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132nd Legislature, First Regular and First Special Sessions

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

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Executive Summary

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 establishment of the commission was recommended by the Joint Standing Committee on Health Coverage, Insurance and Financial Services following consideration of three bills related to the regulatory review and oversight of health care transactions during the First Regular Session of the 132nd Legislature: LD 985, An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts; LD 1578, An Act to Require the Department of Health and Human Services to Review Disruption to or Removal of Health Services; and LD 1972, An Act to Enhance Transparency and Value in Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions. While the committee held public hearings and work sessions on each bill, the committee members felt that there was not adequate time left in the legislative session to allow the committee to fully understand and consider the proposed bills and analyze the policy and legal issues raised by stakeholders. Instead, the committee chose to amend LD 1578 to establish the commission and drafted the resolve so that the substantive duties of the commission reflected the issues raised by these bills.

As finally passed by the Legislature, Resolve 2025, chapter 106 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 commission was chaired by Senator Mike Tipping and Representative Michelle Boyer. Other voting members of the commission were appointed to represent stakeholder interests, including hospitals and other health care providers, such as independently owned specialty practices, nursing homes or other long-term care facilities; health insurance consumers; health insurance carriers; and health care purchasers. The commission also included a member with expertise 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 and the designee of the Commissioner of Health and Human Services or the commissioner's designee.

The commission met five times: October 8th, October 22nd, November 5th, November 17th and December 8th. Over the course of five meetings, the commission used its time to fulfill the duties set forth in its authorizing legislation. During its meetings, the commission received and discussed information relating to the regulatory oversight of health care facilities in Maine and in other states. In addition to the proposed legislation that initiated the establishment of the commission, the current and former authority provided in State law related to the regulatory oversight of health care transactions also informed the commission's work, particularly the Certificate of Need (CON) laws and the authority of the Attorney General to enforce antitrust laws.

At the request of the chairs, individual commission members suggested potential recommendations for consideration by the full commission. The commission discussed each suggested recommendation and took initial straw votes to gauge the commission's interest in continued discussion of each suggestion. The commission focused its consideration on those potential recommendations developed over the course of its meetings that were of interest to all or a majority of commission members present and voting. (As the designee of the Commissioner of Health and Human Services, Commissioner Montejo abstained and did not participate in the commission's straw votes or final votes.) The commission agreed that this report would include only those recommendations that represented the consensus of all members or were supported by a majority of seven or more commission members.

Commission members acknowledge that it was not possible to consider and understand all of the implications and consequences of these recommendations. The recommendations suggested to the Legislature in this report are based on the information available to members at the time of the meetings and the commission encourages the Legislature to engage commission members and other stakeholders in additional discussion before moving forward. Commission members also want to note that it will be important for the Legislature to carefully consider the scope of any proposed legislation, to pay particular attention to how specific terms are defined and to understand the potential impact of these recommendations on the State's existing health care delivery system and infrastructure. With these considerations in mind, the commission provides the following comments and recommendations. Unless otherwise noted, the recommendations reflect the consensus of all commission members.

Potential Changes Related to the Certificate of Need Program

The commission recommends that the Legislature consider the following changes to the Certificate of Need (CON) program.

- **Increase the monetary threshold in current law that requires CON review and approval to establish a new health care facility based on the estimated cost of the facility from $3 million to the 2025 amount as adjusted to reflect the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index and require that the threshold amount for review be adjusted annually based on the change in that index**

- **Codify the voluntary guidance developed by the Department of Health and Human Services, Division of Licensing and Certification to require that hospitals provide at least 120-days' prior notice to the division of a permanent closure of a hospital's labor and delivery unit or of a change in the level of care a hospital provides for maternity and newborn services**

- **Expand the criteria considered during a CON review to include consideration of a proposal's impact on affordability and accessibility of health care for all Maine consumers and provide any additional resources needed to implement the expanded scope of review**

Potential Changes Related to the Regulatory Oversight Over Health Care Transactions

The commission recommends that the Legislature consider the following changes related to the regulatory oversight over health care transactions.

- **Require a health care entity to provide notice to the Attorney General about a pending merger or acquisition at the same time a health care entity is required to notify the Federal Trade Commission in accordance with federal law and regulations**

- **Require that a health care entity provide notice to the State of a transaction between a health care entity and a private equity company, hedge fund or management services organization when a private equity company, hedge fund or management services organization acquires a majority ownership interest in a health care entity or a private equity company, hedge fund or management services organization takes operational control over a health care entity**

- **Develop a regulatory process for review and approval of transactions when a private equity company, hedge fund or management services organization acquires a majority ownership interest in a health care entity or when a private equity company, hedge fund or management services organization takes operational control over a health care entity** *(Commission Vote: 7-6)*

Potential Changes to Address Role of Private Equity Investment in Health Care

The commission recommends that the Legislature consider the following changes to address the role of private equity investment in health care.

- **Expand the scope of CON review when there is a change in ownership of an entity to:**
  - **Review and analyze the extent to which the applicant's ownership structure involves a private equity company or real estate investment trust;**
  - **Require that the department contract with a consultant funded by the applicant to review and investigate the prior activities and conduct of the private equity company or real estate investment trust;**
  - **Authorize the department to consult with the Attorney General; and**

- **Broaden the authority of the department to impose conditions on an applicant and to conduct subsequent reviews following a conditional approval of an applicant for CON**

❖ **Prohibit any private equity company or real estate investment trust from entering any arrangement with a health care entity for the sale and leaseback of the health care entity's main campus or primary location to the private equity company or real estate investment trust**

❖ **Prohibit any transaction involving a health care entity in which the ratio of debt to equity is greater than 50%**
(Commission Vote: 9-4)

❖ **Prohibit any person from interfering with the professional judgment or clinical decision of a licensed health care professional with independent practice authority** *(Commission Vote: 7-6)*

Potential Recommendations with Broader Scope

The commission recommends that the Legislature consider the following recommendations with a broader scope that the members believe will further the purposes of the commission's evaluation of the State's health care delivery system.

❖ **Recommend that the Legislature re-establish statewide health care services planning by increasing coordination and information sharing between state agencies responsible for community health needs assessments, regional public health planning and implementation of the rural health transformation program**

❖ **To the maximum extent possible, recommend use of federal grant funding through the Rural Health Transformation Program to support the sustainability of rural health care providers**

❖ **Prohibit provider non-compete clauses and non-disparagement clauses in contracts with licensed health care professionals** *(Commission Vote: 8-4)*

❖ **Recommend that the Legislature consider the creation of 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** *(Commission Vote: 10-1)*

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 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. Pursuant to Joint Rule 353, an extension of the deadline was granted by the Legislative Council to December 15, 2025. The resolve authorizes the committee to report out legislation based on the report to the Second Regular Session of the 132nd Legislature. A copy of the resolve establishing the commission is included in Appendix A.

