An Act To Repeal the Certificate of Need Requirement for Hospitals

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

Sec. 1. 22 MRSA c. 103-A, as amended, is repealed.

Sec. 2. 22 MRSA §1708, sub-§3, ¶D, as amended by PL 2013, c. 594, §1, is repealed.

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

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

Sec. 4. 22 MRSA §1715, sub-§1, ¶A, as corrected by RR 2001, c. 2, Pt. A, §34, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 8. 24-A MRSA §4204, sub-§1, as amended by PL 2003, c. 510, Pt. A, §20 and c. 689, Pt. B, §6, is repealed.

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

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

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

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

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

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

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

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

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

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

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

(iv) Confidentiality policies and procedures;

(v) A system of ongoing evaluation activities;

(vi) A system of focused evaluation activities;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The adequacy of working capital;

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

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

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

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

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

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

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

I. If any agreement, as set forth in paragraph D, subparagraph (2), division (c), is made by the health maintenance organization, the entity executing the agreement with the health maintenance organization must demonstratedemonstrates to the superintendent's satisfaction that the entity has sufficient unencumbered surplus funds to cover the assured payments under the agreement, otherwise the superintendent shall disallow the agreement. In considering approval of such an agreement, the superintendent shall consider the entity's record of earnings for the most recent 3 years, the risk characteristics of its investments and whether its investments and other assets are reasonably liquid and available to make payments for health services.;

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

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

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

O. EachThe health maintenance organization shall provideprovides basic health care services.

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

Sec. 10. 24-A MRSA §4225, as amended by PL 1975, c. 293, §4 and enacted by c. 503 and amended by PL 2003, c. 689, Pt. B, §7, is further amended to read:

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

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

Sec. 11. 24-A MRSA §6203, sub-§1, ¶A, as amended by PL 2003, c. 510, Pt. A, §22, is further amended to read:

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

Sec. 12. 24-A MRSA §6203, sub-§1, ¶G, as enacted by PL 1995, c. 452, §11, is amended to read:

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

Sec. 13. 24-A MRSA §6203, sub-§2, as amended by PL 1995, c. 452, §§12 to 16, is further amended to read:

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

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

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

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

G. The provider certifies to the superintendent either:

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

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

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

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

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

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

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

Sec. 14. 24-A MRSA §6203, sub-§6, as amended by PL 2003, c. 155, §1, is further amended to read:

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

Notwithstanding this subsection, a life-care community that holds a final certificate of authority from the superintendent and that was operational on November 18, 2002 and that is barred from seeking reimbursement or financial assistance under the MaineCare program from a state or federal agency may

continue to admit nonresidents of the community to its skilled nursing facility after its first 3 years of operation with the approval of the superintendent. A life-care community that admits nonresidents to its skilled nursing facility as permitted under this subsection may continue to admit nonresidents after its first 3 years of operation only for such period as approved by the superintendent after the superintendent's consideration of the financial impact on the life-care community and the impact on the contractual rights of subscribers of the community.

Sec. 15. 24-A MRSA §6226, as amended by PL 2003, c. 510, Pt. A, §23, is repealed.

Sec. 16. 24-A MRSA §6951, sub-§6, as enacted by PL 2003, c. 469, Pt. A, §8, is amended to read:

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

Sec. 17. 35-A MRSA §10122, as enacted by PL 2011, c. 424, Pt. A, §6 and affected by Pt. E, §1, is amended to read:

§ 10122.Health care facility program

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

Sec. 18. 38 MRSA §1310-X, sub-§4, ¶A, as amended by PL 2003, c. 551, §17, is further amended to read:

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

SUMMARY

Under current law, before introducing additional health care services and procedures in a market area, a person must apply for and receive a certificate of need from the Department of Health and Human Services. This bill eliminates that requirement.