. Term. Except for members who are Legislators, members of the council serve 5-year terms except for initial appointees. Initial appointees must include 3 members appointed to 3-year terms, 4 members appointed to 4-year terms and 4 members appointed to 5-year terms. A member may not serve more than 2 consecutive terms. Members of the Legislature serve 2-year terms coterminous with their elected terms. Except for a member who is a Legislator, a member may continue to serve after expiration of the member's term until a successor is appointed.

3. Compensation. Members of the council are entitled to compensation according to the provisions of Title 5, chapter 379. Members of the council who are Legislators are entitled to receive the legislative per diem as defined in the Maine Revised Statutes, Title 3, section 2 and reimbursement for travel for attendance at meetings of the council.

4. Quorum. A quorum is a majority of the members of the council.

5. Chair. The council shall annually choose one of its members to serve as chair for a one-year term.

6. Meetings. The council shall meet at least 4 times a year at regular intervals and may meet at other times at the call of the chair or the Governor. Meetings of the council are public proceedings as provided by Title 1, chapter 13, subchapter 1.

7. Duties. The council shall advise the Governor in developing the plan to the extent data and resources are available by:

A. Collecting and coordinating data on health systems development in this State;

B. Synthesizing relevant research;

C. Conducting at least 2 public hearings on the plan and the capital investment fund each biennium;

D. Conducting a systemic review of cost drivers in the State's health care system, including, but not limited to, market failure, supply and demand for services, provider charges and costs, public and commercial payor policies, consumer behavior, cost and pricing of pharmaceuticals and the need for and availability and cost of capital equipment and services;

E. Collecting and reporting on health care cost indicators, including the cost of services and the cost of health insurance. The council shall report on both administrative and service costs. These indicators must, at a minimum, include:

(1) The annual rate of increase in the unit cost, adjusted for case mix or other appropriate measure of acuity or resource consumption, of key components of the total cost of health care, including without limitation hospital services, surgical and diagnostic services provided outside of a hospital setting, primary care physician services, specialized medical services, the cost of prescription drugs, the cost of long-term care and home health care and the cost of laboratory and diagnostic services;

(2) The interaction of indicators including, but not limited to, cost shifting among public and private payors and cost shifting to cover uncompensated care to persons unable to pay for items or services and the effect of these practices on the total cost paid by all payment sources for health care;

(3) The administrative costs of health insurance and other health benefit plans, including the relative costliness of private insurance as compared to Medicare and MaineCare, and the potential for measures and policies that would tend to encourage greater efficiency in the administration of public and private health benefit plans provided to consumers in this State;

(4) Geographic distribution of services with attention to appropriate allocation of high-technology resources;

(5) Regional variation in quality and cost of services; and

(6) Overall growth in utilization of health care services.

F. Identifying specific potential reductions in total health care spending without shifting costs onto consumers and without reducing access to needed items and services for all persons, regardless of individual ability to pay. In identifying specific potential reductions pursuant to this paragraph, the council shall recommend methods to reduce the rate of increase in overall health care spending and the rate of increase in health care costs to a level that is equivalent to the rate of increase in the cost of living to make health care and health coverage more affordable for people in this State;

G. Beginning March 1, 2008 and annually thereafter, making specific recommendations relating to paragraphs A to F and to paragraph H to the joint standing committee of the Legislature having jurisdiction over insurance and financial services

matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters and to any appropriate state agency; and

H. Reviewing and evaluating strategies for payment reform in the State's health care system to assess whether proposed payment reform efforts follow the guiding principles developed by the council and identifing [1] any statutory or regulatory barriers to implementation of payment reform.

8. Staff support. The Governor's office shall provide staff support to the council. The Department of Health and Human Services, Maine Center for Disease Control and Prevention, the Maine Health Data Organization and other agencies of State Government as necessary and appropriate shall provide additional staff support or assistance to the council.

9. Data. The council shall solicit data and information from both the public and private sectors to help inform the council's work.

A. The following organizations shall forward data that documents key public health needs, organized by region of the State, to the council annually:

(1) The Department of Health and Human Services, Maine Center for Disease Control and Prevention; and

(2) Deleted. Laws 2007, c. 539, § N-3.

(3) A statewide public health association.

B. Public purchasers using state or municipal funds to purchase health care services or health insurance shall, beginning January 1, 2004, submit to the council a consolidated public purchasers expenditure report outlining all funds expended in the most recently completed state fiscal year for hospital inpatient and outpatient care, physician services, prescription drugs, long-term care, mental health and other services and administration, organized by agency.

C. The council shall encourage private purchasers established under Title 13, Title 13-B and Title 13-C to develop and submit to the council a health expenditure report similar to that described in paragraph B.

D. The Maine Health Data Organization and the Maine Quality Forum shall forward cost and quality data annually and any ad hoc data requested by the council.

10. Funding. The council may apply for grants and other nongovernmental funds to provide staff support or consultant support to carry out the duties and requirements of this section.

Credits

2003, c. 469, § B-1; 2007, c. 441, § 1, eff. June 27, 2007; 2007, c. 539, § N-3; 2009, c. 179, § 1; 2009, c. 609, §§ 1 to 3.

Maine Revised Statutes Annotated
Title 2. Executive
Chapter 5. State Health Planning [Repealed] (Refs & Annos)

This section has been updated. Click here for the updated version.

2 M.R.S.A. § 105

§ 105. Rulemaking

The Governor shall adopt rules for the implementation of this chapter. Rules adopted pursuant to this chapter are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

Credits
2003, c. 469, § B-1.

2 M. R. S. A. § 105, ME ST T. 2 § 105
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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Hospital and Health Care Provider Cooperation Act ("Certificate of Public Advantage") overview

The Hospital and Health Care Provider Cooperation Act ("the Act") allowed the Department of Health and Human Services ("DHHS") to issue a certificate of public advantage ("COPA") to encourage hospitals and other health care providers to cooperate and enter into agreements to facilitate cost containment, improve quality of care and increase access to health care services.

The intent of the Act was that a COPA approved under the statutory provisions provided state action immunity under applicable federal antitrust laws.

Review criteria; final decision

For a COPA to be approved by DHHS, DHHS determined that the applicants demonstrated by a preponderance of the evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition likely to result from the disagreement.

The Act specified what DHHS consider when examining potential benefits of a cooperative agreement and evaluation of any disadvantages attributable to a reduction in competition likely to result from a competitive agreement (22 MRSA §1844, sub-§5).

The Act said DHHS had to issue a final decision to grant or deny an application for a COPA no less than 40 days and no more than 90 days after the filing of an application. DHHS had to issue a preliminary decision at least 5 days prior to issuing the final decision.

Periodic reporting; supervisory review of certificate holder by DHHS

As a condition of receiving a COPA, the certificate holders were subject to periodic reporting and subject to supervisory review by DHHS. Periodic reporting included extent of the benefits realized and compliance with other terms and conditions of the certificate. This reporting was also required to be submitted to the Attorney General. The Attorney General could also submit to DHHS comments on the report. Within 60 days after receipt of the certificate holder's report, DHHS had to make findings on the report and determine whether to institute any additional supervisory activities and to notify the certification holder. Additional supervisory activities that the certificate holder may be subject to were described statutorily (22 MRSA §1845, sub-§§2 and 3).

Additional conditions; revocation of COPA

DHHS had the authority to impose additional conditions to ameliorate any disadvantages attributable to any reduction in competition or to seek a court order to revoke the COPA if DHHS determined that because of changes or unanticipated circumstances the benefits resulting from the activities authorized under the COPA and the unavoidable costs of revoking the COPA are outweighed by disadvantages attributable to a reduction in competition resulting from the activities under the COPA.