Resolve 2025, chapter 106 was finally passed as an emergency measure effective July 1, 2025. Pursuant to the resolve, the commission has 15 members: four Legislators and 11 non-legislative members appointed by the President of the Senate or the Speaker of the House of Representatives to represent interests specifically identified in the resolve. Members were appointed to represent hospitals and other health care providers, such as independently owned specialty practices, nursing homes or other long-term care facilities; health insurance consumers; health insurance carriers; and health care purchasers. The commission also included a member appointed as 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 or 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 five times: October 8th, October 22nd, November 5th, November 17th and December 8th. Materials distributed and reviewed at each meeting, including meeting agendas, meeting materials and presentations, as well as additional background materials, are posted on the commission's webpage at: https://legislature.maine.gov/commission-to-evaluate-regulatory-review-and-oversight-of-health-care-transactions.

II. ESTABLISHMENT OF COMMISSION

The establishment of the commission was recommended by the Joint Standing Committee on Health Coverage, Insurance and Financial Services following consideration of three bills related to the regulatory review and oversight of health care transactions during the First Regular Session and First Special Sessions of the 132nd Legislative. A brief summary of each bill is provided below.

- LD 985, An Act to Impose a Moratorium on the Ownership or Operation of Hospitals in the State by Private Equity Companies or Real Estate Investment Trusts

LD 985 was brought forward to address concerns about the growth of private equity investment in health care facilities in Maine and in other states and how the interests of private equity

investors may negatively impact the delivery of health care services and the financial health of Maine's hospitals. The bill sought to maintain the nonprofit status of Maine's hospitals and to prohibit a private equity company or real estate investment trust from acquiring or increasing an ownership interest or operational or financial control of a hospital until June 15, 2029. After consideration by the committee, the bill was amended to reduce the moratorium from three years to one year so that, while a limited moratorium was in place, the Legislation could have time to study whether to regulate the practices of private equity companies or real estate investment trusts in the State in a more permanent manner. The Legislature enacted the bill as Public Law 2025, chapter 401; the moratorium will expire June 15, 2026.

- LD 1578, An Act to Require the Department of Health and Human Services to Review Disruption to or Removal of Health Services

LD 1578 was brought forward following the closure of labor and delivery units at hospitals in rural areas of the State. Concerns were raised about the lack of public input prior to the closures and about the loss of access to needed maternity and newborn health care service in these communities. As drafted, the bill proposed to provide additional time (after the 3-year period in current law) for the Commissioner of Health and Human Services to conduct a subsequent review following an approval of a certificate of need to ensure the maintenance of health services after a health care facility terminates a health service or changes the delivery of a health services in a manner that causes a significant disruption. LD 1578 was subsequently amended by the committee to replace the bill's language with the proposal to establish the commission; it was finally passed as Resolve 2025, chapter 106.

- LD 1972, An Act to Enhance Transparency and Value in Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions

LD 1972 was a comprehensive proposal drafted with input from the Office of Affordable Health Care. While the proposal did not ban private equity investment, the bill did propose to provide more regulatory oversight over transactions among health care entities, including transactions involving private equity companies and real estate investment trusts, that may not be fully addressed by the current CON law. As drafted, the bill proposed to enact laws governing consequential transactions, such as transfers of ownership or control, among health care entities, including health care providers, health care facilities, provider organizations, pharmacy benefits managers and carriers. It proposed to establish a preliminary and comprehensive review process carried out by the Department of Health and Human Services in consultation with the Office of Affordable Health Care and provide for post-transaction oversight. It also proposed to create provisions governing reporting on the ownership and control of health care entities upon the completion of a transaction. LD 1972 was voted "Ought Not to Pass" by the committee because the issues raised in the bill were incorporated into the commission's duties.

While the committee held public hearings and work sessions on each bill, the committee members felt that there was not adequate time left in the legislative session to allow the committee to fully understand and consider the proposed bills and analyze the policy and legal issues raised by stakeholders. Instead, the committee chose to amend LD 1578 to establish the

commission and drafted the resolve so that the substantive duties of the commission reflect the issues raised by these bills.

As finally passed by the Legislature, Resolve 2025, chapter 106 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 include 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.

III. BACKGROUND ON CURRENT AND FORMER LAWS RELATED TO THE REGULATORY OVERSIGHT OF HEALTH CARE TRANSACTIONS

In addition to the proposed legislation that initiated the establishment of the commission, the current and former authority provided in State law related to the regulatory oversight of health care transactions also informed the commission's work, particularly the Certificate of Need (CON) laws and the authority of the Attorney General to enforce antitrust laws. A brief summary and history, including actions taken by other states, is provided below.

Certificate of Need. Certificate of Need (CON) laws are statutory provisions that govern approval of major capital expenditures and other projects for health care facilities. States with CON programs require a state agency or other entity to approve the creation of new health care facilities or the expansion of an existing facility's services in a specified area. The objective of CON laws is to control health care costs to the State by avoiding unnecessary expansion or duplicative services within an area.

CON originated in New York in 1964 when that state passed the first law implementing CON. In the following decade, 26 states enacted CON laws. These early CON programs regulated capital expenditures of greater than $100,000, facilities expanding bed capacity and facilities establishing or expanding health care services. By 1982, the federal government required states to adopt CON laws similar to the federal model. This resulted in all states, except Louisiana, enacting some form of CON law. The federal mandate was repealed in 1987 and federal funding to states that regulated new health care services receiving Medicare and Medicaid dollars ceased.

Since 1987, states have repealed or modified CON laws in various ways. According to the National Conference of State Legislatures (NCSL), 35 states and Washington, D.C., operate CON programs. The criteria for what requires CON approval and what is subject to CON laws vary widely by jurisdiction.

Under the current Maine CON law, codified in Title 22, chapter 103-A, CON approval from the Department of Health and Human Services is required for the following projects:

- Transfers of ownership of a health care facility or the acquisition by lease, donation or transfer of a health care facility or the acquisition of control of a health care facility;
- Acquisitions of major medical equipment, such as MRI machines;
- Capital expenditures by or on behalf of an existing or new health care facility in excess of certain statutory review thresholds;
- Establishment of a new health care facility;
- Development of any new health service; or
- Increases of over 10% in the licensed bed category of a health care facility, excluding nursing homes.

There are also specific CON requirements that apply to nursing homes or long-term care facilities.

One parameter governing the CON laws in Maine is a monetary threshold that is used in determining whether a CON is required or not. State law establishes monetary thresholds that vary by the project covered. For example, a new health care facility that has an anticipated cost of $3,000,000 or more is subject to a certificate of need. Other covered projects, such as capital expenditures for new or existing hospitals or other healthcare facilities, excluding nursing facilities, have a base monetary threshold of $10,000,000 but are subject to adjustment to account for inflation by the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index.

