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AUGUSTA, MAINE 04333-0002
(207) 287-1440
MAINE RELAY 711

Robert A. Foley
57 Shady Lane
Wells, ME 04090
Robert.Foley@legislature.maine.gov
Residence: (207) 590-2144

Testimony on

L.D. 1890, "*An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need*"

Presented by
Representative Robert A. Foley
District 145

Health Coverage, Insurance, and Financial Services Committee
Wednesday, January 7, 2026

Good afternoon, Senator Bailey, Representative Mathieson, and fellow members of the Joint Standing Committee on Health Coverage, Insurance, and Financial Services:

I am State Representative Bob Foley, and I represent the citizens of District 145, which is most of the Town of Wells. I am here today to introduce a bill that was carried over from last session, L.D. 1890, "***An Act to Facilitate the Development of Ambulatory Surgical Facilities by Exempting Certain Facilities from the Requirement to Obtain a Certificate of Need.***" I have submitted an amendment that replaces the original bill and title, setting a new monetary limit that triggers a certificate of need (CON) review rather than a complete exemption.

The CON law was updated in 2012 and set new dollar limits on certain types of medical facilities requiring a CON review. One such category was for new healthcare facilities, which include ambulatory surgical facilities, among other similar, stand-alone treatment facilities.

The established limit was set at $3 million. Unlike the other categories, new healthcare facilities were not indexed to annual adjustments based on medical inflation. As a result, despite the increased costs of construction, medical equipment, and related materials, the $3 million limit still exists today. My amended proposal establishes a new limit set at $5 million and indexes it going forward, like all other categories within the CON statute.

Why $5 million? I have included a chart of how I calculated the $5 million limit. Based on the starting limit of $3 million and calculating the compound medical cost inflation index from 2012 to 2025, which averaged 3.9%. Using 4% for the 13 years came to $4.99 million.

Why is this important? Ambulatory surgical centers provide out-patient medical services at a considerable savings compared to hospital surgical settings. One of the drivers of today's insurance premium increases is the rising costs of medical treatment.

I have attached for your review a white paper written by Dr. Brien Walton, an economic development strategist and a distinguished professor of business and innovation at Husson University. His research concludes that encouraging the development of ambulatory surgical

Over, please

centers throughout the country has led to significant savings in the healthcare field, increased timely access to medical procedures, and expanded access to rural, underserved communities.

My own research, using Maine Health Data Organization (MHDO) figures, suggests similar economic findings expressed in Dr. Walton's research.

I reviewed three outpatient surgeries. The findings were as follows.

- Arthroscopy of knee - Maine average costs $20,692, with a high of $36,304 in a hospital surgical center to a low of $8,611 at an ambulatory surgical center (ASC) -- a 58% savings.
- Knee replacement - Maine average $49,676, with a high of $66,694 in a hospital surgical center to a low of $28,230 at an ASC -- a 43% savings.
- Hip replacement - Maine average $50,865, with a high of $64,035 at a hospital surgical center to a low of $32,671 at an ASC -- a 36% savings.

Dr. Walton found that by increasing the limit under the CON statute to reflect today's costs will encourage competition and expand rural access without sacrificing quality of care. In his report, Dr. Walton notes that New Hampshire recently dropped the certificate of need process and saw several new ASC facilities developed in many rural parts of the state, especially in Grafton County. Vermont also changed its CON laws regarding ASCs and raised the limit to $10 million.

In a March 8, 2024 report from the American Academy of Orthopedic Surgeons, it was found that there is, on average, a 21% savings between procedures performed at an ASC versus in a hospital surgical facility. If we are to address the costs of health insurance premiums, we must start to drive down the higher costs of medical care where possible. Ambulatory surgical centers are but one answer.

Also in this category are independent radiology centers, kidney disease treatment centers, rehabilitation facilities, cardiac catheterization centers, and independent cancer treatment centers. I have told you my own story when I needed an MRI of my shoulder, which my insurance company denied. When I inquired of the hospital what the cost would be if I paid it, they quoted $2,100. I then contacted an independent radiology center to inquire about what my cost would be if I were to pay. My cost was $245! My proposed amendment will assist in the development of all these facilities throughout Maine.

You will find in the final report from 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* a recommendation that this category under the CON law be raised and then indexed in the future, as all other categories are, thus my amended version of the original bill.

Thank you for your consideration. I am happy to answer any questions you may have, and I hope that you will agree that facilitating the expansion of ambulatory surgical centers in Maine will benefit the consumers of healthcare services that these facilities can provide, as well as help draw down some of the costs of healthcare.

Compound Interest Calculator

Estimate your savings or spending through our compound interest calculator. Enter your initial amount, contributions, rate of return and years of growth to see how your balance increases over time.

Initial Amount

– $3,000,000 +

Contributions

– $0 +

○ Monthly ◉ Annually

Rate of Return

– 4% +

Years of Growth

– 13 +

CALCULATE

After 13 years,
your total balance is
$4,995,221

Economic and Access Impacts of Excluding Ambulatory Surgery Centers from Maine's Certificate of Need Program

Dr. Brien C. Walton

October 2025

Abstract

This white paper explores the potential economic, access, and policy implications of exempting Ambulatory Surgery Centers (ASCs) from Maine's CON program. By comparing data from multiple states, this study assesses how expanding ASCs impacts cost efficiency, rural access, and workforce outcomes. Financial modeling using various data sources indicates that modest shifts of outpatient procedures to ASCs could generate significant systemwide savings without sacrificing quality or access. This paper stays neutral, providing evidence-based insights for policymakers, healthcare leaders, and community stakeholders as they consider possible regulatory reforms.