Application fees; assessments

To obtain a COPA, covered entities were subject to an application fee.

- COPA of merger of 2 or more hospitals, each with 50 or more beds, $10,000; or
- COPA filed by health care providers or hospitals not subject to the $10,000 fee, $2,500.

Under the Act, any hospital licensed by DHHS was subject to an annual assessment, except for state-owned mental health hospitals. The amount of the assessment was based on each hospital's gross patient service revenue. The aggregate amount raised by assessment could not exceed $200,000 in any fiscal year. The intent of the assessment was to carry out the purposes of the Act.

Repeal

In the 131st Legislature, Public Law 2023, c. 37 repealed the Act. According to testimony from DHHS, COPAs have not been utilized frequently, and DHHS was aware of only 2 recent instances in which health care facilities pursued COPA approvals (on in 2009 and one in 2010). They had since expired. DHHS cited studies by the Federal Trade Commission in its testimony in support of repeal of the Act.

Re", Resist Repeal of CopA law

Maine Revised Statutes Annotated
Title 22. Health and Welfare
Subtitle 2. Health
Part 4. Hospitals and Medical Care
Chapter 405-a. Hospital and Health Care Provider Cooperation Act (Refs & Annos)

This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1841

§ 1841. Short title

This chapter may be known and cited as "the Hospital and Health Care Provider Cooperation Act."

Credits
2005, c. 670, § 1.

22 M. R. S. A. § 1841, ME ST T. 22 § 1841
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1842

§ 1842. Legislative findings and intent

The Legislature finds that it is necessary and appropriate to encourage hospitals and other health care providers to cooperate and enter into agreements that will facilitate cost containment, improve quality of care and increase access to health care services. This Act provides processes for state review of overall public benefit, for approval through certificates of public advantage and for continuing supervision. It is the intent of the Legislature that a certificate of public advantage approved under this chapter provide state action immunity under applicable federal antitrust laws.

Credits
2005, c. 670, § 1.

22 M. R. S. A. § 1842, ME ST T. 22 § 1842
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1843

§ 1843. Definitions

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

1. Cooperative agreement. "Cooperative agreement" means an agreement that names the parties to the agreement and describes the nature and scope of the cooperation for:

A. The sharing, allocation or referral of patients, personnel, instructional programs, medical or mental health services, support services or facilities or medical, diagnostic or laboratory facilities, procedures or other services traditionally offered by hospitals or health care providers;

B. The coordinated negotiation and contracting with payors or employers; or

C. The merger of 2 or more hospitals or 2 or more health care providers.

A cooperative agreement under this chapter is an agreement between 2 or more hospitals or an agreement between 2 or more health care providers. An agreement between one or more hospitals and one or more health care providers is not a cooperative agreement for the purposes of this chapter.

2. Covered entity. "Covered entity" means a hospital or health care provider.

3. Health care provider. "Health care provider" means a licensed community mental health services provider, a physician licensed under Title 32, chapter 36 [1] or 48 [2] and operating in this State or a corporation or business entity engaged primarily in the provision of physician health care services.

4. Hospital. "Hospital" means:

A. An acute care institution licensed and operating in this State as a hospital under section 1811 or the parent of such an institution; or

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B. A hospital subsidiary or hospital affiliate in the State that provides medical services or medically related diagnostic and laboratory services or engages in ancillary activities supporting those services.

5. Merger. "Merger" means a transaction by which ownership or control over substantially all of the stock, assets or activities of one or more covered entities is placed under the control of another covered entity. A merger between one or more hospitals and one or more health care providers is not a merger for the purposes of this chapter.

Credits

2005, c. 670, § 1.

Footnotes

1 32 M.R.S.A. § 2561 et seq.

2 32 M.R.S.A. § 3263 et seq.

22 M. R. S. A. § 1843, ME ST T. 22 § 1843

Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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Chapter 405-a. Hospital and Health Care Provider Cooperation Act (Refs & Annos)

This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1844

§ 1844. Certificate of public advantage

1. Authority. A covered entity may negotiate and enter into a cooperative agreement with another covered entity and may file an application for a certificate of public advantage pursuant to this section. The approval of an application for a certificate of public advantage is governed by the standards of subsection 5.

2. Application for certificate. The application process for a certificate of public advantage is as follows.

A. At least 45 days prior to filing an application for a certificate of public advantage for a merger, the parties to a merger agreement shall file a letter of intent with the department describing the proposed merger. Copies of the letter of intent and all accompanying materials must be submitted to the Attorney General at the time the letter of intent is filed with the department.

B. The parties to a cooperative agreement shall file with the department an application for a certificate of public advantage with regard to the cooperative agreement and pay the application fee established under section 1851.

C. The application must include a signed copy of the original cooperative agreement and must state all consideration passing to any party under the agreement.

D. The parties to a cooperative agreement shall submit copies of the application and all the accompanying materials to the Attorney General at the time they file the application with the department.

Copies of the application and all accompanying materials filed by the applicant, public comments, records of the department maintained with regard to the application and copies of the letter of intent filed for a merger may be examined at an office of the department.

3. Public notice. Within 10 business days of the filing of an application under this section, the department shall give public notice of the filing as follows.

A. The department shall publish notice in a newspaper of general circulation in Kennebec County and in a newspaper published within the service area in which the proposed cooperative agreement would be effective.

(7)

B. The department shall provide notice by mailing copies of the application and letter of intent, if any, to all persons who request notification from the department.

C. Notice under this subsection must include:

(1) A brief description of the proposal;

(2) A description of the review process and schedule; and

(3) A statement of the availability of the application and records pertaining to it and letter of intent as provided in subsection 2.

4. Procedure for department review. The following procedures apply to review by the department of an application filed under this section.

A. The department shall review and evaluate the application in accordance with the standards set forth in subsection 5.

B. Any person may provide the department with written comments concerning the application within 30 days after the public notice in subsection 3, paragraph A.

C. The department shall provide the Attorney General with copies of all comments from persons submitted under paragraph B.

D. This paragraph applies with regard to a public hearing.

(1) The department may hold a public hearing when it determines a public hearing is appropriate.

(2) The department shall hold a public hearing if 5 or more persons who are residents of the State and who are from the health service area to be served by the applicant request, in writing, that a hearing be held. A request under this subparagraph must be received by the department no later than 30 days after publication of the notice under subsection 3.

(3) If a public hearing is held, an electronic or stenographic record of the public hearing must be kept as part of the record of the application by the department.

E. The parties to a cooperative agreement may withdraw their application and thereby terminate all proceedings under this chapter as follows:

(1) Without the approval of the department, any party or the Superior Court at any time prior to the filing of an answer or responsive pleading in a court action under section 1848, subsection 2 or prior to entry of a consent decree under section 1848, subsection 9; or

(2) Without the approval of the department or any party at any time prior to the issuance of a final decision under paragraph F if a court action has not been filed under section 1848, subsection 2.

F. The department shall issue a final decision to grant or deny an application for a certificate of public advantage under this section no less than 40 days and no more than 90 days after the filing of the application. The department shall issue a preliminary decision at least 5 days prior to issuing the final decision. The preliminary and final decisions must be in writing and set forth the basis for the decisions. The department shall provide copies of the preliminary and final decisions to the applicants, the Office of the Attorney General and all persons who requested notification from the department under subsection 3, paragraph B.