In determining whether to approve a CON, the Department of Health and Human Services examines several criteria specified in statute. This includes:

- If the applicant is fit, willing and able to provide the services proposed;
- The economic feasibility and sustainability of the proposed project;
- The public need for the proposed project;
- The impact on total health care expenses and examination of alternatives to the project, as well as the impact on access to services;
- The outcomes and community impact of the project or service, including ensuring high quality outcomes and assessing the impact on other service providers; and
- Examining whether the project results in inappropriate increases in service utilization.

The commissioner of the Department of Health and Human Services may conditionally approve an application for a CON, subject to conditions as determined by the commissioner. If so, the commissioner may conduct a subsequent review to ensure compliance with any terms of conditions of approval within three years after the approved activity is undertaken. If, upon

review, the commissioner determines that any terms or conditions of the approval have not been met, the commissioner may take enforcement action as specified in statute.

State law also provides for subsequent review and approval of a previously issued CON if specific circumstances occurring within three years after the previously approved activity is undertaken.

State Health Plan. Until the law's repeal in 2011, the State had a state health planning process that was used in conjunction with CON. That law required a state health plan to set forth a comprehensive, coordinated approach to the development of health care facilities and resources in the State based on statewide cost, equality and access goals and strategies to ensure access to affordable health care, maintain a rational system of health care and to promote the development of the healthcare workforce.

The former law established a capital investment fund which required that resources allocated annually under the CON program did not exceed the monetary cap established for the fund. The process for determining the amount of the fund had to consider the state plan. The state plan was required to be consistent with the requirements of the CON program and to guide the issuance of CON by the State. The law specified that a CON or public financing that affects health care costs could not be provided unless it meets goals and budgets explicitly outlined in the plan. Approval of a CON by the State was conditioned on the project being consistent with the plan and funded within the capital investment fund.

The former law also amended the threshold review amounts of CON projects to require that the monetary threshold must be annually updated by the Commissioner of the Department of Health and Human Services to reflect the change in the Consumer Price Index medical care services index.

As noted, the state health plan law was repealed in 2011. However, the laws governing CON remain in place that require approval before certain projects are pursued by health care entities within the State.

Antirust authority of the Attorney General. The Attorney General (AG), through its Consumer Protection Division, enforces state antitrust laws, including those prohibiting anticompetitive mergers by investigating, suing to enjoin (stop) such deals, and partnering with federal agencies like the Department of Justice and the Federal Trade Commission, aiming to protect consumers from reduced choice and higher prices. Maine's antitrust law is based on federal law, federal guidance and federal case law. The AG can independently bring actions, issue subpoenas and seek injunctions under state law, specifically the Maine Revised Statutes, Title 10, section 1102-A (also known as "Maine's merger law"). Maine's antitrust laws apply to any person engaged in commerce; however, in the context of this study, it is worth noting that the Attorney General is authorized to oversee transactions in the health care market, including vertical and horizontal transactions between health care providers of all types.

The AG also serves as the state's primary watchdog for charities under the Maine Revised Statutes, Title 5, section 194. The law authorizes the AG to ensure funds given to public

charities, including nonprofit hospitals, are used for their intended charitable purposes and to investigate potential fraud, misuse of funds or misleading solicitations. In addition, under the Maine Revised Statutes, Title 5, sections 194-A through 194-K, the AG has specific authority over "conversion transactions" where a charity changes form or merges, particularly large conversions (over $500,000). The AG can investigate non-compliant conversions or applications of funds and take legal action to stop them or get remedies.

IV. COMMISSION PROCESS

Over the course of five meetings, the commission used its time to fulfill the duties set forth in its authorizing legislation as described in section II of this report. During its meetings, the commission received and discussed information relating to the regulatory oversight of health care facilities in Maine and in other states.

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. Toward 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, the commission members were tasked with developing and submitting preliminary recommendations to commission staff who then compiled submissions in preparation for the third meeting on November 5th. The third meeting was primarily a discussion of potential recommendations and straw votes on preliminary recommendations were taken.

The purpose of the fourth meeting was to finalize recommendations and formal votes were taken. However, the commission members determined more time was needed to complete their work; the commission held a fifth meeting on December 8th where commission members reviewed and edited final recommendations. Upon completion of deliberations, the commission puts forward the following recommendations, which can be found in section V of this report, for consideration by the 132nd Maine Legislature.

The commission also wants to acknowledge that the members had a substantive discussion related to proposed changes to CON review of ambulatory surgical centers. One of the commission members, Rep. Foley, is the sponsor of LD 1890, An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need, which has been carried over for consideration in the Second Regular Session of the 132nd Legislature. Rep. Foley discussed his intention to propose an amendment to LD 1890 and outlined the potential changes to the original bill that he is considering.

V. RECOMMENDATIONS

At the request of the chairs, individual commission members suggested potential recommendations for consideration by the full commission. The commission discussed each suggested recommendation at the November 5th meeting and took initial straw votes to gauge the commission's interest in continued discussion of each suggestion. During the November 17th meeting, the commission reviewed the results of the straw votes and focused its consideration on those potential recommendations developed over the course of its previous meetings that were of interest to all or a majority of commission members present and voting. (As the designee of the Commissioner of Health and Human Services, Commissioner Montejo abstained and did not participate in the commission's straw votes or final votes.) The commission agreed that this report would include only those recommendations that represented the consensus of all members or were supported by a majority of seven or more commission members. At the December 8th meeting, the commission reviewed the recommendations that were supported by consensus or formally voted on at the November 17th meeting. More information about all of the potential recommendations considered by the Commission, including the potential recommendations not supported by a majority of the Commission members, the Commission's voting process and the results of straw votes and final votes, can be found in the meeting materials for the Commission's November 5th, November 17th and December 8th meetings.

Commission members acknowledge that it was not possible to consider and understand all of the implications and consequences of these recommendations. The recommendations suggested to the Legislature in this report are based on the information available to members at the time of the meetings and the commission encourages the Legislature to engage commission members and other stakeholders in additional discussion before moving forward. Commission members also want to note that it will be important for the Legislature to carefully consider the scope of any proposed legislation, to pay particular attention to how specific terms are defined and to understand the potential impact of these recommendations on the State's existing health care delivery system and infrastructure. With these considerations in mind, the commission provides the following comments and recommendations. Unless otherwise noted, the recommendations reflect the consensus of all commission members.

Potential Changes Related to the Certificate of Need Program

The commission recommends that the Legislature consider the following changes to the Certificate of Need (CON) program.