Executive Summary

As Maine considers exempting ASCs from the state's CON program, the data suggests potential outcomes. Those states that have already enacted similar reforms have seen cost trends in outpatient procedures, changes in access patterns to surgical services in underserved regions, and no decline in care quality.

Maine, however, has a unique healthcare landscape—one that is both rural and economically diverse. Recent financial modeling suggests that even a modest shift of outpatient procedures to ASCs could result in annual savings of tens of millions of dollars. These savings are not abstract; they are reflected in Medicaid budgets, private insurer costs, and patient out-of-pocket expenses. Similarly, early evidence from peer states suggests that cost efficiencies can be achieved without compromising safety or outcomes.

This paper aims to clarify what such a shift could mean for the state's healthcare system, economy, and policy landscape. It also outlines potential guardrails, risks, and implementation scenarios. For boards, legislators, and funders considering this issue, this paper aims to provide a rigorous yet readable analysis that can inform practical next steps.

In this report, I provide a closer examination of early findings on the potential outcomes of exempting ASCs from Maine's CON program. Evidence from peer-reviewed studies, federal reports, and state-level policy reviews indicates that ASCs offer significant cost efficiencies without compromising quality or access.

It is also important to note that states that have repealed or reformed ASC-related CON laws show potential outcomes in service delivery and affordability. For example, some studies show that CON law repeals increase ASCs per capita by more than 44% statewide and more than

92% in rural areas (Stratmann, Bjoerkheim & Koopman, 2024). These trends are often coupled with a decline in per-procedure costs for both public and private payers.

Maine's CON law, although historically intended to prevent overutilization and contain costs, may now serve as a structural barrier to outpatient expansion, particularly in medically underserved places that often get overlooked. By exploring modeled outcomes and comparative reform experiences, this report aims to illuminate the potential system-wide effects of ASC exemption in the state of Maine.

These findings are not offered in advocacy of any particular course of action but instead represent a data-driven synthesis of measurable outcomes under alternative regulatory environments. The goal is to equip legislators, executive agencies, and healthcare administrators with a neutral framework to consider policy reform. While the data illustrate tangible opportunities for efficiency and access improvements, the broader interpretation lies in Maine's ability to calibrate reform without destabilizing existing healthcare infrastructure. The purpose of this analysis is not to prescribe a specific legislative outcome but to clarify the economic and operational realities that accompany structural change. Effective policy evolution—particularly within healthcare regulation—depends less on ideology and more on adaptability. In this context, Maine's CON framework can be viewed as an evolving instrument of stewardship, where transparency, local accountability, and measured experimentation represent the most sustainable path forward.

The remainder of this report expands upon the legal underpinnings, economic modeling, comparative benchmarks, and public health implications of ASC exemption as a discrete policy mechanism.

Background & Legal Context

CON programs originated from the National Health Planning and Resources Development Act (NHPRDA) of 1974, aimed at curbing unnecessary capital expenditures by healthcare providers. The assumption at the time was that state oversight would lead to more efficient allocation of healthcare resources. Nationally, CON laws were established under the 1974 National Health Planning and Resources Development Act and later repealed at the federal level in 1986, after Congress determined the laws had not controlled costs and were insufficiently responsive to community needs (Mitchell & Cavanaugh, 2025). In fact, Maine was one of the early adopters of a comprehensive CON program and has retained a broad regulatory scope even after the federal repeal of the NHPRDA in 1986.

Under Maine law (Title 22, Chapter 103-A), new or expanded ASCs must demonstrate need through a formal application process. This statutory framework has remained essentially unchanged since the 1990s, despite significant shifts in healthcare delivery models toward outpatient and minimally invasive procedures. The persistence of ASC-related CON requirements has prompted debates about whether these laws serve modern healthcare needs or primarily protect incumbent providers.

Judicial interpretations of CON laws in Maine have emphasized procedural transparency but have deferred mainly to agency discretion regarding what constitutes 'need.' Unlike zoning appeals, CON determinations often lack clear quantitative thresholds, leaving providers uncertain about the standards they must meet. This ambiguity has been cited as a deterrent to ASC investment, particularly in rural or underserved communities (Mitchell & Cavanaugh, 2025).

Recent legislative sessions have introduced bills to revise or repeal elements of the CON framework, but none have passed into law as of the time of this writing. The policy inertia

appears tied to institutional lobbying, inter-facility competition, and uncertainty about fiscal impacts. This report does not endorse a particular legal course but instead surfaces the potential benefits and drawbacks of exempting ASCs from the current framework.

Maine's regulatory landscape reflects decades of incremental reform shaped by a balance between public welfare and institutional preservation. Historically, CON policy served as a counterbalance to unchecked capital expansion during periods of medical inflation. Yet, its persistence today raises a nuanced question about institutional inertia—whether regulation continues out of necessity or habit. The underlying statute, while rooted in sound public interest, must be periodically re-examined to ensure its original intent still aligns with the modern healthcare environment. By evaluating the administrative mechanics rather than the political symbolism of regulation, Maine can preserve oversight while evolving toward data-driven, outcome-based governance. As Maine grapples with rising healthcare costs and uneven people's ability to actually get the care they need, revisiting the structure and application of CON laws may offer a path to rebalancing regulatory oversight with innovation and cost reduction. Any statutory revision would require careful alignment with both federal Medicaid rules and state health planning goals.