5. Standards for approval of a certificate of public advantage. The department shall issue a certificate of public advantage for a cooperative agreement if it determines that the applicants have demonstrated by a preponderance of the evidence that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition likely to result from the agreement. The department may not issue to health care providers a certificate of public advantage for a cooperative agreement that allows coordinated negotiation and contracting with payors or employers unless such negotiation and contracting are ancillary to clinical or financial integration. In issuing a decision on an application for a certificate of public advantage under this section, the department shall make specific findings as to the nature and extent of any likely benefits and disadvantages found under this subsection.

A. In evaluating the potential benefits of a cooperative agreement, the department shall consider whether one or more of the following benefits are likely to result from the cooperative agreement:

(1) Enhancement of the quality of care provided to citizens of the State;

(2) Preservation of hospitals or health care providers and related facilities in geographical proximity to the communities traditionally served by those facilities;

(3) Gains in the cost efficiency of services provided by the hospitals or others;

(4) Improvements in the utilization of hospital or other health care resources and equipment;

(5) Avoidance of duplication of hospital or other health care resources; and

(6) Continuation or establishment of needed educational programs for health care providers.

B. The department's evaluation of any disadvantages attributable to a reduction in competition likely to result from a cooperative agreement may include, but is not limited to, the following factors:

(9)

(1) The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care service agents or other health care payors to negotiate optimal payment and service arrangements with hospitals or health care providers;

(2) The extent of any disadvantages attributable to reduction in competition among covered entities or other persons furnishing goods or services to, or in competition with, covered entities that is likely to result directly or indirectly from the cooperative agreement;

(3) The extent of any likely adverse impact on patients or clients in the quality, availability and price of health care services;

(4) The extent of any likely adverse impact on the access of persons enrolled in in-state educational programs for health professions to existing or future clinical training programs; and

(5) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.

C. In evaluating a cooperative agreement under the standards in paragraphs A and B, the department shall consider the extent to which any likely disadvantages may be ameliorated by any reasonably enforceable conditions under subparagraph (1) and the extent to which the likely benefits or favorable balance of benefits over disadvantages may be enhanced by any reasonably enforceable conditions under subparagraph (2). Reasonably enforceable conditions are those conditions that the department determines are subject to future measurement or evaluation in order to assess compliance with those conditions.

(1) In a certificate issued under this subsection, the department may include conditions reasonably necessary to ameliorate any likely disadvantages of the type specified in paragraph B.

(2) In a certificate issued under this subsection, the department may include additional conditions, if proposed by the applicants, designed to achieve public benefits, which may include but are not limited to the benefits listed in paragraph A.

D. In a certificate of public advantage issued under this subsection, the department may include a condition requiring the certificate holders to submit fees sufficient to fund expenses for consultants or experts necessary for the continuing supervision required under section 1845. These fees must be paid at the time of any review conducted under section 1845. The total amount charged to the certificate holders for continuing supervision may not exceed $5,000 for mergers involving hospitals with 50 or more beds and $2,500 for all other cooperative agreements.

6. Intervention. The Attorney General may intervene as a right in any proceeding under this chapter before the department. Except as provided in this subsection, intervention is governed by the provisions of Title 5, section 9054.

7. Attorney General enforcement. The Attorney General may file an action in Superior Court to enforce any final action taken by the department under this section. In the event that the Attorney General files an action pursuant to its separate authority outlined in section 1848, pending department proceedings in accordance with this section are stayed pursuant to section 1848, subsection 2.

Credits

2005, c. 670, § 1; 2011, c. 90, §§ J-11 to J-15; R.R.2021, c. 2, § A-55, eff. Oct. 1, 2022.

22 M. R. S. A. § 1844, ME ST T. 22 § 1844

Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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Title 22. Health and Welfare
Subtitle 2. Health
Part 4. Hospitals and Medical Care
Chapter 405-a. Hospital and Health Care Provider Cooperation Act (Refs & Annos)

This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1845

§ 1845. Continuing supervision

Continuing supervision of holders of certificates of public advantage under this chapter may consist of periodic reports, supervisory reviews and additional supervisory activities.

1. Periodic report and supervisory review. With regard to a certificate of public advantage approved under this chapter, the certificate holder shall report periodically to the department on the extent of the benefits realized and compliance with other terms and conditions of the certificate. The certificate holder shall submit copies of the report to the Attorney General at the time the report is filed with the department. The Attorney General may submit to the department comments on the report filed under this subsection. The department shall consider any comments on the report from the Attorney General in the course of its evaluation of the certificate holder's report. Within 60 days of receipt of the certificate holder's report, the department shall make findings regarding the report, including responses to any comments from the Attorney General, determine whether to institute additional supervisory activities under this section and notify the certificate holder.

2. Additional supervisory activities. The provisions of this subsection apply to additional supervisory activities determined necessary under subsection 1.

A. The department shall conduct additional supervisory activities whenever requested by the Attorney General or whenever the department, in its discretion, determines those activities appropriate, and:

(1) For certificates of public advantage not involving mergers, at least once in the first 18 months after the transaction described in the cooperative agreement has closed; and

(2) For certificates of public advantage involving mergers, at least once between 12 and 30 months after the transaction described in the cooperative agreement has closed.

B. In its discretion, the department may conduct additional supervisory activities by:

(1) Soliciting and reviewing written submissions from the certificate holders, the Attorney General or the public;

(2) Conducting a hearing in accordance with Title 5, chapter 375, subchapter 4 [1] and the department's administrative hearings rules; or

(3) Using any alternative procedures appropriate under the circumstances.

C. The department shall notify the certificate holders if it intends to consider the imposition of any additional conditions or measures authorized under subsection 3. If the department notifies certificate holders under this paragraph, the certificate holders may request and are entitled to a hearing in accordance with Title 5, chapter 375, subchapter 4.

D. A decision of the department regarding additional supervisory activities is governed by the standards set forth in subsection 3. The burden of proof is on the parties seeking any remedial order. A remedial order may not issue unless the basis for it is established by a preponderance of the evidence.

3. Standards governing additional supervisory activities. The provisions of this subsection govern the standards of any additional supervisory activities conducted under subsection 2.

A. If the department determines in any additional supervisory activities conducted under subsection 2 that the certificate holders are not in substantial compliance with any conditions included in the certificate under section 1844, subsection 5 or in a consent decree entered into by the department, the department may at its discretion:

(1) Impose additional conditions to secure compliance with any conditions included in the certificate or consent decree; or

(2) Issue notice to the certificate holders compelling compliance with any conditions included in the certificate or consent decree. If after 30 days the department determines that the notice was not effective in securing compliance with the conditions, the department may impose any additional measures authorized by law to compel compliance with the conditions, or seek a court order revoking the certificate in accordance with subsection 4.

B. The department may impose additional conditions to ameliorate any disadvantages attributable to any reduction in competition, or seek a court order revoking the certificate in accordance with subsection 4, if the department determines in any additional supervisory activities conducted under subsection 2 that, as a result of changed or unanticipated circumstances, the benefits resulting from the activities authorized under the certificate and the unavoidable costs of revoking the certificate are outweighed by disadvantages attributable to a reduction in competition resulting from the activities authorized under the certificate. For purposes of this paragraph, "unanticipated circumstances" includes the failure to realize anticipated benefits of the agreement or the realization of unanticipated anticompetitive effects from the agreement.