- **Increase the monetary threshold in current law that requires CON review and approval to establish a new health care facility based on the estimated cost of the facility from $3 million to the 2025 amount as adjusted to reflect the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index and require that the threshold amount for review be adjusted annually based on the change in that index**

The commission recommends that the CON law be amended to increase the monetary threshold that requires CON review and approval to establish a new health care facility by adjusting the $3 million threshold to the 2025 amount as adjusted by inflation and to require that the threshold amount be adjusted annually based on the change in that index. As required by the Legislature, the commission reviewed the current CON law and noted that the law had not been updated in any significant way for many years. One area the commission focused on during its review was the monetary thresholds in current law that determine whether a particular project affecting Maine's health care delivery system and infrastructure is subject to prior review and approval by the CON program. Under the CON program, there is only one project — the establishment of a new health care facility — that is not updated to reflect any increase due to inflation or a change in construction costs over time. Commission members believe that the monetary threshold for all types of projects subject to CON review should be updated on an annual basis.

In order to be consistent, the commission recommends that the Legislature amend the CON law so that the monetary threshold that triggers CON review prior to the establishment of a new health care facility is increased from $3 million to the 2025 adjusted amount based on the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index. The commission also recommends that the law be amended to require that the threshold be adjusted annually based on any changes to that index in the same way other monetary thresholds in the CON law are adjusted.

- **Codify the voluntary guidance developed by the Department of Health and Human Services, Division of Licensing and Certification to require that hospitals provide at least 120-days' prior notice to the division of a permanent closure of a hospital's labor and delivery unit or of a change in the level of care a hospital provides for maternity and newborn services**

The commission recommends that the Legislature enact legislation to codify the voluntary guidance developed by the Department of Health and Human Services, Division of Licensing and Certification to require that hospitals provide at least 120 days' prior notice to the department of a hospital's permanent closure of a labor and delivery unit or of a change in the level of care a hospital provides for maternity and newborn services. A copy of the DHHS guidance is included as Appendix C. During its meetings, the commission members discussed recent closures of hospital labor and delivery units in rural areas of the State and noted that prior notice of a closure provided the necessary level of transparency to the affected communities but also provided an opportunity for more careful planning to maintain access to maternity and

newborn services. While current law does not require CON review and approval before a hospital terminates health care services, the department has developed guidance asking that hospitals provide at least 120 days' prior notice before closing labor and delivery units. Commissioner Montejo shared that some hospitals were willing to provide notice as provided in the guidance, but not all hospitals have voluntarily complied. Some commission members also noted that, depending on the circumstances, some hospitals were unable to provide 120 days' prior notice. The commission believes it is important for the department and the public to have prior notice of a closure so that the department can engage with the hospital and other health care providers to plan for the loss of these services and take appropriate steps to transition care to other providers.

- **Expand the criteria considered during a CON review to include consideration of a proposal's impact on affordability and accessibility of health care for all Maine consumers and provide any additional resources needed to implement the expanded scope of review**

The commission recommends that the CON law be amended to expand the criteria considered during review of all proposed projects subject to CON review to include consideration of a proposal's impact on the affordability and accessibility of health care for all Maine consumers. The commission learned during its meetings that while the CON review criteria does take into account the financial impact of a proposal on the State's MaineCare program, the review process does not appear to consider and analyze how a proposal may affect health care costs for all Maine consumers, including any impact of those costs on access to services and on health insurance premiums paid by employers and individuals. The commission believes it is important that the CON review process be broadened to include consideration of how a proposal, if approved, may impact the affordability and accessibility of care: How will it affect prices for health care services? How will it increase health insurance premiums? How will it affect access to health care services? The commission noted that it will be important for the Legislature to consider how to define the terms "affordability" and "accessibility" for the purposes of analyzing how a proposal may affect health care costs and access to services. Because the purposes of CON laws are focused on controlling health care costs and determining whether new spending on health care services meets the needs of the community, the commission feels that the CON review process must consider the impact of a proposal on all Maine consumers by evaluating how it may affect the affordability and accessibility of health care overall.

Potential Changes Related to the Regulatory Oversight Over Health Care Transactions

The commission recommends that the Legislature consider the following changes related to the regulatory oversight over health care transactions.

- **Require a health care entity to provide notice to the Attorney General about a pending merger or acquisition at the same time a health care entity is required to notify the Federal Trade Commission in accordance with federal law and regulations**

The commission recommends that the Legislature enact legislation to require that a health care entity provide notice to the Attorney General about a pending merger or acquisition at the same time a health care entity is required to notify the Federal Trade Commission in accordance with federal law and regulations. During its meetings, the commission learned from the Attorney

General's Office that, while the Attorney General has independent authority to enforce antitrust laws if a pending merger or acquisition in any industry may create a monopoly, the Attorney General's Office is not notified prior to a pending merger or acquisition. Under federal law and regulations, entities in all industries are required to notify the Federal Trade Commission of pending mergers or acquisitions valued at $50 million or more as adjusted to inflation; the 2025 threshold is approximately $126.4 million. To that end, the Attorney General's Office told the commission that the Uniform Law Commission has developed the Uniform Pre-Merger Notification Act to require such notices to states as model legislation for states to consider. Given the increased concern about consolidation of the State's health care delivery system and the potential negative impact of private equity financing, the commission believes it is appropriate to require health care entities involved in any large mergers and acquisitions in the State to notify the Attorney General at the same time notice is provided to the Federal Trade Commission. The commission recommends that the Legislature enact legislation to require health care entities to provide prior notice of pending mergers and acquisitions to the Attorney General.

- **Require that a health care entity provide notice to the State of a transaction between a health care entity and a private equity company, hedge fund or management services organization when a private equity company, hedge fund or management services organization acquires a majority ownership interest in a health care entity or a private equity company, hedge fund or management services organization takes operational control over a health care entity**

The commission recommends that the Legislature enact legislation to require that a health care entity provide notice to the State of a transaction between a health care entity and a private equity company, hedge fund or management services organization when a private equity company, hedge fund or management services organization acquires a majority ownership interest in a health care entity or a private equity company, hedge fund or management services organization takes operational control over a health care entity. The commission acknowledged that private equity companies have invested in Maine's health care entities but there is no mechanism for the reporting of these transactions or for the collection of data about these transactions**,** particularly transactions that are not subject to CON review under existing law. Commissioner Montejo noted that certain singular transactions involving changes in ownership are reviewed under the existing CON laws, but that there is no mechanism for notice to the State when multiple transactions that are subsequent to an initial CON review result in a majority ownership interest being acquired or in a change in operational control over a health care entity. The commission also noted that it will be important for the Legislature to consider how these entities are defined, e.g. private equity company, hedge fund and management services organization. The commission believes that it is important for such transactions to be transparent so that State policymakers, regulators and the public know when these transactions occur and that it is necessary to enact legislation to require notice of any transaction.