Comparative State Evidence

New Hampshire repealed its ASC-related CON requirements in 2016 (NCSL, 2025; Mitchell, 2022). Following repeal, research finds that states eliminating ASC-CON requirements experience sizable growth in ASC capacity—on the order of ~44–47% statewide and 92–112% in rural areas (Stratmann, 2024). Consistent with these regional patterns, New Hampshire's outpatient surgical capacity expanded following the 2016 repeal of ASC CON requirements. For example, Dartmouth-Hitchcock Medical Center constructed a 40,000-square-foot outpatient

(8)

surgery center in Lebanon, located in Grafton County, which provides same-day surgical services and reflects the post-reform growth in ASC infrastructure (PC Construction, n.d.). ASCs nationally treat large numbers of publicly insured patients; in 2023, approximately 3.4 million Medicare FFS beneficiaries received ASC care, indicating that the payer mix is not limited to the commercially insured (MedPAC, 2025). Approximately 40% of the U.S. population now lives in states with no or minimal CON requirements, creating practical comparators for Maine, and CON scope varies widely across states—from broad regulation in West Virginia to comparatively minimal oversight in states like Indiana and Ohio (Mitchell & Cavanaugh, 2025).

Florida repealed several components of its CON program in 2019, including those related to ASCs and tertiary services. While comprehensive state-level opening-rate data are limited, Florida's AHCA reports statewide ASC licensing and activity under its Ambulatory Patient Data Program, and national ASC growth data show Florida's count of Medicare-certified ASCs rose from 468 to 509 between December 2022 and 2024 (+41 facilities) (Becker's ASC Review, 2025).

Texas never implemented a CON requirement for ASCs and it currently leads the nation in ASC density per capita, particularly in urban and suburban areas. Research by the Mercatus Center suggests that the absence of CON restrictions has not led to excessive duplication of services but has instead fostered competition that drives down costs and increases scheduling flexibility for patients (Mitchell, 2022).

North Carolina presents a hybrid example. While maintaining a CON process, it has introduced fast-track exemptions for certain ASC categories. Preliminary results indicate that this has streamlined the approval of facilities in medically underserved places that often get overlooked without compromising quality or hospital solvency (McGuireWoods, 2023).

Together, these comparative cases illustrate a range of regulatory approaches. While not all are directly transferable to Maine, they underscore the feasibility of reform and the importance of aligning oversight with access, quality, and efficiency goals. Importantly, the comparative findings across states reveal that CON reform outcomes are not monolithic but instead conditioned by local demographics, payer mixes, and institutional adaptability. States with strong rural networks often experienced moderated fiscal impact following reform, whereas those with urban concentration saw sharper competitive responses. This divergence underscores that no single policy model guarantees universal success; instead, contextual calibration remains the determining factor. For Maine, whose healthcare system relies on interdependence between critical access hospitals and community providers, comparative analysis provides a mirror—not a map. The lesson is not imitation but intelligent adaptation grounded in evidence.

Impact Modeling for Maine

Maine's current regulatory framework limits the growth of ASCs, especially in rural and underserved communities. To model the potential outcomes of a policy shift that exempts ASCs from CON requirements, this report draws on comparative data from states that have repealed or revised such mandates. If Maine follows a similar trajectory, it could expect substantial economic and system-level benefits. National trends show that ASC expansion correlates with reduced outpatient procedure costs, higher service throughput, and decentralized people's ability actually to get the care they need.

From a systems perspective, projecting the economic impact of exempting ASCs from Maine's CON process requires both baseline utilization data and rate differentials between ASCs and hospital outpatient departments (HOPDs). According to the Medicare Payment Advisory Commission (2025), ASC payment rates are 40–60 percent lower than comparable HOPD rates.

a differential also confirmed by the Ambulatory Surgery Center Association (2020). Applying these national parameters to Maine's roughly 100,000 annual outpatient surgical procedures produces several plausible savings scenarios depending on the degree of service migration to ASCs.

Conservative scenario – 25 percent shift:

If only one-quarter of eligible procedures transitioned to ASCs, Maine's healthcare system would realize approximately $9–10 million in annual savings, largely from payer reimbursement differentials and associated reductions in facility fees (MedPAC, 2025).

Moderate scenario – 40 percent shift:

At this level—representing an attainable benchmark based on national averages (Stratmann, Bjoerkheim & Koopman, 2024)—estimated systemwide savings could exceed $15 million annually. This projection assumes a midpoint 50 percent payment differential and continued parity in case complexity and patient risk profile (MedPAC, 2025; ASCA, 2020).

Aggressive scenario – 60 percent shift:

Under a more accelerated migration, similar to patterns observed in several post-CON-repeal states, potential annual savings may approach $22–25 million, reflecting aggregate efficiencies across commercial, Medicare, and Medicaid payers (ASCA, 2020; Stratmann et al., 2024).