4. Action to revoke certificate. The department is authorized to seek a court order revoking a certificate of public advantage under the circumstances specified in subsection 3, paragraph A, subparagraph (2) or subsection 3, paragraph B. In any such action the standards for adjudication to be applied by the court are the same as in section 1848, subsections 5 and 6. In assessing disadvantages attributable to a reduction in competition likely to result from the agreement, the court may draw upon the determinations of federal and Maine courts concerning unreasonable restraint of trade under 15 United States Code, Sections

1 and 2 and Title 10, sections 1101 and 1102. The department's burden of proof is the same as that for the Attorney General in an action under section 1848, subsections 5 and 6.

5. Attorney General enforcement. The Attorney General may file an action in Superior Court to enforce any final action taken by the department as a result of additional supervisory proceedings under this section. In the event that the Attorney General files an action pursuant to its separate authority outlined in section 1848, any pending department proceedings are stayed pursuant to section 1848, subsection 7.

6. Fees and costs. If the department prevails in an action under this section, the department and the Attorney General are entitled to an award of the reasonable costs of deposition transcripts incurred in the course of the action and reasonable attorney's fees, expert witness fees and court costs incurred in the action.

Credits

2005, c. 670, § 1; 2011, c. 90, §§ J-16, J-17.

Footnotes

1 5 M.R.S.A. § 9051 et seq.

22 M. R. S. A. § 1845, ME ST T. 22 § 1845

Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1846

§ 1846. Record keeping

The department shall maintain records of all applications for a certificate of public advantage, together with the records of all submissions, comments, reports and department proceedings with respect to those applications, certificates approved by the department, continuing supervision and any other proceedings under this chapter.

Credits
2005, c. 670, § 1.

22 M. R. S. A. § 1846, ME ST T. 22 § 1846
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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22 M.R.S.A. § 1847

§ 1847. Judicial review of department action

An applicant, certificate holder or intervenor aggrieved by a final decision of the department in granting or denying an application for a certificate of public advantage, refusing to act on an application or imposing additional conditions or measures with regard to a certificate of public advantage is entitled to judicial review of the final decision in accordance with the Maine Administrative Procedure Act.

Credits
2005, c. 670, § 1.

22 M. R. S. A. § 1847, ME ST T. 22 § 1847
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1848

§ 1848. Attorney General authority

1. Investigative powers. The Attorney General, at any time after an application or letter of intent is filed under section 1844, subsection 2, may require by subpoena the attendance and testimony of witnesses and the production of documents in Kennebec County, or the county in which the applicants are located, for the purpose of investigating whether the cooperative agreement satisfies the standards set forth in section 1844, subsection 5. All documents produced and testimony given to the Attorney General are confidential. The Attorney General may seek an order from the Superior Court compelling compliance with a subpoena issued under this section.

2. Court action; time limits. The Attorney General may seek to enjoin the operation of a cooperative agreement for which an application for a certificate of public advantage has been filed by filing suit against the parties to the cooperative agreement in Superior Court. The Attorney General may file an action before or after the department acts on the application for a certificate; however, the action must be brought no later than 40 days following the department's approval of an application for a certificate of public advantage. After the filing of a court action under this subsection, the department may not take any further action under this chapter and the time periods specified for departmental action under section 1844, subsection 4 are tolled until the court action is dismissed by the Attorney General or the Superior Court orders the department to take further action.

3. Automatic stay. Upon the filing of a complaint in an action under subsection 2, the department's approval of a certificate of public advantage, if previously issued, must be stayed unless the court orders otherwise or until the action is concluded. The applicant for a certificate may apply to the Superior Court for relief from that stay. Relief may be granted only upon showing of compelling justification. The Attorney General may apply to the court for any temporary or preliminary relief to enjoin the implementation of the cooperative agreement pending final disposition of the case.

4. Standard for adjudication. In an action brought under subsection 2, the applicants for a certificate of public advantage bear the burden of establishing by a preponderance of the evidence that, in accordance with section 1844, subsection 5, the likely benefits resulting from the cooperative agreement and any conditions proposed by the applicants outweigh any disadvantages attributable to a reduction in competition that may result from the agreement. In assessing disadvantages attributable to a reduction in competition likely to result from the agreement, the court may draw upon the determinations of federal and Maine courts concerning unreasonable restraint of trade under 15 United States Code, Sections 1 and 2 and Title 10, sections 1101 and 1102.

5. Ongoing evaluation of benefits. If, at any time following the 40-day period specified in subsection 2, the Attorney General determines that, as a result of changed circumstances or unanticipated circumstances, the benefits resulting from a certified cooperative agreement or a consent decree entered under subsection 9 do not outweigh any disadvantages attributable to a

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reduction in competition resulting from the agreement, the Attorney General may file suit in the Superior Court seeking to revoke the certificate of public advantage. The standard for adjudication for an action to revoke brought under this subsection is as follows.

A. Except as provided in paragraph B, in an action brought under this subsection, the Attorney General has the burden of establishing by a preponderance of the evidence that, as a result of changed circumstances or unanticipated circumstances, the benefits resulting from the cooperative agreement and the unavoidable costs of revoking the certificate are outweighed by disadvantages attributable to a reduction in competition resulting from the agreement. For purposes of this paragraph, " unanticipated circumstances" includes the failure to realize anticipated benefits of the agreement or the realization of unanticipated anticompetitive effects from the agreement.

B. In an action brought under this subsection, if the Attorney General first establishes by a preponderance of the evidence that the department's certification was obtained as a result of material misrepresentation to the department or the Attorney General or as the result of coercion, threats or intimidation toward any party to the cooperative agreement, then the parties to the agreement bear the burden of establishing by clear and convincing evidence that the benefits resulting from the agreement and the unavoidable costs of revoking the agreement outweigh the disadvantages attributable to any reduction in competition resulting from the agreement.

6. Enforcement of conditions. Conditions and measures included in a certificate of public advantage may be enforced according to this subsection.

A. If the certificate holders in a cooperative agreement not involving a merger are not in substantial compliance with the conditions included in the certificate of public advantage under section 1844, subsection 5 or a consent decree entered under subsection 9 or with the conditions or measures added pursuant to additional supervisory activities under section 1845, subsection 3, the Attorney General may seek an order from the Superior Court compelling compliance with such conditions or measures or other appropriate equitable remedies. If the Superior Court grants such relief and that relief is not effective in securing compliance with the conditions or measures, the Superior Court may impose additional equitable remedies, including the exercise of civil contempt powers, or may revoke the certificate upon a determination that advantages to be gained by revoking the certificate outweigh the unavoidable costs resulting from a revocation of the certificate.

B. If the certificate holders in a cooperative agreement involving a merger are not in substantial compliance with the conditions included in the certificate of public advantage under section 1844, subsection 5 or a consent decree entered under subsection 9 or with the conditions or measures added pursuant to additional supervisory activities under section 1845, subsection 3, the Attorney General may seek an order from the Superior Court compelling compliance with such conditions or measures. If the certificate holders to the merger fail to comply with any court order compelling compliance with such conditions or measures, the Superior Court may impose additional equitable remedies to secure compliance with its orders, including the exercise of civil contempt powers or appointment of a receiver. If these additional measures are not effective in securing compliance with the conditions or measures and the Superior Court determines that the advantages to be gained by divestiture outweigh the unavoidable costs of requiring divestiture, the Superior Court may revoke the certificate and order divestiture of assets.

C. In an action brought under this subsection, the Attorney General has the burden of proving by a preponderance of the evidence the basis for any equitable remedies requested by the Attorney General and adopted by the Superior Court.

7. Effect of court action. After the filing of a court action under subsection 5 or 6, the department may not take any further action under this chapter until the court action is dismissed by the Attorney General or the Superior Court orders the department to take further action.