- **Develop a regulatory process for review and approval of transactions when a private equity company, hedge fund or management services organization acquires a majority ownership interest in a health care entity or when a private equity company, hedge fund or management services organization takes operational control over a health care entity**

A majority[1] of the commission members recommend that the Legislature consider enacting legislation to develop a regulatory process for review and approval of transactions when a private equity company, hedge fund or management services organization acquires a majority ownership interest in a health care entity or when a private equity company, hedge fund or management services organization takes operational control over a health care entity. While all commission members support a statutory requirement to provide notice to the State when these types of transactions occur, the members supporting this recommendation also believe it is important that there be a regulatory process to review and approve these transactions. These members expressed concerns about the consolidation of the State's health care delivery system and the potential negative impact of private equity financing on competition and health care costs. These members also noted that these types of transactions may also negatively impact access to health care services in the State and the quality of health care services delivered to Maine consumers. In putting this recommendation forward, the members suggested that legislation should be enacted to authorize State regulators to provide a mechanism for the State to approve, modify or deny such transactions to address these concerns and to monitor the impact of private equity interests on Maine's health care delivery system. As an example, the Legislature recently considered LD 1972, An Act to Enhance Transparency and Value in Substantial Health Care Transactions by Changing the Review and Approval Process for Those Transactions. The legislation proposed to establish a review process over certain health care transactions, such as transfers of ownership or control, among health care entities, including post-transaction oversight.

Potential Changes to Address Role of Private Equity Investment in Health Care

The commission recommends that the Legislature consider the following changes to address the role of private equity investment in health care.

- **Expand the scope of CON review when there is a change in ownership of an entity to:**
  - **Review and analyze the extent to which the applicant's ownership structure involves a private equity company or real estate investment trust;**
  - **Require that the department contract with a consultant funded by the applicant to review and investigate the prior activities and conduct of the private equity company or real estate investment trust;**
  - **Authorize the department to consult with the Attorney General; and**

[1] The vote in favor of this recommendation was 7-6 of the members present and voting. In favor were Sen. Tipping, Reps. Boyer and Foley and Commissioners Cheff, Ende, Garratt-Reed and Putnoky. Opposed were Commissioners Maguire, Ossenfort, Poitras, Prescott, Vienneau and Westhoff. Commissioner Montejo abstained and Sen. Haggan was absent.

- **Broaden the authority of the department to impose conditions on an applicant and to conduct subsequent reviews following a conditional approval of an applicant for CON**

The commission recommends that the Legislature enact legislation to amend the scope of CON review when there is a change in ownership of a health care entity. The members recommend that there should be increased scrutiny using the existing CON process when there is a change in ownership of a health care entity to review and analyze the extent to which the applicant's ownership structure involves a private equity company or real estate investment trust. As part of this enhanced CON review, the members recommend that the department be required to contract with a consultant funded by the CON applicant to review and investigate the prior activities and conduct of the private equity company or real estate investment trust and that the department be authorized to consult with the Attorney General and to have broader authority to impose conditions on an applicant, including post-transaction reviews following a conditional approval. While the current CON law provides some authority to the department to impose certain conditions, Commissioner Montejo noted the department's authority for subsequent review of previously approved transactions is generally limited to the three years following approval.

❖ **Prohibit any private equity company or real estate investment trust from entering any arrangement with a health care entity for the sale and leaseback of the health care entity's main campus or primary location to the private equity company or real estate investment trust**

The commission recommends[2] that the Legislature enact legislation to prohibit any private equity company or real estate investment trust from entering into any arrangement with a health care entity for the sale and leaseback of the health care entity's main campus or primary location to the private equity company or real estate investment trust. During its meetings, the commission learned that this type of practice by a private equity company or real estate investment trust contributed to the significant financial difficulties and closures of several hospitals in Massachusetts and has also led to problems in other states. The commission members believe that a health care entity's main campus or primary location should not be used as part of a sale and leaseback arrangement because of the potential financial risk to a health care entity if it is not able to manage the debt payments required for such a transaction. The commission agrees that it is appropriate to ban this practice to protect health care entities from experiencing the financial problems caused by this practice in other states.

❖ **Prohibit any transaction involving a health care entity in which the ratio of debt to equity is greater than 50%**

A majority[3] of the commission members recommend that the Legislature enact legislation to prohibit any transaction involving a health care entity in which the ratio of debt to equity is

[2] Following the Commission's unanimous vote, Commissioner Westhoff raised concern at the December 8 meeting about how a statutory ban on this type of sale and leaseback may impact existing contractual arrangements already in place involving long-term care entities.

[3] The vote in favor of this recommendation was 9-4 of the members present and voting. In favor were Sen. Tipping, Rep. Boyer and Commissioners Cheff, Ende, Garratt-Reed, Ossenfort, Poitras, Prescott and Putnoky. Opposed were Rep. Foley and Commissioners Maguire, Vienneau and Westhoff. Commissioner Montejo abstained and Sen. Haggan was absent.

greater than 50%. During its meetings, these commission members noted that transactions engaged in by private equity companies and real estate investment trusts in other states with an unbalanced debt to equity ratio have led to financial failures and closures of health care entities. The commission members supporting this recommendation believe that a private equity company or real estate investment trust that seeks to invest in health care entities located in Maine should be required to maintain a 50/50 ratio of debt to equity so that these transactions do not transfer significant amounts of debt to Maine health care entities that would endanger them financially and put them at risk of closure. The commission members in support of this recommendation agree that it is appropriate to prohibit transactions that have a debt-to-equity ratio greater than 50% to minimize the financial risk to Maine's health care entities.

- **Prohibit any person from interfering with the professional judgment or clinical decision of a licensed health care professional with independent practice authority**

A majority[4] of the commission members recommend that the Legislature enact legislation to prohibit any person from interfering with the professional judgment or clinical decision of a licensed health care professional with independent practice authority. The members supporting this recommendation expressed concern about the potential risks to the professional judgment or clinical decision of health care professionals in Maine if private equity companies or management services organizations establish management practices or policies that may have a negative impact on the ability of a licensed health care professional to practice independently and deliver patient care. The commission reviewed similar legislation proposed or enacted in other states to address this issue; an overview of the statutory language used in that legislation is included as Appendix D.

Potential Recommendations with Broader Scope

The commission recommends that the Legislature consider the following recommendations with a broader scope that the members believe will further the purposes of the commission's evaluation of the State's health care delivery system.

- **Recommend that the Legislature re-establish statewide health care services planning by increasing coordination and information sharing between state agencies responsible for community health needs assessments, regional public health planning and implementation of the rural health transformation program**

The commission recommends that the Legislature enact legislation to reestablish a statewide planning process for health care services. Until the law's repeal in 2011, the State required the development of a statewide health plan and the Commissioner of Health and Human Services was required to consider the state health plan when making decisions during the CON review process, such as whether to approve new health care facilities, expand health care services or make capital expenditures and investments in health care facilities or medical equipment. The commission believes such a planning process may enhance coordination and communication

[4] The vote in favor of this recommendation was 7-6 of the members present and voting. In favor were Sen. Tipping and Reps. Boyer and Foley and Commissioners Ende, Garratt-Reed, Ossenfort and Putnoky. Opposed were Commissioners Maguire, Ossenfort, Poitras, Prescott, Vienneau and Westhoff. Commissioner Montejo abstained and Sen. Haggan was absent.

among the state agencies that make health care-related planning and regulatory decisions to ensure that the State's health care delivery system and infrastructure can meet the needs of all Maine consumers to ensure access to needed health care services. It is important that the criteria for CON review include consideration of the most current information and strategic planning for statewide public health and health needs.