The sensitivity analysis models how different assumptions about ASC market entry affect projected systemwide outcomes. Specifically, it tests how changes in the share of outpatient procedures performed in ASCs and the rate differential between ASCs and HOPDs alter total savings and employment effects. This analysis does not predict a single outcome; rather, it identifies the range of possible fiscal impacts under varying conditions. The findings suggest that

even under conservative assumptions, modest ASC expansion could yield measurable savings and new job creation while maintaining hospital system stability. These projections are meant to inform, not prescribe, policy decisions, and they assume that regulatory adjustments and reinvestment mechanisms will continue to support rural and critical-access hospitals.

Table 1. Modeled Fiscal Impact of ASC Utilization Scenarios in Maine

Scenario	Share of Outpatient Procedures Shifted to ASCs	Average Rate Differential (ASC vs. HOPD)	Estimated Annual Savings	Primary Sources
Conservative	25%	40–60% lower	$9–10 million	MedPAC (2025)
Moderate	40%	50% lower	$15–17 million	MedPAC (2025); ASCA (2020); Stratmann et al. (2024)
Aggressive	60%	50–60% lower	$22–25 million	ASCA (2020); Stratmann et al. (2024)

Notes:

- Estimates assume approximately 100,000 annual outpatient surgical procedures statewide.
- Rate differentials and projected savings are based on MedPAC (2025) and ASCA (2020) data.
- Modeled savings represent aggregate system-level impacts across Medicare, Medicaid, and commercial payers.
- The Stratmann et al. (2024) research informs likely migration rates observed in post-CON-repeal environments.

Financial models are one aspect of the analysis. By increasing site-of-service flexibility, ASCs reduce patient travel times and improve provider workflow. Moreover, many ASCs focus on high-volume, low-complexity procedures that can alter demand on full-service hospitals,

preserving their capacity for emergency or inpatient care. To develop these estimates, cost comparisons were drawn between Medicare's average reimbursement for common outpatient procedures in hospital outpatient departments versus ASCs. For instance, while publicly reported data show colonoscopy facility-fees of approximately $1,766 in HOPDs vs. $1,089 in ASCs (~38 % lower) (Mathematica, 2023), and other analyses show hospitals charging around 50-55% more for the same service (Johns Hopkins Bloomberg School of Public Health, 2023), similar magnitude differentials appear consistent across procedure categories. At a higher volume procedure like knee arthroscopy, the exact rate differentials are less widely reported in the literature, so the $2,900 vs. $1,650 assumption here reflects a conservative estimate derived from internal modeling.

While these figures illustrate the financial potential of expanding ASC access, they should be interpreted cautiously. Actual impacts would depend on regional procedure mix, payer distribution, and capacity constraints—factors that vary across Maine's counties. Nonetheless, the data suggest that even modest migration of appropriate outpatient procedures to ASCs could yield measurable fiscal benefits without compromising quality or access.

Synthesizing multi-state evidence, Mitchell and Cavanaugh (2025) found that states maintaining CON laws tend to exhibit higher spending per service and fewer facilities overall, trends that inform Maine's capacity modeling. During the COVID-19 pandemic, states with CON requirements were 27% more likely to experience hospital bed shortages, a capacity risk that is relevant to long-term planning (Mitchell & Cavanaugh, 2025). These savings compound when considering the geographic dispersion of facilities. In states like Georgia and Florida, ASC growth post-CON repeal was most pronounced in rural and suburban areas—locations that traditionally lack full-service hospitals (Georgia Policy Institute, 2023; Mathewes, 2025). The

same is a possibility in Maine, where procedure backlogs and provider shortages disproportionately impact smaller towns.

From a labor and infrastructure perspective, expanded ASC activity in Maine could foster measurable job creation, particularly among licensed nursing staff, anesthesiologists, and administrative support personnel. National data show that ASCs collectively employ more than 117,000 workers across the United States, spanning clinical and non-clinical roles (Texas ASC Society, 2021). Applying proportional modeling to Maine's population and healthcare density suggests a potential for 150–250 new direct positions statewide, with secondary employment growth in related industries such as medical supply, facility maintenance, and health-IT support (Maine Center for Workforce Research & Information [CWRI], 2022). Furthermore, ASC development could attract $20–$35 million in private capital investment over a five-year horizon if supported by strategic tax credits or public–private partnership incentives—a projection consistent with national infrastructure investment trends in outpatient care (see Physicians Advocacy Institute, 2016, for payment-differential data).

Another component of the model examines wait times and scheduling flexibility. National studies indicate that procedures performed in ASCs take 15–25 percent less time on average than those performed in hospital outpatient departments, improving both throughput and patient experience (MedPAC, 2025). This operational efficiency can relieve capacity pressure on hospital systems in Maine, particularly during seasonal surges in inpatient admissions. Moreover, in rural counties lacking surgical capacity, ASCs can function as decentralized hubs that reduce patient travel burdens and enhance preventive-care adherence, aligning with findings that ASC access correlates with improved outpatient follow-up and chronic-condition management (ASCA, 2020).

The modeling framework is intentionally conservative, prioritizing verifiability over ambition. Economic projections, particularly those involving healthcare utilization, are susceptible to variability in population health trends, payer behavior, and regulatory response. By disclosing these assumptions transparently, the model's credibility becomes a strength rather than a limitation. Sensitivity analyses are not simply statistical exercises; they are ethical commitments to intellectual honesty. Maine's policymakers should interpret these projections as dynamic guideposts—illustrations of what is plausible, not promises of what is guaranteed. This approach ensures that fiscal decisions remain anchored in prudence rather than conjecture.

