REPORT OF THE TASK FORCE TO MONITOR HOSPITAL DEREGULATION

PRESENTED TO THE
SECOND REGULAR SESSION OF
THE 117th LEGISLATURE

January 23, 1996

TASK FORCE TO MONITOR DEREGULATION OF HOSPITALS
(Chapter 368, § W-12, P.L. 1995)

Senator I. Joel Abromson
Task Force Chairman

*Senator Joan M. Pendexter**

Senator Rochelle Pingree

Representative Michael J. Fitzpatrick

Representative Gordon Gates

Representative Jeffrey G. Joyner

Warren Kessler, President
Kennebec Valley Medical Center

Richard Hanley
Chief Executive Officer
Downeast Community Hospital

Christopher Nolan
Director
Financial Reimbursement,
Bureau of Medical Services,
Department of Human Services

Francis Finnegan
Director
Bureau of Medical Services
Department of Human Services

Harvey Picker
Commissioner
Maine Health Care Finance Commission

John Wipfler
Executive Director
Maine Health Care Finance Commission

Glenn J. Griswold
Health Policy Development Specialist
Bureau of Insurance
Department of Professional and Financial Regulation

**Senator Pendexter was an active participant in the Task Force, but chose not to sign the Report.*

MAINE STATE LEGISLATURE
Augusta, Maine 04333

TASK FORCE TO MONITOR DEREGULATION OF HOSPITALS

January 23, 1996

Honorable Jeffrey H. Butland, President of the Senate
Honorable Dan A. Gwadosky, Speaker of the House

Dear President Butland and Speaker Gwadosky:

In accordance with P.L. 1995, c. 368, Sec. W-12 (effective June 29, 1995), the Task Force to Monitor Deregulation of Hospitals hereby submits its findings and recommendations regarding the impact of deregulation of hospitals on providers and consumers and the need to continue to maintain and expand a health information database that is currently maintained and administered by the Maine Health Care Finance Commission.

Enclosed is the Report of the Task Force to Monitor Hospital Deregulation, accompanied by suggested statutory changes necessary to implement the elimination of the regulatory functions of the Maine Health Care Finance Commission. Also attached is proposed legislation that would establish the Maine Health Data Organization and implement the recommendations of the Task Force.

Sincerely,

Joel Abromson

Senator I. Joel Abromson
Chair

Enclosure

REPORT TO THE 117th LEGISLATURE

BY

THE TASK FORCE TO MONITOR HOSPITAL DEREGULATION

INTRODUCTION

The Task Force to Monitor Hospital Deregulation was created by the Legislature to monitor the impact of deregulation on health care providers and consumers, propose recommendations concerning data collection and financial analysis and recommend statutory changes to carry out the elimination of regulatory functions of the Maine Health Care Finance Commission.

This Report to the Legislature contains the findings and recommendations of the Task Force concerning the collection, processing and analysis of clinical, financial, and restructuring data. The legislation that created the Task Force also included direction to address long term monitoring of deregulation which the Task Force has determined is more appropriately addressed by the State Legislature when more health data from a managed care environment is available. The most important function of the Task Force was to review the need for data collection and analysis and determine the means by which these functions can be best achieved when the data collection, processing and analysis functions now performed by the Health Care Finance Commission cease on June 30, 1996.

TASK FORCE RECOMMENDATIONS

STATUTORY CHANGES TO EFFECTUATE THE ELIMINATION OF MAINE HEALTH CARE FINANCE COMMISSION REGULATORY FUNCTIONS

The Legislature directed the Task Force to recommend any statutory changes necessary to further implement the elimination of the regulatory functions of the Maine Health Care Finance Commission. Attached to this report is proposed legislation that serves to implement the repeal of all regulatory provisions contained in the Health Care Finance Commission's enabling statute, 22 M.R.S.A §381 et seq.

The Task Force recommends that the Legislature adopt the report and repeal all referenced statutory citations.