- **To the maximum extent possible, recommend use of federal grant funding through the Rural Health Transformation Program to support the sustainability of rural health care providers**

The commission recommends that the State use any federal grant funding received under the federal Rural Health Transformation Program to support the sustainability of rural health providers to the maximum extent possible. During the commission's work, the Department of Health and Human Services and the Governor's Office of Policy Innovation and the Future were working to develop the State's application for the Rural Health Transformation Program. Rural hospitals in the State face increasing financial pressures to maintain services and commission members are concerned about the potential for hospital closures. The commission believes that the State needs to make every effort to ensure the sustainability of rural health care providers, particularly in the most rural areas of the State. The commission strongly suggests that the sustainability of rural health providers must be a high priority under the federal Rural Health Transformation Program and targeted supports, including financial assistance, must be focused on maintaining access to health care services in the most rural areas of the State.

- **Prohibit provider non-compete clauses and non-disparagement clauses in contracts with licensed health care professionals**

A majority[5] of the commission members recommend that the Legislature enact legislation to prohibit provider non-compete clauses and non-disparagement clauses in contracts with licensed health care professionals. The commission noted that Maine law prohibits non-compete clauses in certain contracts with veterinarians and Sen. Tipping explained that the Legislature acted in that area because concerns were raised about a loss of access to veterinary care. A majority of the commission members believe that the ability of licensed health care professionals should not be restricted by non-compete clauses and that providers should not be restricted from speaking about the employment practices of health care providers that may have led to changes in employment, especially if the health and safety of patients may be at risk. Members suggested that physicians and other licensed health care professionals should not be restricted in the areas they practice because it is important to maintain access to care, especially in rural areas. While members recognized that employers of physicians and other health care professionals have invested significant resources in their employees, these financial factors did not persuade a majority of members that employers should not be able to use non-compete clauses in their contracts. The members supporting this recommendation also believe that physicians and other licensed health care professionals should be able to raise concerns about any potential negative

[5] The vote in favor of this recommendation was 8-4 of the members present and voting. In favor were Sen. Tipping, Rep. Boyer and Commissioners Cheff, Ende, Garratt-Reed, Maguire, Putnoky and Westhoff. Opposed were Rep Foley and Commissioners Ossenfort, Poitras and Prescott. Commissioner Montejo abstained and Sen. Haggan and Commissioner Vienneau were absent.

impacts they have identified when private equity companies or management services organizations participate in the State's health care delivery system.

- **Recommend that the Legislature consider the creation of 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**

A majority[6] of the commission members recommend that the Legislature consider the creation of a task force to study the demand for long-term care in the State to determine the appropriate number of long-term care beds that are needed and to increase the capacity for long-term care beds statewide to meet those needs. The commission members supporting this recommendation agreed that long-term care is an urgent priority given Maine's demographics. Current federal and State requirements related to long-term care bed capacity, to reimbursement rates for care and to staffing ratios limit the ability of long-term care providers to expand or to build new facilities to meet the demand for long-term care services throughout the State. The members believe that planning for long-term care needs is unique and that policymakers should address policy questions about the sustainability of the State's long-term care infrastructure separately.

[6] The vote in favor of this recommendation was 10-1 of the members present and voting. In favor were Sen. Tipping, Rep. Foley and Commissioners Cheff, Ende, Maguire, Ossenfort, Poitras, Prescott, Putnoky and Westhoff. Opposed was Rep. Boyer. Commissioners Garratt-Reed and Montejo abstained, and Sen. Haggan and Commissioner Vienneau were absent.

APPENDIX A

Authorizing Legislation: Resolve 2025, chapter 106

APPROVED
JULY 1, 2025
BY GOVERNOR

CHAPTER
106
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-FIVE

H.P. 1036 - L.D. 1578

Resolve, to Establish 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

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this resolve establishes a 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; and

Whereas, the Legislature believes it is important to conduct this evaluation because the State's health care delivery system faces significant financial and workforce challenges; and

Whereas, this legislation must take effect as soon as possible in order to provide adequate time for the commission to complete its work in a timely manner before submitting its report; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That 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 resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 15 members appointed as follows:

1. Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature, appointed by the President of the Senate;

2. Two members of the House of Representatives, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature, appointed by the Speaker of the House;

3. Two members representing hospitals, one member appointed by the President of the Senate and one member appointed by the Speaker of the House;

4. Two members representing health care providers, one of whom must represent an independently owned specialty practice and is appointed by the President of the Senate and the other of whom is appointed by the Speaker of the House;

5. One member representing a statewide association of nursing homes or other long-term care facilities, appointed by the President of the Senate;

6. One member of the public representing health insurance consumers, appointed by the Speaker of the House;

7. One member representing health insurance carriers, appointed by the President of the Senate;

8. One member representing a statewide association of health care purchasers, appointed by the Speaker of the House;

9. One member of the public who is a lawyer who has practiced in the field of certificate of need law or mergers or acquisitions of health care entities, appointed by the Speaker of the House;

10. The executive director of the Office of Affordable Health Care or the executive director's designee; and

11. The Commissioner of Health and Human Services or the commissioner's designee.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

Sec. 5. Duties. Resolved: That the commission shall:

1. 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;

2. Evaluate 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;

3. Evaluate 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; and

4. Examine any other issues to further the duties and purposes of the study.

The commission shall review and identify best practices learned from similar efforts in other states. The commission may hold hearings and invite testimony from experts and the public to gather information.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Stakeholder participation. Resolved: That the commission may invite the participation of stakeholders to participate in meetings or subcommittee meetings of the commission to ensure the commission has the information and expertise necessary to fulfill its duties, including the Maine Health Data Organization.

Sec. 8. Report. Resolved: That, notwithstanding Joint Rule 353, no later than December 10, 2025, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health Coverage, Insurance and Financial Services. The joint standing committee may report out legislation based on the report to the Second Regular Session of the 132nd Legislature.