8. Fees and costs. If the Attorney General prevails in an action under this section, the Attorney General and the department are entitled to an award of the reasonable costs of deposition transcripts incurred in the course of the investigation or litigation and reasonable attorney's fees, expert witness fees and court costs incurred in litigation.

9. Resolution by consent decree. The Superior Court may resolve any action brought by the Attorney General under this chapter by entering an order with the consent of the parties. The consent decree may contain any conditions authorized by section 1844, subsection 5, paragraph C or conditions or measures authorized under section 1845, subsection 3. A consent decree under this subsection may not be filed with the Superior Court until 30 days after the filing of the application under section 1844, subsection 2. Upon the entry of such an order, the parties to the cooperative agreement have the protection specified in section 1849 and the cooperative agreement has the effectiveness specified in section 1849.

Credits

2005, c. 670, § 1; R.R.2005, c. 2, § 16, eff. Oct. 1, 2006.

22 M. R. S. A. § 1848, ME ST T. 22 § 1848

Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1849

§ 1849. Effect of filing an application under this chapter; applicability

1. Validity of certified cooperative agreements. Notwithstanding Title 5, chapter 10; [1] Title 10, chapter 201 [2]; or any other provision of law, a cooperative agreement for which a certificate of public advantage has been issued is a lawful agreement. Notwithstanding Title 5, chapter 10; Title 10, chapter 201; or any other provision of law, if the parties to a cooperative agreement file an application for a certificate of public advantage governing the agreement with the department, the conduct of the parties in negotiating and entering into a cooperative agreement is lawful conduct. This subsection does not provide immunity to any person for conduct in negotiating and entering into a cooperative agreement for which an application for a certificate of public advantage is not filed.

2. Validity of cooperative agreements determined not in public interest. In an action by the Attorney General under section 1848, subsection 2, if the Superior Court determines that the applicants have not established by a preponderance of the evidence that the likely benefits resulting from a cooperative agreement outweigh any disadvantages attributable to any potential reduction in competition resulting from the agreement, the cooperative agreement is invalid and has no further force or effect when the judgment becomes final after the time for appeal has expired or the judgment of the Superior Court is affirmed on appeal.

3. Other laws, rules and regulations. This chapter does not exempt covered entities from compliance with laws governing certificates of need or other applicable laws, rules and regulations.

4. Contract disputes. A dispute between parties to a cooperative agreement concerning its meaning or terms is governed by normal principles of contract law.

5. Termination; surrender. This chapter does not prohibit certificate holders from terminating their cooperative agreement by mutual agreement, consent decree or court determination or by surrendering their certificate of public advantage to the department. Any certificate holder that terminates the agreement shall file a notice of termination with the department within 30 days after termination, surrender the certificate of public advantage and submit copies to the Attorney General at the time the notice of termination is submitted to the department.

Credits
2005, c. 670, § 1; 2011, c. 90, § J-18.

Footnotes

1 5 M.R.S.A. § 205-A et seq.

2 10 M.R.S.A. § 1101 et seq.

22 M. R. S. A. § 1849, ME ST T. 22 § 1849

Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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This section has been updated. Click here for the updated version.

22 M.R.S.A. § 1850

§ 1850. Assessment

Except for state-operated mental health hospitals, any hospital licensed by the department is subject to an annual assessment under this chapter. The department shall determine and collect the assessment. The amount of the assessment must be based upon each hospital's gross patient service revenue. For any fiscal year, the aggregate amount raised by assessment may not exceed $200,000. The department shall deposit funds collected under this section into a dedicated revenue account. Funds remaining in the account at the end of each fiscal year do not lapse but carry forward into subsequent years. Funds deposited into the account must be allocated to carry out the purposes of this chapter.

Credits
2005, c. 670, § 1.

22 M. R. S. A. § 1850, ME ST T. 22 § 1850
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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22 M.R.S.A. § 1851

§ 1851. Application fee

The application fee for a certificate of public advantage is governed by this section. The application fee for a certificate of public advantage that involves a merger of 2 or more hospitals, each of which has 50 or more beds, is $10,000. The application fee is $2500 for a certificate of public advantage filed by health care providers or hospitals that are not subject to the $10,000 fee pursuant to this section. The department shall deposit all funds received under this section and section 1844, subsection 5 into a nonlapsing dedicated revenue account to be used only by the Attorney General for the payment of the cost of experts and consultants in connection with reviews conducted under this chapter.

Credits
2005, c. 670, § 1.

22 M. R. S. A. § 1851, ME ST T. 22 § 1851
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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22 M.R.S.A. § 1852

§ 1852. Rulemaking

The department shall adopt rules to carry out the purposes of this chapter. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [1]

Credits
2005, c. 670, § 1.

Footnotes

1 5 M.R.S.A. § 8071 et seq.

22 M. R. S. A. § 1852, ME ST T. 22 § 1852
Current with 2025 First Regular and First Special Sessions of the 132nd Legislature of Maine. The First Regular Session convened December 4, 2024 and adjourned sine die March 21, 2025. The general effective date for nonemergency laws passed in the First Regular Session of the 132nd Legislature is June 20, 2025. The First Special Session convened March 25, 2025 and adjourned sine die June 25, 2025. The general effective date for nonemergency laws passed in the First Special Session of the 132nd Legislature is September 24, 2025.

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Re: Recommend use of federal grant funding through Rural Health Transformation Program to provide financial assistance to struggling rural hospitals

Summary of Maine's RHTP Application

The State of Maine has applied for federal funding through the Rural Health Transformation Program (RHTP). The RHTP was created within the federal budget reconciliation bill and provides temporary, one-time resources to help states protect and sustain access to care.

Rural Health in Maine

With a population of approximately 1.36 million people spread across a land area nearly equivalent to all other New England states combined, Maine is one of America's most rural states and also has the oldest population. Under the Federal Office of Rural Health Policy definition, over 690,000 Maine residents (51% of the population) live in rural areas, compared to 19% nationally, and 12 of Maine's 16 counties are considered fully rural.

Rural residents in Maine face far higher risks of chronic disease than the national average. Adults in these communities are more likely to have heart disease, the leading cause of death in our state. Nearly one in eight lives with diabetes, and one in five has lost six or more teeth to decay or disease. Behavioral health needs are also more acute, with higher rates of depression, suicide, and substance use disorder-related deaths. Maternal and infant outcomes reflect similar disparities, and birthing unit closures have increased the distance rural families must travel for perinatal and delivery care.

These complex health needs, combined with our aging population, drive rising demand for services, while rural geography adds costs, logistical barriers, and workforce shortages. Together, these challenges call for a distinct approach to delivering rural health care. Maine's RHTP proposes a coordinated strategy to strengthen and modernize rural health systems across the state.

Vision for the Future

Maine's RHTP strategy envisions a future in which where one lives no longer dictates health outcomes or access to care. A stronger workforce, mobility innovations, and modern technologies ensure quality care is available to rural Mainers when they need it, where they need it. The result is a rural health system that is strong and sustainable for generations of Mainers.

Maine's proposed plan is organized around five initiatives.

1. Population Health: Promoting timely access to high-quality care
2. Workforce: Strengthening Maine's rural health workforce
3. Technology Innovation: Modernizing rural care delivery with digital health technology
4. Access: Bridging the healthcare affordability gap for rural Mainers
5. Sustainable rural health ecosystems: Addressing financial instability of providers serving rural Mainers

By the conclusion of this work, rural Mainers will have a more resilient, integrated health system that is accessible to all and delivers consistent, high-value care and better health outcomes statewide.