COLLECTION, PROCESSING AND ANALYSIS OF CLINICAL, FINANCIAL AND RESTRUCTURING DATA

The Task Force was directed by the Legislature to review the need for data collection and financial analysis and determine the means by which these functions can be best achieved when the Health Care Finance Commission ceases operations on June 30, 1996.

After extensive review of the need for continued health data collection, processing and analysis, the Task Force recommends that the Legislature adopt legislation creating an independent executive agency called the Maine Health Data Organization. The purpose of the organization is to create and maintain the accuracy and integrity of a comprehensive health information data base for the State of Maine. The Task Force recommends that the organization be granted authority to maintain existing clinical and financial data bases currently administered and maintained by the Maine Health Care Finance Commission and to expand beyond the existing data sources to ensure that the State has access to health data information from managed care organizations and other potential data sets. The Task Force further recommends that the Maine Health Care Finance Commission be granted authority to collect, process and analyze clinical and financial data until such time as the Maine Health Data Organization becomes operational, as determined by the board, or December 31, 1996, whichever is earlier.

MAINE HEALTH DATA ORGANIZATION

Governance

The Task Force recommends that the agency be governed by a stakeholder board of directors appointed by the Governor and confirmed by the Senate. The board of directors shall be comprised of seventeen (17) members as follows: 3 consumer representatives, 2 state government representatives, 2 legislative representatives, 2 payor representatives, 2 employer representatives, 6 provider representatives of which 2 shall be representatives of hospitals, both chosen from a list of at least five current hospital representatives provided by the Maine Hospital Association, 2 physician representatives at least one of whom shall be appointed from a list of at least five physicians provided jointly by the Maine Medical Association and the Maine Osteopathic Association, and 2 representatives from other medical practices, at least one of which shall be a current representative of a home health care agency. The terms of the members of the board should be staggered to provide continuity of administration with legislative members serving two-year terms.

Objectives

The Task Force recommends that the Maine Health Data Organization be granted legal authority to set policy; determine the scope of data to be collected, processed and analyzed; provide analysis of data upon request; promulgate rules implementing policy; and enforce data submission requirements. The Task Force recommends further that the legislation creating the Maine Health Data Organization specify that its Board of Directors shall be required to enter into a contract with a qualified non-governmental entity identified through the state request for proposal process for collection and processing of data. It is the intent of the Task Force that in the event that the Board of Directors of the Maine Health Data Organization determines that hospitals must continue to file restructuring information, that the same data submission requirement be applied to all non-hospital health care data providers.

Financing

The Task Force recommends that financing for the Maine Health Data Organization shall be the responsibility of the Board of Directors and that the legislation creating the agency expressly provide that the Board of Directors is responsible for creating a permanent funding mechanism, including the ability to request an appropriation and allocation from the Legislature, and that the Board has authority to set an equitable fee schedule and to collect user fees. The Task Force recommends that the current hospital assessment be continued at a lower percentage of each hospital's gross patient service revenues, until March 31, 1997, by which time the Board of Directors of the Maine Health Data Organization will have had an opportunity to implement an equitable user fee schedule and arrange for permanent financing.

Maine Health Care Finance Commission

All functions of the Maine Health Care Finance Commission will cease on June 30, 1996, pursuant to PL 1995, c. 368. To ensure continuity of data submission and to ensure the completeness of all data bases currently maintained by the Commission, the Task Force recommends that the Legislature approve emergency legislation creating the Maine Health Data Organization effective April 1, 1996. This effective date allows for a reasonable transition period for the start up of the new agency while existing MHCFC functions are being performed. In the event that the new agency is not fully operational on June 30, 1996, the Task Force recommends that the current legislation, PL 1995, Chapter 368, Sec. 10 be amended to extend the Commission's authority over data collection, and processing tasks from June 30, 1996 until such time as the new agency becomes operational, as determined by the new agency, or December 31, 1996, whichever is earlier. The Task Force emphasizes the importance of ensuring that all current data functions are continued while the new agency is formed.

CHARITY CARE GUIDELINES

The Task Force was directed to recommend reasonable guidelines for policies to be adopted and implemented to ensure the provision of health care services to patients who are determined to be unable to pay for services received.