Sec. 9. Outside funding. Resolved: That the commission may seek funding contributions to contribute to the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership List: 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

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

Resolve 2025, c. 106

MEMBERSHIP LIST

Name	Representation
Sen. Mike Tipping	Member of the Senate, including one member of the party holding the largest number of seats, appointed by the President of the Senate
Rep. Michelle Boyer	Member of the House of Representatives, including one member of the party holding the largest number of seats, appointed by Speaker of the House
Sen. David Haggan	Member of the Senate, including one member of the party holding the 2nd largest number of seats, appointed by the President of the Senate
Rep. Robert A. Foley	Member of the House of Representatives, including one member of the party holding the 2nd largest number of seats, appointed by Speaker of the House
Susan Cheff	Member representing health care providers, appointed by Speaker of the House
Kate Ende	Member of the public representing health insurance consumers, appointed by Speaker of the House
Adam Prescott	Member of the public who is a lawyer who has practiced in the field of certificate of need law or mergers or acquisitions of health care entities, appointed by the Speaker of the House
Trevor Putnoky	Member representing a statewide association of health care purchasers, appointed by the Speaker of the House
Marie Vienneau	Member representing hospitals, appointed by the Speaker of the House
Angela Cole Westhoff	Member representing a statewide association of nursing homes or other long-term care facilities, appointed by the President of the Senate
Kristine M. Ossenfort, Esq.	Member representing the insurance carriers, appointed by the President of the Senate
Christina Maquire	Member representing hospitals, appointed by the President of the Senate
Roger Poitras	Member representing an independently owned specialty health care practice, appointed by the President of the Senate
William Montejo	Designee of the Commissioner of Health and Human Services
Meg Garratt-Reed	Executive Director of the Office of Affordable Health Care

APPENDIX C

Department of Health and Human Services Guidance on Notice of Maternity and/or Newborn Care Changes

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
286 Water Street
Augusta, Maine 04333-0011
Tel; (207) 287-8016; Fax (207) 287-9058
TTY: Dial 711 (Maine Relay)

Notice of Maternity and/or Newborn Care Changes

Purpose statement: The purpose of this policy is to ensure the Department of Health and Human Services (DHHS), surrounding hospitals, local EMS, fire and law enforcement services and registered patients are notified when a Maine birthing hospital either temporarily or permanently changes the maternity and newborn services they offer.

Policy background: In 2020-21, DHHS underwent the process of assessing the maternity and newborn Levels of Care (LOC) with each hospital in the State of Maine. The hospitals offering labor and delivery services and newborn care provided information to DHHS, which outlined their resources and capacity to provide care, and a joint determination between DHHS and the hospitals was done to determine the appropriate LOC (1, 2, 3, or 4) for each service. The LOC are publicly posted on the Maine CDC website.

There are times when a hospital may need to suspend or close the labor and delivery department or change the LOC they are providing. The Department requests an opportunity to review capacity and resources with the licensee as the LOC is a joint determination. This information will be used by surrounding communities to identify the closest hospital that offers the appropriate LOC needed by pregnant people and/or newborn at any given time.

Temporary or Permanent Termination of Maternity and/or Newborn Care

Hospitals should provide notice of temporary closure at least 30 days prior to the effective date, and 120 days prior to the effective date, for a permanent termination of service, In cases when such notice cannot be done, the hospital should provide notice soon as reasonably practical for a temporary termination of service, by sending a Change in Service Notification to the Maine Department of Health and Human Services Division of Licensing and Certification (DLC) State House Station #11 41 Anthony Avenue Augusta, ME 04333. DLC will share the notice of closure information received with the DHHS Child Health Officer and the Maine CDC Maternal and Child Health Program Director. The notice should include:

- Hospital Name;
- Contact Person with Name, Title, Email, and Phone Number;
- Date/Time of change;
- Statement noting whether the notice is for Temporary or Permanent Termination of Service and the Reason for Termination;
- A list and description of notifications sent to:
    - Surrounding hospitals within 50 miles and Level 2/3/4 Newborn Nurseries
    - All local EMS, fire, and law enforcement services
    - All registered patients that are affected by the change
- How the hospital provided public notification;
- Plan for emergency care; and

- The hospital's plan for policy and procedure development and review around maternity emergencies for the hospital and local EMS agencies, including a plan for training Emergency Department and Family Practice staff on emergency obstetric care that incorporates teaching with didactic and simulation, if one exists. It is recommended that each hospital adopts one, however, if your hospital does not have one, please state that in the notification letter.

Change in Level of Care for Maternity and Newborn Services (Level 1, 2, 3, or 4)

Provide notice of at least 30 days and within 120 days notice for a proposed change in LOC to the Maine CDC Maternal and Child Health Program Director who will notify the DHHS Chief Child Health Officer. The notice should include:

- Hospital Name;
- Contact Person with Name, Title, Email, and Phone Number;
- Date/Time of proposed change; and
- An outline for the proposed change in LOC and reasons for change.

The Maine CDC Maternal and Child Health Program Director will schedule a virtual or on-site meeting with the hospital to review the proposed change in LOC. The meeting will include the Maine CDC Maternal and Child Health Program Director, a Neonatologist, a Maternal-Fetal Medicine provider, the Maine CDC Perinatal Nurse Outreach Educator, the DHHS Chief Child Health Officer, and representatives from the hospital who should include the Medical and Nursing Directors of the Newborn Nursery and Maternity Service, Respiratory Therapy, and the Quality Assurance Office. The Maine CDC may ask the hospital to complete the Federal CDC LOCATe tool to assess the proposed LOC, if this tool was not completed within the last two years.

After meeting with the hospital and the Maine CDC to discuss the LOC designation and agreement is reached on the level of care, the hospital should send notifications to:

- Surrounding hospitals within 50 miles and Level 2/3/4 Newborn Nurseries
- All local EMS, fire, and law enforcement services
- All registered patients that are affected by the change
- Public notification to include ensuring notice is posted on hospital website

Additionally, the Maine CDC will update the map of Birthing Hospitals with Levels of Care that is publicly posted on their website and this document with the new Levels of Care. The Maine CDC will notify the EMS-Children (EMS-C) coordinator at Maine EMS of the changes so they can share the updated information with EMS organizations. The Maine CDC Perinatal Nurse Outreach Educator will notify the Perinatal Nurse Leadership Group with this updated document.

DocuSigned by:
Maryann Harakall
52C621591FE3412...

Maryann Harakall, MPPM
MCH Program Director

DocuSigned by:
Jamie Cotnoir
8290E62E1F644CC...