Community Input

Maine's RHTP plan was shaped by extensive public input, including 300+ public comments, four community listening sessions, and consultations with other partners including with Tribal Representatives, the Maine Hospital Association, the Maine Primary Care Association, the Alliance for Addictions and Mental Health, and Consumers for Affordable Health Care (CAHC). Public comments were received from all counties and a wide range of affiliations, including individuals, community organizations, hospitals, and non-hospital providers, as well as from out-of-state vendors, technology firms, and health consultancies.

From these stakeholders, we sought input about the biggest challenges facing rural health in Maine and what kinds of solutions Maine's RHTP plan should prioritize. The challenges expressed were consistent:

- Unaddressed root causes of disease and barriers to care such as transportation
- Workforce shortages
- Gaps in technology and infrastructure
- Concerns about losing access to care
- Financial instability of hospitals and providers serving rural Mainers.

These challenges shaped the five initiatives that form Maine's plan and reflect the creativity, insights, and priorities voiced by rural communities. They informed the overall structure of Maine's RHTP plan, which is organized into the five initiatives that directly respond to the needs identified by residents, providers, and community partners across rural Maine.

As implementation begins, community engagement will continue. Maine will work with regional partners to ensure priorities are informed by lived experience, local data, and frontline provider insight. This ongoing collaboration will help ensure that strategies are practical, culturally appropriate, and responsive to the evolving needs of rural Maine communities.

Maine's RHTP Plan

Maine's Rural Health Transformation Program strategy is organized around five coordinated initiatives. To empower rural Mainers to achieve their own healthy living goals, we will **adopt and expand proven population health solutions**. To expand the supply of care, we will **grow our rural healthcare workforce** and **spread technologies** that connect every community to advanced care. And, to ensure care remains accessible long into Maine's future, we will pair **affordability measures** with s**trategies that advance quality, efficiency, and sustainability**.

The scale of the State's investments in these initiatives will be determined by the final award amount. The U.S. Centers for Medicare and Medicaid Services (CMS) directed all states to use a hypothetical award amount of $1 billion, or $200 million annually, in presenting their proposed activities. Maine's proposed budget and associated activities, including the amounts indicated below for each activity, remain subject to change pending Maine's final award total.

The RHTP is providing a one-time $50 billion to states with approved applications using two allocations of funding:

- The first $25 billion is expected to be allocated evenly among all 50 states. That would equal $100 million each year for the next five years for Maine.

- The second $25 billion will be distributed to a subset of states at CMS' discretion and according to a variety of rural and competitive factors over the next five years.

CMS directed states to submit proposals using a theoretical $200 million a year for each of five years. Many states will receive the minimum $100 million a year, and some (at least 13) will receive more than the minimum.

Initiative 1) **Population Health: Promoting timely access to high-quality care**

The first pillar of our strategy empowers rural Mainers across all stages of life to achieve their own healthy living goals by expanding their access to high-quality preventive, primary, chronic, and specialty care in their own communities.

It responds to the growing complexity of rural health needs tied to aging populations, increases in chronic disease and behavioral health conditions, and fragmented care delivery infrastructure that together make it harder for rural Mainers to stay healthy or recover from illness. This initiative increases the reach of Evidence-Based Practice (EBP) interventions for chronic disease management and other conditions, and by supporting new access points that promote preventive health and address root causes of disease.

This initiative also promotes Sustainable Access by helping rural providers become long-term access points for care. It does this by expanding mobile and co-located services and by strengthening navigation supports and care delivery alternatives through community-based models.

Key activities within this initiative included in Maine's RHTP proposal include the following, along with proposed allocation of funds. However, it should be noted that these activities and potential funding amounts for specific activities will likely need to be adjusted based on CMS' final decision on Maine's funding amount.

Activities: Initiative 1	**Potential allocation of $1B ($MM)**
1.1 Alternative Sites of Care: Making Care Available Where People Are	$20.9
1.2 Spreading Effectiveness and Implementation of Evidence-Based Practices	$46.8
1.3 Nutrition Education Infrastructure	$26.0
1.4 Transforming Care Capacity through Community Paramedicine	$30.7
1.5 Expand Community Health Worker and Peer Support Programs	$52.5
1.6 Supporting Access to the Continuum of Care for Mental Health and SUD Services for Special Populations	$6.0
Initiative total	$183.0

This strategy will expand School-based Health Clinics (SBHCs), increasing access for students, and add new Opioid Treatment Programs (OTPs) in rural areas, improving access to treatment services for those struggling with substance use. It will also expand mobile health and behavioral health services, helping more rural residents receive timely support. Finally, it will establish a Community Paramedicine (CP) program in every county and expand support for Community Health Workers, bringing needed care into local communities. Together, these activities strengthen Maine's rural healthcare system, improve outcomes, and ensure all services are closer to home.

Initiative 2) **Workforce: Strengthening Maine's rural health workforce**

The second pillar of our strategy grows the local health workforce in rural communities. Despite recent progress, shortages of clinicians and health support workers persist in rural Maine, limiting patient choice, driving up costs, and increasing strain on remaining providers.

This initiative strengthens cultivation, recruitment, and retention of healthcare workers in rural communities, helping rural providers practice at the top of their license, and developing a broader set of providers to serve the healthcare needs of Maine's rural communities.

Key activities within this initiative include:

Activities: Initiative 2	**Potential allocation of $1B ($MM)**
2.1 Training, recruitment and retention	$109.8
2.2 Local Workforce Development and Training Pipelines	$92.9
2.3 Innovation: New Models and Technology	$1.3
Initiative total	$204.0

These activities will build Maine's rural health workforce by expanding rural school-based career programs, training more nurses and allied health professionals with five-year commitments to serve rural areas, and increasing preceptors mentoring students. This initiative will also provide incentives to attract more physicians, clinicians, and advanced practice providers to rural communities, bringing critical care closer to home for rural Mainers.

Initiative 3) **Technology Innovation: Modernizing rural care delivery with digital health technology**

Investments in growing Maine's workforce will be complemented by the third pillar of our strategy: accelerating the connection to and adoption of health-enabling technologies. These technologies will give people better access to their health information, expand care delivery options, and provide local access to world-class specialty expertise.

The core of this initiative is modernizing and interconnecting electronic medical record (EMR) systems among providers serving rural Mainers, recognizing that these platforms often serve as the foundation into which telehealth, AI solutions, consumer tools, and other health technologies are built.

Our strategy recognizes AI as a promising solution for rural health, with opportunities to develop new innovations that could help to overcome many challenges faced by rural providers. This initiative aligns with the RHTP Tech Innovation strategic goal, as it fosters the adoption of innovative technologies that promote efficient care delivery, data security, improved connectivity, and access to digital health tools.

By expanding and strengthening access to and use of telehealth services, this initiative also supports the RHTP Sustainable Access strategic goal by increasing the availability of primary, specialty, behavioral health, oral, and perinatal care to patients in their own home or community, reducing transportation barriers, allowing for flexible scheduling, and providing cost-effective, competent care. This initiative will also support the use of patient-facing digital health applications and remote monitoring programs, providing opportunities to more directly engage individuals in improving their own health care.