The Legislature has already assigned and authorized the Department of Human Services the task of determining and implementing reasonable guidelines for provision of charity care. The Department, in the context of rulemaking pursuant to the Maine Administrative Procedure Act, has begun the process of implementing a system of reasonable guidelines. The Task Force recommends that the current statute be amended to direct the Department to include in its rules, a fair hearing mechanism to resolve disputes concerning the determination of eligibility of Maine citizens for charity care. A proposed amendment regarding the fair hearing process is included in the Task Force's proposed legislation.

The Task Force is aware that in a managed care environment, hospitals will be less able to absorb the cost of providing charity care. The Task Force is deeply concerned that the ability of hospitals and other health care providers to continue to provide care for those unable to pay for services received is in jeopardy and urges the Legislature to address this crisis situation during the second regular session of the 117th Legislature.

TRANSITION PROVISIONS

The Task Force was directed to recommend any transition provisions needed to implement the proposals and recommendations of the Task Force with regard to existing contracts and agreements, records, property and equipment, rules and procedures of the Maine Health Care Finance Commission.

The Task Force recommends that all existing grants, contracts and agreements, records, property and equipment, rules and procedures of the Maine Health Care Finance Commission relating to data and analysis be transferred to the proposed independent executive agency. All other records of the Maine Health Care Finance Commission should be archived in the State Archive facility, all property and equipment not related to data presently on site at the Health Care Finance Commission should be assigned to the new independent executive agency and all rules and procedures relating to data shall remain in full force and effect until such time as the proposed independent executive agency acts to revise, amend or repeal those rules and procedures.

I. SUMMARY OF RECOMMENDED STATUTORY CHANGES TO TITLE 22, CHAPTER 107

Public Law 1995, Chapter 368, directs the Maine Health Care Finance Commission to review its laws for the purpose of recommending to the Task Force to Monitor Deregulation of Hospitals the statutory changes which are necessary to repeal the Commission's cost containment functions and other changes identified in Chapter, 368, Part W. The recommendations are as follows:

§381. Repeal sub-§§1 and 2(A), 2(C).
Amend sub-§2(B) to eliminate 3rd word--"further"

§382. Repeal sub-§§1, 1-A, 11, 12, 15, 16, 16-A, 17, 18, and 20.

§384. Repeal sentences with references to Deputy Director.

§385. Amend as follows:

The commission shall appoint, with the approval of the Attorney General, a general counsel and one Staff attorney ~~as it deems necessary.~~ The general counsel shall serve at the pleasure of the commission and ~~his~~ the salary for that position shall be set by the commission within the range established by Title 2, section 6-B. ~~Other staff attorneys~~ The staff attorney shall serve at the pleasure of the ~~commission~~ general counsel and ~~their salaries~~ the salary for that position shall be set by the commission. The general counsel and ~~any other staff attorneys~~ the staff attorney may represent the commission or its staff in any proceedings, investigation or trial. Private counsel may be employed, from time to time, with the approval of the Attorney General.

§386. Repeal sub-§5.

§387. Amend sub-§1 as follows:

Any information, except confidential commercial information obtained from a payor or a hospital or privileged medical information, and any studies or analyses that are filed with, or otherwise provided to, the commission under this chapter must be made available to any person upon request, provided that individual patients or health care practitioners are not directly identified. The commission shall adopt rules governing public access in the least restrictive means possible to information that may directly identify a particular patient or health care practitioner.

§388. Repeal sub-§§1A, 2-8, and 1B.

§391. Re-enact sub-§4 except for the last sentence.

§392. Repeal §2.

§394. Repeal sub-§§1, 4, and 5, and amend sub-§2C to read as follows:

A completed uniform hospital discharge data set, or comparable information, for each patient discharged from the facility after June 30, 1983; ~~and~~ for each major ambulatory service listed pursuant to subsection 11, occurring after January 1, 1990, and for each hospital outpatient service occurring after February 9, 1993.

§395. Amend to delete reference to subchapter III.

§395-A. Repeal sub-§1 last sentence; 2; and 3.