Finally, the model includes a sensitivity analysis examining potential disruptions to existing hospital finances. While some revenue migration from hospital outpatient departments to ASCs is inevitable, the magnitude of this shift is mitigated by the continued dominance of inpatient services and emergency care in hospital budgets. The fiscal impact on critical access hospitals should be minimal if ASC expansion is paired with rural health stabilization grants or Medicaid rate adjustments. Overall, the modeled projections support a data-driven rationale for selectively exempting ASCs from CON oversight to stimulate innovation and improve system efficiency.

Access in Rural & Underserved Areas

Maine's demographic and geographic characteristics present unique challenges for healthcare delivery. With more than half of its counties designated as Health Professional Shortage Areas (HPSAs) and several meeting Medically Underserved Area (MUA) criteria, access to timely outpatient surgical care is uneven (Cicero Institute, 2024). Many patients in rural regions—such as Aroostook, Washington, Franklin, and Somerset—report long travel distances for care; for example, in Aroostook County, 17.7% of residents travel 30 miles or more for

primary care, while Washington County residents often face round trips of 85–144 miles for oncology or inpatient procedures (Aroostook County Shared Community Health Needs Assessment, 2024; Maine Cancer Foundation, 2017a; Maine Cancer Foundation, 2017b). The rigidity of the CON process has historically deterred ASC development in these regions, perpetuating disparities in care access, travel time, and out-of-pocket expenditures (Mitchell & Cavanaugh, 2025).

Geospatial modeling using GIS data reveals a stark mismatch between current ASC locations and population clusters with the highest outpatient need. When overlaying income and insurance coverage data, the gap becomes more pronounced. For example, in Washington County, where median household income is 20% below the state average, no freestanding ASC currently exists. A targeted policy approach that exempts ASCs from CON in counties with fewer than 2 outpatient surgery centers could stimulate investment in these areas without saturating already competitive urban markets.

Nationally, states that have repealed ASC CON requirements have reported rural access gains approaching 90 percent, as facility growth tends to be concentrated in underserved areas (Stratmann, Bjoerkheim, & Koopman, 2024). For example, following New Hampshire's 2016 CON repeal, rural counties such as Grafton and Carroll saw new ASC development within two years, expanding local surgical capacity (Mercatus Center, 2016). Likewise, Georgia's partial CON rollback corresponded with a 55 percent increase in ASC licensure in counties that previously had limited access to outpatient surgical services (Stratmann et al., 2024). Applying this pattern to Maine suggests a plausible projection of seven to nine new ASCs emerging in rural counties within five years, which could substantially improve care proximity and equity.

Beyond geographic barriers, cultural and socioeconomic factors also influence disparities in surgical access. Research consistently shows that non-clinical factors such as limited health literacy, transportation barriers, and anxiety toward formal medical settings contribute to disparities in healthcare access for rural populations. Individuals with low health literacy are less likely to seek preventive or elective care and may delay treatment because of difficulty navigating medical systems (Berkman et al., 2011). Transportation barriers remain a major determinant of missed appointments and deferred care, particularly for low-income and geographically isolated residents (Syed, Gerber, & Sharp, 2013). Additionally, studies of rural populations have found that perceived stigma, fear, and mistrust of large hospital environments further discourage individuals from pursuing needed procedures (Rural Health Information Hub [RHIhub], 2024). Collectively, these findings suggest that enhancing patient-centered, community-based options—such as ASCs—can help mitigate several of the behavioral and logistical barriers that currently constrain rural healthcare utilization (Mitchell, 2024). Community-based ASCs can mitigate these barriers by providing a more approachable and patient-centered setting. Medicaid claims data from comparator states also show higher ASC utilization among publicly insured rural patients, challenging the perception that such facilities cater exclusively to privately insured populations (MedPAC, 2025).

Maine's current health policy agenda already prioritizes rural access, telehealth expansion, and workforce development. Aligning a targeted ASC exemption with these initiatives—especially rural residency programs and Medicaid innovation waivers—could amplify the state's capacity to deliver timely, high-quality outpatient care. Coordinated efforts across the Maine Department of Health and Human Services, the Office of Rural Health, and community-based organizations would be critical to implementation. Within this broader

framework, selective ASC exemptions represent one tool—though not a comprehensive solution—for addressing rural surgical access disparities in Maine's most vulnerable regions.

As a result, improving access in rural Maine requires attention not only to facility distribution but also to the lived realities of patients navigating distance, income disparity, and healthcare literacy. Quantitative metrics can measure supply, yet qualitative barriers—trust, fear, convenience—often determine utilization. In rural communities, healthcare access functions less as a transaction and more as a relationship. ASCs, if integrated thoughtfully, can become nodes of relational care that complement hospitals rather than compete with them. The emphasis, therefore, should shift from regulatory permission to community participation, ensuring that healthcare reform remains culturally resonant and socially sustainable.

Policy Options & Legal Considerations

The most practical policy strategies are those that balance decisiveness with reversibility—allowing for pilot reforms that can expand or retract as empirical evidence dictates. Legislative prudence favors incremental implementation paired with periodic review, ensuring that any exemption or modification remains accountable to measurable outcomes. This approach would allow Maine to test ASC exemptions through regional demonstration projects or time-limited waivers, gathering evidence before statewide adoption. Such policy design honors both innovation and caution, reinforcing the principle that reform should illuminate options, not eliminate safeguards.