Key activities within this initiative include:

Activities: Initiative 3	**Potential allocation of $1B ($MM)**
3.1 Expanded Use of Telehealth Services to Improve Access to Care	$45.8
3.3 Support data integration and reliable exchange of healthcare data	$25.1
3.4 Provide individuals with technology to improve their own health outcomes	$7.0
3.2 Expand the utility, functionality, and security of Electronic Medical Record (EMR) systems	$121.8
3.5 Create Maine Rural AI Hub and Rural Health AI Innovation Institute	$2.5
Initiative total	$202.2

As a result, Maine will increase the percentage of adults who have had a primary care visit delivered via telehealth, the percentage of youth who are accessing behavioral health services via tele-behavioral health (tele-BH), the percentage of practices that gain access to specialty consultations via telehealth, and the percentage in rural practices implementing AI tools.

Initiative 4) **Access: Bridging the healthcare affordability gap for rural Mainers**

Our strategy's fourth pillar protects the long-term accessibility and affordability of rural healthcare in Maine by ensuring hospitals and other providers remain available as reliable access points, supporting the RHTP goal of Sustainable Access.

This initiative will improve access to services via enhanced provider enrollment systems in MaineCare, coordinated use of transportation resources for health and wellness services, the provision of payments to providers serving rural, uninsured Mainers, and improved consumer technology tools that empower CoverME.gov customers to make the best health coverage choices for their needs.

Expanded access to care through provider payments for services to the uninsured will strengthen disease prevention, chronic disease management, and behavioral health outcomes. It will also better enable residents to pursue employment and educational opportunities that increase self-

sufficiency, open long-term health coverage options, and Make Rural America Healthy Again. The Office of MaineCare Services (OMS) will administer this strategy.

Key activities within this initiative include:

Activities: Initiative 4	**Potential allocation of $1B ($MM)**
4.1 Uncompensated Care Payments (Year 1)	$30.3
4.2 Provider Payments for Essential Health Benefits to Uninsured (Years 2-5)	$140.6
4.3 Enable Dynamic Medicaid Provider Enrollment Experience (Years 4-5)	$8.1
4.4 Coordinated Transportation (Years 1-5)	$5.9
4.5 Consumer Transparency Tool for State-Based Marketplace	$1.7
Initiative total	$186.7

This initiative will serve to expand access to chronic disease management, substance use disorder treatment, primary care, and preventive services in rural communities.

Initiative 5) **Sustainable rural health ecosystems: Addressing financial instability of rural providers**

The final pillar of our strategy promotes the long-term resilience of Maine's rural health ecosystem through systems-level incentives and operational strategies that complement the prior initiative's focus on patient-facing barriers to care.

Nearly 40% of Maine's rural hospitals are stand-alone facilities facing significant financial headwinds due to an aging and shrinking population, changes in payer composition, and workforce shortage. This puts them at high risk of service reduction or closure. This initiative aligns with the **Sustainable Access** strategic goal and is designed to stabilize and develop the infrastructure, partnerships, operational structures, and financing models needed to sustain advancements after RHTP funding ends.

Initiative Five begins with the short-term provision of tools and tailored technical assistance to improve the efficiency and financial management of at-risk hospitals serving rural Maine residents. Strategic investments in capital improvements and technology, aligned with these plans, will help these hospitals strengthen their financial stability.

Once financial stability plans and investments are underway, the strategy moves into a second phase: coordinated regional strategic planning to assess community needs, right-size services, build non-hospital care capacity, and enhance collaboration among rural providers.

The strategy also includes two targeted activities to address critical structural needs and improve access to appropriate levels of care for rural residents. The first will coordinate with hospitals to establish a sustainable system for inter-hospital patient transfers. The second will increase inpatient step-down treatment capacity for children with complex behavioral health needs in a psychiatric residential treatment facility (PRTF).

To implement this strategy, Maine DHHS will collaborate with the Office of Affordable Health Care (OAHC), Maine's all-payer claims database (Maine Health Data Organization, MHDO), the Maine Hospital Association (MHA), and behavioral health providers.

Key activities within this initiative include:

Activities: Initiative 5	**Potential allocation of $1B ($MM)**
5.1 Support Hospital Efficiency and Financial Management	$108.2
5.2 Regional Health Ecosystems Planning and Implementation	$73.8
5.3 Multi-Payer Alternative Payment Model (APM) Development	$7.0
5.4 Interfacility Transport System	$5.1
5.5 Access to Full Care Continuum for Children with Complex Behavioral Health Needs	$4.6
Initiative total	$198.6

Implementation

Maine will engage a third-party evaluator to guide continuous learning and assess the plan's effectiveness and impact, as well as with an administrative support entity to ensure efficient and transparent program delivery. Funding for five years of oversight, evaluation, and related activities for Maine's entire RHTP program would total $25.4 million (approximately 2.5% of all funds awarded).

Stability and Resilience in Rural Health Care

As a result of this initiative, Maine will increase regional rural healthcare provider collaboration, the percentage of MaineCare payments that are made through alternative payment models (APMs), the number of hospitals that develop and implement financial management plans, the percentage of Maine children and youth who receive high-acuity behavioral health services in-state, and access to transportation in rural areas.

Because RHTP funding is temporary, planning for financial sustainability is built into every initiative. Maine will use this funding to strengthen capacity, improve system efficiency, and expand access in ways that reduce long-term costs and reliance on emergency care. These steps are intended to stabilize rural providers now and position them for financial durability after the federal funding period concludes.

The RHTP funding comes at a time of permanent and substantial reductions to MaineCare through the federal budget reconciliation bill, cuts that will increase the number of uninsured people and put new pressure on Maine's rural health care systems. This makes the stakes clear: Maine must act now, and we must act with purpose. While the RHTP funding is temporary, the solutions are designed to last. This includes expanding the rural workforce, strengthening provider stability, improving access to behavioral and primary care, and modernizing the infrastructure that connects care across the state.

Support for Maine's Rural Health Transformation Proposal

Maine's proposal is supported by the State's full Congressional Delegation, as well as many other partners across the state. Letters of support were included from 16 organizations, including Consumers for Affordable Health Care, Healthcare Purchaser Alliance of Maine, HealthInfoNet, Maine Chamber of Commerce, Maine Community College System, Maine Community Health Worker Initiative, Maine Council on Aging, Maine EMS, Maine Hospital Association, Maine Public Health Association, Maine Alliance for Addiction and Mental Health Services, Maine Primary Care Association, New England Rural Health Association, Northeast Telehealth Resource Center, University of Maine System, and Wabanaki Public Health & Wellness.

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Appendices

Executive Summary

[To Be Added]

I. INTRODUCTION

The Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State, referred to in this report as the "commission" was established by Resolve 2025, chapter 106. The resolve requires the commission to evaluate potential changes to health care regulations and practices, including: assessing certificate of need laws and their impact on health services, reviewing substantial health care transactions and the role of private equity in hospitals, gathering best practices from other states, and holding public comment sessions for input.

Specifically, the resolve requires the commission to evaluate:

- Potential changes to the State's certificate of need laws, including, but not limited to, expanding the scope of review to the termination or disruption of health care services and changing the monetary thresholds that trigger review;

- Potential legislative changes to require regulatory review and oversight of substantial health care transactions, such as transfers of ownership or control, among hospitals, health care facilities and health care provider organizations; and

- The role of a private equity company or real estate investment trust taking a direct or indirect ownership interest, operational control or financial control of a hospital in the State.

The law directs the commission to submit a report to the Joint Standing Committee on Health Coverage, Insurance and Financial Services no later than December 10, 2025, and authorizes the committee to report out legislation based on the report to the Second Regular Session of the 132nd Legislature. Resolve 2025, chapter 106 was finally passed as an emergency measure effective July 1, 2025. A copy of the commission's authorizing legislation (Resolve 2025, chapter 106) is included in Appendix A.