Jamie Cotnoir
Associate Director, Division of Disease Prevention

APPENDIX D

Examples of Legislation Proposing to Prohibit Interference with Licensed Professionals' Clinical Judgment

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

Examples Of Legislation Proposing to Prohibit Interference with Licensed Professionals' Clinical Judgement

State Legislation or Model Legislation	Excerpt of Legislative Language
Oregon SB 951(enacted)	[ ], a management services organization or a shareholder, director, member, manager, officer or employee of a management services organization may not: (H) Exercise de facto control over administrative, business or clinical operations of a professional medical entity in a manner that affects the professional medical entity's clinical decision making or the nature or quality of medical care that the professional medical entity delivers, which de facto control includes, but is not limited to, exercising ultimate decisionmaking authority over: (i) Hiring or terminating, setting work schedules or compensation for, or otherwise specifying terms of employment of medical licensees; (ii) Setting clinical staffing levels, or specifying the period of time a medical licensee may see a patient, for any location that serves patients; (iii) Making diagnostic coding decisions; (iv) Setting clinical standards or policies; (v) Setting policies for patient, client or customer billing and collection; (vi) Advertising a professional medical entity's services under the name of an entity that is not a professional medical entity; (vii) Setting the prices, rates or amounts the professional medical entity charges for a medical licensee's services; or (viii) Negotiating, executing, performing, enforcing or terminating contracts with third party payors or persons that are not employees of the professional medical entity.
CA AB 3129 (vetoed)	A private equity group or hedge fund involved in any manner with a physician, psychiatric, or dental practice doing business in this state, including as an investor in that physician, psychiatric, or dental practice or as an investor or owner of the assets of that practice, shall not do either of the following with respect to that practice: (1) Interfere with the professional judgment of physicians, psychiatrists, or dentists in making health care decisions, including any of the following:

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

State Legislation or Model Legislation	Excerpt of Legislative Language
	(A) Determining what diagnostic tests are appropriate for a particular condition. (B) Determining the need for referrals to, or consultation with, another physician, psychiatrist, dentist, or licensed health professional. (C) Being responsible for the ultimate overall care of the patient, including treatment options available to the patient. (D) Determining how many patients a physician, psychiatrist, or dentist shall see in a given period of time or how many hours a physician, psychiatrist, or dentist shall work. (2) Exercise control over, or be delegated the power to do, any of the following: (A) Owning or otherwise determining the content of patient medical records. (B) Selecting, hiring, or firing physicians, psychiatrists, dentists, allied health staff, and medical assistants based, in whole or in part, on clinical competency or proficiency. (C) Setting the parameters under which a physician, psychiatrist, dentist, or physician, psychiatric, or dental practice shall enter into contractual relationships with third-party payers. (D) Setting the parameters under which a physician, psychiatrist, or dentist shall enter into contractual relationships with other physicians, psychiatrists, or dentists for the delivery of care. (E) Making decisions regarding coding and billing procedures for patient care services. (F) Approving the selection of medical equipment and medical supplies for the physician, psychiatric, or dental practice.
MA S 2871 (proposed)	(2) Health care facilities or entities that hold a license issued by the department of public health pursuant to sections 51, 51M, 51N or 52 of chapter 111, providers and provider organizations shall not, themselves or through a management services organization that the provider organization fully or partially owns or controls, directly or indirectly interfere with, control or otherwise direct the professional judgment or clinical decisions of clinicians with independent practice authority who receive compensation, including, but not limited to, as employees or independent contractors, from the health care facility, provider, provider organization or an entity that the provider

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

State Legislation or Model Legislation	Excerpt of Legislative Language
	organization fully or partially owns or controls. Conduct prohibited under this paragraph shall include, but not be limited to, controlling, either directly or indirectly, through discipline, punishment, threats, adverse employment actions, coercion, retaliation or excessive pressure, regarding: (i) the amount of time spent with patients, including the time permitted to triage patients in the emergency department or evaluate admitted patients; (ii) the time period within which a patient must be discharged; (iii) decisions involving the patient's clinical status, including, but not limited to, whether the patient should be kept in observation status, whether the patient should receive palliative care and where the patient should be placed upon discharge; (iv) the diagnosis, diagnostic terminology or codes that are entered into the medical record; or (v) any other conduct the department of public health determines by regulation would interfere with, control or otherwise direct the professional judgement or clinical decisions of clinicians with independent practice authority.
Connecticut SB 1507 (proposed)	(b) No health care facility or entity that holds a license issued by the Department of Public Health or the Department of Mental Health and Addiction Services and no management services organization shall directly or indirectly interfere with, control or otherwise direct the professional judgment or clinical decisions of a health care practice or a clinician with independent practice authority who provides health care services at or through such facility or entity or at or through a health care practice. (c) Conduct prohibited under subsection (b) of this section shall include, but need not be limited to, controlling, either directly or indirectly, through discipline, punishment, threats, adverse employment actions, coercion, retaliation or excessive pressure any of the following: (1) The amount of time spent with patients or the number of patients seen in a given time period, including, but not limited to, the time permitted to triage patients in the emergency department or evaluate admitted patients; (2) the time period within which a patient must be discharged;

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

State Legislation or Model Legislation	Excerpt of Legislative Language
	(3) decisions involving the patient's clinical status, including, but not limited to, whether the patient should be kept in observation status, whether the patient should receive palliative care and where the patient should be placed upon discharge; (4) the diagnosis, diagnostic terminology or codes that are entered into the medical record; (5) the appropriate diagnostic test for medical conditions; or (6) any other conduct the Department of Public Health determines would interfere with, control or otherwise direct the professional judgment or clinical decision of a clinician with independent practice authority.
NASHP model legislation	(F) Ban on Relinquishing Control of the Medical Practice i. A medical practice may not by means of a contract or other agreement or arrangement, by providing in the medical practice's articles of incorporation or bylaws, by forming a subsidiary or affiliated entity or by other means, relinquish control over or otherwise transfer de facto control over any of the medical practice's administrative, business or clinical operations that may affect clinical decision-making or the nature or quality of medical care that the medical practice delivers. ii. Conduct prohibited under paragraph (i) of this subsection includes, but is not limited to, relinquishing ultimate decision-making authority over: a. Hiring or terminating, setting work schedules and compensation, or otherwise specifying terms of employment of employees who are licensed to practice medicine in this state or who are licensed in this state as physician assistants or nurse practitioners; b. The disbursement of revenue generated from physician fees and other revenue generated by physician services.

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	c. Collaboration and negotiation with hospitals and other institutions in which the licensees of the medical practice may deliver clinical care, particularly with regard to controlling licensee schedules as a means of discipline. d. Setting staffing levels, or specifying the period of time a licensee may see a patient, for any location that serves patients; e. Making diagnostic coding decisions; f. Setting clinical standards or policies; g. Setting policies for patient, client, or customer billing and collection; h. Setting the prices, rates, or amounts the medical practice charges for a licensee's services; or i. Negotiating, executing, performing, enforcing, or terminating contracts with third-party payors or persons that are not employees of the medical practice. iii. The conduct described in paragraph (ii) of this subsection do not prohibit: a. Collection of quality metrics as required by law or in accordance with an agreement to which the medical practice is a party; or b. Setting criteria for reimbursement under a contract between the medical practice and an insurer or payer or entity that otherwise reimburses the medical practice for medical care. Notwithstanding subparagraph (i) of this subsection, a medical practice may delegate administrative, business, or clinical operations described in subparagraph (ii) of this subsection to a managed services organization, provided that (a) the medical practice's shareholder agreement bestows this delegation authority exclusively to the majority of shareholders who are licensee-owners, and (b) such delegation does not relinquish de facto control of the medical practice to non-licensees.