§§396 - 396-D. Repeal.

§396-E. Repeal sub-§1.

§§396-F - 396-K. Repeal.

§396-L. Amend sub-§1 to add:

(9) spin-offs of services to subsidiaries, for-profit and not-for-profit organizations.

Repeal sub-§2(B), 2nd sentence and references to subsection 5 and 396-E in 2(C); last sentence of 3; 4(A) - (F), 4(H); first sentence of 4(I); and 5.

§§396-M - 396-S. Repeal.

§398. Repeal.

§399. Amend as follows:

In addition to the powers granted to the commission elsewhere in this chapter, the commission may conduct investigations, require the filing of information, and subpoena witnesses, papers, records, documents and all other data sources relevant to ~~the establishment and apportionment of gross patient service revenue limits and compliance therewith~~ its clinical and financial data collection functions, its monitoring of restructurings, and reorganizations and significant transactions~~, and other matters regulated by the commission pursuant to subchapter III~~.

An Act to Establish the Maine Health Data Organization

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

Whereas, current law requiring the Maine Health Care Finance Commission to collect and analyze health care data will expire on June 30, 1996; and

Whereas, the Task Force to Monitor Hospital Deregulation has determined that the health data collection and analysis should continue after June 30, 1996, and;

Whereas, it is necessary to provide for the transition from the Maine Health Care Finance Commission to the Maine Health Data Organization for the purpose of continuation of the health data collection and analysis functions, 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 enacted by the People of the State of Maine as follows:

Sec. 1 22 M.R.S.A. c._____ is enacted to read:

MAINE HEALTH DATA ORGANIZATION

§ **DEFINITIONS**

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

1. Board. "Board" means the organization board established pursuant to section 1 of this chapter.

2. Clinical data. "Clinical data" includes but is not limited to the data required to be submitted by providers pursuant to 22 M.R.S.A. § 394 (2)(C);(2-A), § 395, and § 395-A.

3. Department. "Department" means the Department of Human Services.

4. Financial data. "Financial data" includes but is not limited to financial

information required to be submitted pursuant to 22 M.R.S.A. § 394(2)(A);(B) and § 395.

5. Health care facility. "Health care facility" means a private or public, proprietary or not for profit entity or institution providing health services including, but not limited to, a health care facility licensed under chapter 405, a home health care provider licensed under chapter 419, a residential care facility licensed under chapter 1665, a community rehabilitation program licensed under Title 20-A, chapter 701, a hospice provider licensed under chapter 1681, a state institution as defined under Title 34-B, chapter 1 and a mental health facility licensed under Title 34-B, chapter 1.

6. Managed care organization. "Managed care organization" means an organization that manages and controls medical services, including but not limited to, a health maintenance organization, a preferred provider organization, a competitive medical plan, a managed indemnity insurance program and a managed Blue Cross/Blue Shield program, licensed in the State.

7. Organization. "Organization" means the Maine Health Data Organization established under this chapter.

8. Provider. "Provider" means a health care facility, health care practitioner or a health product manufacturer, health product vendor, or pharmacy.

9. Restructuring data. "Restructuring data" includes but is not limited to information required to be submitted pursuant to 22 M.R.S.A. §396(L).

10. Third-party payer. "Third-party payer" means a health insurer, nonprofit hospital, medical services organization, or managed care organization licensed in the State.

§ ESTABLISHMENT

The Maine Health Data Organization is established on April 1, 1996, as an independent, executive agency.

1. Objective. The purpose of the organization is to create and maintain an objective, accurate and comprehensive health information data base for the State of Maine built upon existing clinical and financial data bases currently administered and maintained by the Maine Health Care Finance Commission. The Maine Health Care Finance Commission shall have authority to collect, process and analyze clinical and financial data as defined in this section until such time as the Maine Health Data Organization becomes operational, as determined by the board, or December 31, 1996, whichever is earlier.

2. Board of Directors. The organization operates under the supervision of a board of

directors that consists of 17 voting members as follows.