Pursuant to the resolve, the commission has 15 members: four legislative members and 11 non-legislative members representing interests specifically identified in the resolve. Of the non-legislative members, four members were appointed by the President of the Senate, five members were appointed by the Speaker of the House of Representatives. Members were appointed who have expertise in issues health care services and transactions, including representatives of hospitals and other health care providers, such as independently owned specialty practices, nursing homes or other long-term care facilities; representatives of health insurance consumers, health insurance carriers, and health care purchasers; an expert in the field of certificate of need law or mergers and acquisitions of health care entities; the executive director of the Office of Affordable Health Care of the executive director's designee; and the Commissioner of Health and Human Services or the commissioner's designee. Senator Mike Tipping was named Senate chair and Representative Michelle Boyer was named House chair. The complete membership list of the commission is included in Appendix B.

The commission met four times: October 8, October 22, November 5 and November 17. Meetings were conducted in a hybrid format with participation from commissioner members and presenters taking place in person and through Zoom. The meetings are accessible to the public through live streams on the Legislature's webpage. More information about the commission, including meeting agendas, meeting materials and presentations are posted on the commission's webpage at: https://legislature.maine.gov/commission-to-evaluate-regulatory-review-and-oversight-of-health-care-transactions.

Over the course of four meetings, the commission received and discussed information relating to health care regulations and health care delivery in the state.

At the first meeting, the commission received presentations from commission staff reviewing Resolve 2025, chapter 106 (authorizing legislation for the commission) and the Freedom of Access Act and other proposed legislation that informed the establishment of the commission. William Montejo and Rich Lawrence from the Department of Health and Human Services, Division of Licensing and Certification, also provided an overview of Maine law relative to certificate of need and regulatory oversight of health care transactions. Towards the end of the meeting, members of the public and interested parties were given an opportunity to provide comment on the scope of the commission's review and suggest policy changes.

At the second meeting, the commission received presentations from the following: Assistant Attorney General Christina Moylan, from the Maine Attorney General's Office, on Maine's antitrust laws and the State's role in reviewing for-profit acquisitions of nonprofit health care facilities; Connecticut Senator Saud Anwar, Deputy President Pro Tempore, on the development of Connecticut legislation addressing the role of private equity in health care transactions; and Dr. Zirui Song, associate professor of health care policy and medicine at Harvard Medical School and general internist at Massachusetts General Hospital, on the role of private equity in health care transactions.

Based on the information presented at the first two meetings and after consideration and discussion by commission members, the commission puts forward the following recommendations, which can be found in section III of this report, for consideration by the 132nd Maine Legislature.

II. BACKGROUND

[To Be Added]

III. RECOMMENDATIONS

[To Be Added]

Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Written Comments

Submitted to Commission prior to November 17 Meeting

McCarthyReid, Colleen

From: Keith Knowles <kmknowles123@gmail.com>
Sent: Thursday, November 13, 2025 11:59 AM
To: McCarthyReid, Colleen
Subject: CON System

Dear Members of the Commission,

I live in rural Maine, where access to timely medical care can be a real challenge. We have fewer providers, long drives for appointments, and too often, delays in getting the care we need. I'm grateful you're looking at how our health system is regulated, because for many of us, the current Certificate of Need process makes things harder—not easier.

By limiting who can expand or open facilities, the CON system keeps rural communities from benefiting when new clinics or services are ready to help. Reforming it would mean more choices and shorter wait times for patients like me. I hope you'll make modernizing this process a top priority.

Sincerely,

Keith Knowles, Vassalboro Maine

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McCarthyReid, Colleen

From: Kearsten Crafts <kearstencrafts@gmail.com>
Sent: Thursday, November 13, 2025 2:25 PM
To: McCarthyReid, Colleen
Subject: Concerned Maine Mother

Dear Commission Members,

As a parent raising a family here in Maine, I've seen how difficult it can be to get timely care—especially for kids or aging parents. When health care providers can't expand or open new facilities because of outdated Certificate of Need rules, it's families who pay the price in longer drives, higher costs, and limited options.

I hope your review will lead to meaningful reform of this system. Maine families need a health care network that grows with our needs—not one that's held back by outdated regulations.
Thank you for the time and care you're dedicating to this issue.

With gratitude,
Kearsten Crafts

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McCarthyReid, Colleen

From: 4311 A <superbikegp046@gmail.com>
Sent: Thursday, November 13, 2025 4:33 PM
To: McCarthyReid, Colleen
Subject: CON Impact on Small Business - Thank You

To the Members of the Commission to Evaluate Regulatory Review and Oversight of Health Care Transactions:

As a small business owner here in Maine, I see firsthand how rising health care costs affect working families and local employers. We all want a system that delivers quality care without pushing costs higher. That's why I'm asking you to take a hard look at how the Certificate of Need process impacts access and affordability.

Too often, outdated regulations slow down innovation and prevent new providers from meeting community needs, especially in rural towns. Reforming or streamlining the CON process could lower barriers, encourage investment, and make care more available and affordable across our state.

Thank you for taking this on. Maine's families and small businesses are counting on solutions that make healthcare more efficient and sustainable.

Respectfully,

Aidan Anderson
Owner, Anderson Associates

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McCarthyReid, Colleen

From: Jeff Pierce <jeff@jeffpiercerealty.com>
Sent: Thursday, November 13, 2025 5:17 PM
To: McCarthyReid, Colleen
Subject: Change con process for seniors

Hello Colleen if you could please share this with the healthcare commission

Dear Members of the Commission,

After a lifetime of service here in Maine, I want to spend my retirement years knowing I can count on affordable, quality health care close to home. But too often, care feels out of reach for many. Both in cost and availability.

I appreciate the Commission's work to review Maine's health care oversight system, and I strongly encourage them to update the Certificate of Need laws.

The current rules were meant to control costs but now too often drive them higher by blocking competition. Reform could help make care more affordable and accessible for seniors and families alike.

Thank you for your thoughtful service to our state.

Warm regards,

Hon. Jeffrey K. Pierce

--
Jeff Pierce
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jeff@jeffpiercerealty.com

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Jeff Pierce Realty, Inc.

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McCarthyReid, Colleen

From: Braeden webber <redbraeden@gmail.com>
Sent: Friday, November 14, 2025 10:22 AM
To: McCarthyReid, Colleen
Subject: CON Review

Dear Commission Members,
As a young Mainer building my career and future here, I want to see a health care system that keeps pace with innovation and puts patients first. Our generation expects transparency, fairness, and access-qualities the current Certificate of Need process often fails to deliver.
Modernizing the CON laws could encourage new providers, lower costs, and make care more accessible across Maine. Reform would send a message that our state is ready to embrace a more open, efficient, and patient-centered health care system for years to come.
Thank you for your time and dedication to shaping Maine's future.
Sincerely,
Braeden Webber

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McCarthyReid, Colleen

From: Collin Hovey <hoveycollin@gmail.com>
Sent: Sunday, November 16, 2025 9:34 AM
To: McCarthyReid, Colleen
Subject: Certificate of Need Review

Dear Members of the Commission,

Thank you for your commitment to reviewing Maine's health care oversight system. As someone deeply involved in my local community, I believe it's vital that our regulations promote both quality and access.

The Certificate of Need process was created with good intentions, but today it too often hinders growth and competition. By modernizing these laws, Maine can make health care more responsive, efficient, and equitable for people in every corner of our state.

I appreciate your public service and urge you to consider meaningful reform as part of your recommendations.

Respectfully,
Collin Hovey