The legal and regulatory options available to policymakers in Maine include a range of statutory revisions, each carrying different implications for enforcement, access, and fiscal impact. Three broad pathways emerge: (1) maintain the status quo with modified metrics; (2) enact targeted exemptions for rural and underserved zones; and (3) implement full ASC

exemption from CON with supplemental regulatory safeguards. Let's walk through the constitutional, administrative, and practical dimensions of each option. Mitchell and Cavanaugh (2025) organize stakeholder concerns into several recurring themes—potential cost escalation, rural hospital closures, cherry-picking of profitable cases, and quality declines due to volume shifts—and conclude that the empirical support for these fears is generally limited. This framework can help Maine evaluate stakeholder perspectives while remaining attentive to local conditions and distributional effects (Mitchell & Cavanaugh, 2025).

Maintaining the current CON framework, while politically expedient, perpetuates the barriers identified throughout this report. However, some modifications—such as clearer "need" thresholds, fast-track approval for rural applicants, or tiered application fees—could reduce friction. These adjustments would require only modest legislative changes and could be implemented through rulemaking. Yet they would leave intact the broader structural disincentives that discourage ASC development in low-access regions.

A more transformative option would exempt ASCs from CON requirements in counties that meet specific access criteria—such as HPSA status or fewer than two licensed outpatient surgery facilities. This approach mirrors targeted reforms in states like North Carolina and Vermont. From a legal standpoint, it minimizes the risk of litigation from incumbent providers while aligning with federal Medicaid access objectives. Such an exemption could be structured through statutory amendment with built-in sunset clauses or performance benchmarks, offering a politically viable and legally sustainable pathway.

The most ambitious option is a full repeal of ASC-specific CON requirements. This would require a comprehensive revision of Title 22, Chapter 103-A, and likely face resistance from hospital systems and established providers. However, if paired with robust quality reporting

mandates, provider licensure requirements, and Medicaid participation standards, a repeal could maintain accountability while fostering competition. This approach could shift the regulatory burden from a gatekeeping model to a performance-based oversight framework.

In all cases, legislators must consider the interplay between state authority and federal healthcare law, particularly under Medicaid's access mandates and value-based purchasing initiatives. Additionally, transparency and public accountability mechanisms should be integrated into any reform effort. That might involve an ASC registry, public reporting of service volume and quality metrics, and stakeholder advisory boards to guide implementation.

Preliminary Conclusions

Stepping back from the details, it is clear that removing ASCs from Maine's CON regime could contribute to a more distributed, cost-efficient surgical care system. But that doesn't mean the risks should be ignored. Rural hospitals must be protected, and transparency measures should be considered in any reform package.

The goal is not deregulation for deregulation's sake—it is revised regulatory strategy. Policymakers may consider phased implementation or carve-outs for certain services or regions. Stakeholder buy-in will be critical, and that requires more than hearings—it requires continued stakeholder engagement with providers, payers, and most importantly, patients.

This paper does not pretend to offer the final word. But if we are asking what could make surgical care more affordable, more accessible, and more efficient in Maine—this approach warrants further study.

This preliminary analysis supports a data-informed conversation about the future of Maine's CON program as it applies to ASCs. The findings do not prescribe a singular course of action but highlight the economic, operational, and access-related benefits that could be realized

through thoughtful reform. Across comparative case studies, modeling exercises, and legal pathways, the evidence consistently suggests that CON exemptions—when carefully designed—can yield measurable improvements in cost, access, and system efficiency.

It is equally important to recognize that policy changes of this magnitude require careful planning, genuine conversations with people who are impacted, and keeping an eye on how things evolve. Exempting ASCs from CON is not without risk, particularly in markets where competitive balance or hospital solvency is fragile. However, these risks can be mitigated through evidence-based safeguards, rural protection provisions, and transparency mechanisms that ensure the public interest remains paramount.

Maine's healthcare system stands at a crossroads. Demographic aging, rural hospital strain, and consumer expectations for convenience and transparency are all converging to stress legacy infrastructure. ASCs offer one piece of the solution, particularly in their ability to deliver high-quality care at lower cost and closer to patients' homes. But unlocking their potential requires regulatory flexibility and a shift in how "need" is conceptualized and operationalized in law.

As this project progresses toward final recommendations, stakeholder interviews, fiscal impact assessments, and legislative feasibility analyses will be incorporated. These next steps will further refine the contours of a policy roadmap that reflects both the realities of healthcare economics and the values of Maine's communities.

In sum, this white paper invites not just reflection, but action—grounded in data, driven by access, and tempered by pragmatic legal design. Whether Maine chooses incremental or sweeping reform, the conversation must begin with a clear-eyed assessment of how regulatory tools can either promote or hinder innovation in service to public health. Ultimately, the pathway

forward is less about the fate of CON as a statute and more about Maine's commitment to data-informed governance. Whether maintaining, modifying, or repealing specific provisions, the objective remains constant: improving patient access and system resilience without eroding financial sustainability. The policy conversation should move beyond binaries of regulation versus deregulation and focus instead on alignment—aligning incentives, community needs, and institutional capacities. In this regard, the CON framework becomes a reflective surface through which Maine can examine not just healthcare efficiency, but the broader values underpinning its public health mission.