A. The Governor shall appoint 13 board members, subject to review by the joint standing committee of the Legislature having jurisdiction over human resources and confirmation by the Legislature. The 13 board members appointed by the Governor must be selected in accordance with the following requirements:

(1) Three members represent consumers. For purposes of this section, "consumer" means a person who is not affiliated with or employed by a third-party payer, provider, or association representing those providers or those third party payers;

(2) Two members represent employers;

(3) Two members represent third-party payers;

(4) Six members represent providers. Two provider members shall be representatives of hospitals, both chosen from a list of at least five current hospital representatives provided by the Maine Hospital Association. Two provider members shall be representatives of physicians, at least one of whom shall be chosen from a list of at least five physicians provided jointly by the Maine Medical Association and the Maine Osteopathic Association. Two provider members shall be representatives of other medical practices, at least one of whom shall be a current representative of a home health care company.

B. Two ex-officio members represent the state's interest in maintaining health data to ensure that information collected be made available as a basis of determining public health policy. The two ex-officio members shall be designated by the Governor.

C. Two members representing the Legislature's interest in maintaining health data to ensure that information collected be made available as a basis of determining public health policy. One legislative member shall be appointed by the President of the Senate and one legislative member shall be appointed by the Speaker of the House.

3. Terms of Office. Of the initial appointed members of the board of directors, the terms of office are staggered as follows: 5 members serve 1-year terms; 5 members serve 2-year terms; and 5 members serve 3-year terms. Of the initial appointees, no representatives of the same group may have the same term length except that two provider representatives may have the same term length and the two legislative members shall serve two-year terms coinciding with their legislative terms. Thereafter, members serve 3-year terms, except that a member appointed to fill a vacancy in an unexpired term shall serve only for the remainder of that term. Members shall hold office until the appointment and confirmation of their successors. Non-legislative

board members may serve a maximum of 2 consecutive three-year terms.

4. Officers. Members of the board shall elect the chair of the board.

5. Legal counsel. The Attorney General, when requested, shall furnish such legal assistance, counsel or advice as the organization may require in the discharge of its duties.

6. Compensation. Board members shall be compensated according to the provisions of Title 5, chapter 379.

§ POWERS AND DUTIES OF THE BOARD

The board has the following powers and duties.

1. Uniform reporting systems.

   a. Scope of data elements. The board shall develop and implement data collection policies and procedures that require, at a minimum, the collection, processing, storing and analysis of clinical, financial and restructuring data as defined in section 1 of this chapter.

   b. Scope of data sources. Consistent with the recommendation of the Task Force to Monitor Hospital Deregulation created by the 117th Legislature to expand health data collection to data elements and sources beyond those outlined in section 1(a) above, the board may require the submission of clinical, financial and restructuring data from providers, third party payers, and managed care organizations not currently subject to the requirements of 22 M.R.S.A. §§ 394, 395 and 395-A.

   c. Data analysis. The board shall provide analysis of data upon request.

2. Contracts for data collection and processing. The board shall contract with one or more qualified non-governmental independent third parties for services necessary to carry out the data collection and processing activities required under this chapter. For purposes of this subsection, no group or organization affiliated with the University of Maine system shall be considered a governmental entity. Unless permission is granted specifically by the board, a third party hired by the board may not release, publish or otherwise use any information to which the third-party has access under its contract, and must otherwise comply with the requirements of this chapter.

3. Contracts generally. The board may enter into all other contracts as are necessary or proper to carry out the powers and duties of this chapter.

4. Rulemaking. The board shall promulgate such emergency and permanent rules as may be necessary for the proper administration and enforcement of the requirements of this chapter, in accordance with the Maine Administrative Procedure Act, Title 5, Chapter 375.

5. Public Hearings. The board may conduct any public hearings deemed necessary to carry out its responsibilities.

6. Staff. The board shall appoint staff as needed to carry out the duties and responsibilities of the board under this chapter.