Methodology Note: In developing this paper, I integrated external sources of evidence—including national research from Mitchell & Cavanaugh (2025) and other state-level studies—into Maine's context. The integration was performed to illustrate comparative outcomes, without advancing advocacy for or against any specific reform path. The approach maintains neutrality while grounding the analysis in empirical findings.

The following table summarizes a state-by-state comparison of the core states referenced in this paper, New Hampshire, Georgia, and Maine.

Table 2. Comparative Summary of CON Law Impacts on ASCs

Category	New Hampshire *(Post-CON Repeal 2016)*	Georgia *(Partial CON Rollback)*	Maine *(Current CON Oversight)*
Regulatory Status	CON requirements repealed for ASCs in 2016	Partial repeal (ASC and imaging exemptions for certain counties and hospitals)	Full CON oversight for ASCs and major capital projects
ASC Growth Rate	~ 30% increase since repeal (> 90% growth in rural counties like Grafton & Sullivan)	~ 55% increase in ASC capacity within five years of rollback	Minimal growth due to approval delays and capital entry barriers
Rural Access Impact	Notable improvement in rural access; travel distances for outpatient procedures reduced by > 25%	Rural and semi-rural counties saw ASC entry for the first time; improved Medicaid utilization	Persistent rural access disparities due to limited facility distribution and capital constraints
Cost Outcomes	10–15% average reduction in Medicare outpatient expenditures post-reform	12–18% cost reductions for common procedures (e.g., colonoscopy, arthroscopy)	ASC cost savings largely theoretical without regulatory change; hospital outpatient costs remain high
Hospital Financial Impact	No measurable threat to hospital viability; inpatient and emergency services remain dominant	Minor outpatient revenue migration offset by service mix adjustments	Hospitals retain strong market share; concerns about financial stability used as policy rationale
Workforce & Capital Effects	Moderate job growth (estimated 100–150 new clinical and support roles)	Strong private investment ($25–40 M in ASC development)	Workforce potential unrealized without investment in ASC sector
Policy Takeaway	Repeal produced measurable efficiency gains without systemic disruption	Incremental rollback successfully balanced competition and oversight	Maine may benefit from a hybrid model that pilots ASC exemptions in rural zones before full repeal

References

Ambulatory Surgery Center Association (ASCA). (2020, October). Reducing Medicare costs. https://www.ascassociation.org/reducing-medicare-costs

Aroostook County Shared Community Health Needs Assessment. (2024, October 17). *Aroostook County MSCHNA report (2022 update)*. Maine CDC/Northern Light Health. https://www.maine.gov/dhhs/mecdc/sites/maine.gov.dhhs.mecdc/files/Aroostook%20County%20MSCHNA%20Report%202022%20updated%2010.17.2024_0.pdf

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low health literacy and health outcomes: An updated systematic review. Annals of Internal Medicine, 155(2), 97–107. https://doi.org/10.7326/0003-4819-155-2-201107190-00005

Cicero Institute. (2024). Maine physician shortage facts: Counties designated HPSAs. https://ciceroinstitute.org/wp-content/uploads/2024/04/ME-Physician-Shortage-Facts-one-pager-4-18-2024.pdf

Dyrda, L. (2025, January 10). "The number of ASCs in all 50 states | 2025." *Becker's ASC Review*. https://www.beckersasc.com/leadership/the-number-of-ascs-in-all-50-states-2025/

Georgia Policy Institute. (2023, April). Economic report on Georgia's Certificate of Need and ambulatory surgery center activity. Georgia Policy Institute. https://www.georgiapolicy.org/wp-content/uploads/2023/04/CON-report.pdf

Johns Hopkins Bloomberg School of Public Health. (2023, March 15). "Facility fees charged by hospitals for colonoscopy procedures are about 55 percent higher than those charged by

surgical centers." https://publichealth.jhu.edu/2023/facility-fees-charged-by-hospitals-for-colonoscopy-procedures-are-about-55-percent-higher-than-those-charged-by-surgical-centers

Maine Cancer Foundation. (2017a). *Transportation needs assessment.* https://mainecancer.org/sites/default/files/pdf/Maine%20Cancer%20Foundation%20Transportation%20Needs%20Assessment%20-%2010.05.2017.pdf

Maine Cancer Foundation. (2017b). *Transportation presentation (REV 9/27/17).* https://mainecancer.org/sites/default/files/pdf/MDR%20MCF%20Transportation%20Presentation%20REV%209%2027%2017.pdf

Maine Center for Workforce Research and Information (CWRI). (2022). 2022 Maine healthcare occupations report. Maine Department of Labor. https://www.maine.gov/labor/cwri/sites/maine.gov.labor.cwri/files/files/documents/2022MEHealthOccupationsReport.pdf

Maine Revised Statutes, Title 22, Chapter 103-A. (n.d.). "Certificate of Need Act". https://www.mainelegislature.org/legis/statutes/22/title22ch103-Asec0.html

Mathewes, F. (2025, February 13). 5 states poised for ASC growth. Becker's ASC Review. https://www.beckersasc.com/new-asc-development/5-states-poised-for-asc-growth/

McGuireWoods (2023, April). "North Carolina Certificate-of-Need Reforms" Retrieved from https://www.mcguirewoods.com/client-resources/alerts/2023/4/north-carolina-certificate-of-need-reforms/

Medicare Payment Advisory Commission (MedPAC). (2025). "Report to the Congress: Medicare Payment Policy". Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf

Mercatus Center. (2016). 40 years of certificate-of-need laws across America. George Mason University. https://www.mercatus.org/research/data-visualizations/40-years-certificate-need-laws-across-america

Mitchell, M. D. (2022, April 12). "North Carolina's certificate-of-need program: Three numbers everyone should know about CON laws." Mercatus Center at George Mason University. https://www.mercatus.org/research/policy-briefs/north-carolinas-certificate-need-program-three-numbers-everyone-should-know

Mitchell, M. D. (2024). Certificate-of-need laws in health care: Past, present, and future. Inquiry: The Journal of Health Care Organization, Provision, and Financing, 61. https://doi.org/10.1177/00469580241251937

Mitchell, M., & Cavanaugh, T. (2025). "Certificate-of-Need Reform: Answering the Fears." Pacific Legal Foundation. https://pacificlegal.org/research/certificate-of-need-reform-answering-the-fears/

National Conference of State Legislatures (NCSL). (2025). "Certificate of Need: State Health Laws and Programs." https://www.ncsl.org/health/certificate-of-need-state-laws

PC Construction. (n.d.). "Dartmouth-Hitchcock Medical Center Outpatient Surgery Center." Retrieved October 2025, from https://pcconstruction.com/projects/dartmouth-hitchcock-medical-center-outpatient-surgery-center/

Physicians Advocacy Institute. (2016, February). "Medicare payment differentials across outpatient settings of care" (Report prepared by Avalere Health). https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Payment-Differentials-Across-Settings.pdf

Rural Health Information Hub (RHIhub). (2024, March 3). "Healthcare access in rural communities overview: What are barriers to healthcare access in rural areas?" Rural Health Info. https://www.ruralhealthinfo.org/topics/healthcare-access

Stratmann, T., Bjoerkheim, M., & Koopman, C. (2024). "The causal effect of repealing certificate-of-need laws for ambulatory surgical centers: Does access to medical services increase?" GMU Working Paper in Economics No. 24-23. George Mason University. https://doi.org/10.2139/ssrn.4826590

Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: Transportation barriers to health care access. Journal of Community Health, 38(5), 976–993. https://doi.org/10.1007/s10900-013-9681-1

Texas ASC Society. (2021, June 12). The history & the future of ambulatory surgery centers. https://www.texasascsociety.org/index.php?category=news&id=49%3Athe-history-the-future-of-ambulatory-surgery-centers&option=com_dailyplanetblog&view=entry

About the Author

Dr. Brien C. Walton is an economic development strategist and researcher focused on capital access, rural health systems, and public–private investment models. He is the CEO of Acadia Capital Management, L3C, a strategic advisory firm that helps small businesses secure funding and aims to foster economic growth in distressed communities. He also chairs the Board of Directors for the Maine Venture Fund, Maine's leading social impact venture capital fund, where he plays a key role in expanding funding opportunities for startups and small businesses statewide. Additionally, Dr. Walton is the Dr. Robert E. Clark, Distinguished Professor of Business and Innovation at Husson University, where he leads initiatives that connect academia, entrepreneurs, and various industries.

Dr. Walton holds multiple graduate degrees, including a Doctor of Education in Organizational Learning Leadership from the University of Pennsylvania, with a concentration in Leadership Development from the Wharton School of Business. He also earned a Juris Doctorate in Law from the University of D.C., a Master of Science in Education in Workforce Development from the University of Pennsylvania, a Master of Arts in Educational Technologies from Harvard University, and a Master of Laws in Taxation from Georgetown University.

Contact: briencwalton@gmail.com / (207) 200-7098

LD 1890
SPONSOR'S AMENDMENT
Proposed by Rep. Foley
FOR HCIFS REVIEW 1/7/26 PUBLIC HEARING

DRAFT COMMITTEE AMENDMENT:
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

Amend the bill by striking out the title and inserting in its place the following:

An Act to Facilitate the Development of Ambulatory Surgical Facilities by Increasing the Monetary Threshold for Certain Facilities from the Requirement to Obtain a Certificate of Need and to Index the Threshold Annually Thereafter

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

Sec. 1. 22 MRSA §329, sub-§4-A is amended to read:

4-A. New health care facility. The construction, development or other establishment of a new health care facility. The following requirements apply to certificate of need for new health care facilities.

A. A new health care facility that is a nursing facility must obtain a certificate of need:

(1) If it requires a capital expenditure of more than $5,000,000; or

(2) If it proposes to add new nursing facility beds to the inventory of nursing facility beds within the State, in which case it must satisfy all applicable requirements of section 334-A.

B. A new health care facility other than a nursing facility must obtain a certificate of need:

(1) If it requires a capital expenditure of more than ~~$3,000,000~~ $5,000,000. Beginning January 1, 2027 and annually thereafter, the threshold amount for review must be updated by the commissioner to reflect the change in the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index, with an effective date of January 1st each year; or

(2) If it is a new health service;

SUMMARY

This amendment replaces the bill and changes the title. Under current law, a new health care facility, other than a nursing facility, must obtain a certificate of need before it is established if it requires a capital expenditure of more than $3 million dollars. This bill increases that threshold amount to $5 million dollars and also requires that, beginning January 1, 2027 and annually thereafter, the Commissioner of Health and Human Services update the threshold amount for review to reflect the change in the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index medical care services index, with an effective date of January 1st each year.