7. User fees. The board shall promulgate rules and policies to provide for the establishment of user fees for the right to access and use health data. The board shall also promulgate rules and policies governing the release, publication and uses of analyses, reports or compilations derived from the health data. The board shall waive user fees for public health research conducted by the Department of Human Services. The board shall establish a sliding scale of user fees. The board may waive or set lower fees for users that are engaged in research of value to the general public, if that user can demonstrate to the satisfaction of the board that the user is unable to afford the standard fee. The board may use the revenues collected for the purpose of defraying the operating expenses of the organization.

8. Annual Report. The board shall prepare and submit an annual report on health care trends to the Governor and the joint standing committee of the Legislature having jurisdiction over human resources no later than January 15 of each year. The report shall include an annual accounting of all outside revenue received by the board.

9. Grants. The board may solicit, receive and accept grants, funds or anything of value from any public or private organization and receive and accept contributions from any legitimate source of money, property, labor or any other thing of value. The board shall not accept grants or anything of value, other than user fees pursuant to subsection 7, from any entity that might have a vested interest in the decisions of the board.

10. Other powers. The board may exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed by this chapter.

§ ENFORCEMENT

1. Fine. The failure to file data as required under this chapter is a civil violation. Any provider who fails to file data required under this chapter, may be fined not more than $1000 per day if that provider is a health care facility or $500 per day for all other providers, provided that any forfeiture imposed under this section shall not exceed $25,000 for health care facilities for any one occurrence, and $12,500 for all other providers for any one occurrence.

2. License revoked. If the board finds that a provider has repeatedly and intentionally refused to comply with any requirement of this chapter, the board may file a complaint with the provider's licensing board seeking the revocation of the provider's license.

3. Court order. If a provider refuses to file the data required by this chapter, the board may choose to obtain a court order requiring the provider to submit the data required.

§ REVENUES AND EXPENDITURES

1. Transition funding. Every hospital shall be subject to an assessment of not more than .07% of its gross patient service revenues. For the period of July 1, 1996 through March 31, 1997, the aggregate assessment on all hospitals shall not exceed $1,000,000. The organization shall assess each hospital for its pro rata share prior to July 1, 1996. Each hospital shall pay the assessment charged to it on a quarterly basis, with payments due on or before July 1, 1996, October 1, 1996 and January 1, 1997.

2. Permanent funding. The board may determine an appropriate assessment to be applied to all providers of health data, including hospitals, to defray the expenses of maintaining the health data functions set forth in this chapter. The board may request an appropriation of General Funds from the Legislature.

3. Use of funds. The board may use the revenues from provider assessments and user fees to defray the costs incurred by the board pursuant to this chapter, including staff salaries, administrative expenses, data system expenses, consulting fees and any other reasonable costs incurred to administer this chapter.

4. Budget. The organization's expenditures are subject to legislative approval. The organization shall report annually, before February 1st, to the joint standing committee of the Legislature having jurisdiction over human resources on its planned expenditures for the year and on its use of funds in the previous year.

5. Unexpended funds. Any amount of funds not expended at the end of the fiscal year is not lapsed, but is carried forward to the succeeding fiscal year.

6. Deposit with Treasurer of State. The board shall deposit all payments made pursuant to this section with the Treasurer of State. The deposits shall be used for the sole purpose of paying the expenses of the Maine Health Data Organization.

§ PUBLIC ACCESS TO DATA

1. Public access. Any information, except privileged medical information and confidential commercial information, provided to the organization under this chapter must be

made available to any person upon request, provided that individual patients or health care practitioners are not directly identified.

2. Notice and comment period. The board shall adopt rules establishing criteria for determining whether information is privileged medical information and procedures to afford affected health care practitioners notice and opportunity to comment in response to requests for information that may be privileged.

3. Public health studies. The board shall promulgate rules that allow exceptions solely to the extent authorized in this subsection.

A. In accordance with this subsection, the board may approve access to identifying information for patients or for health care practitioners to the following parties:

(1) the Department of Human Services;

(2) other researchers with established protocols approved by the board for safeguarding confidential or privileged information.

B. The board shall adopt rules that ensure that:

(1) Identifying information is used only to gain access to medical records and other medical information pertaining to public health;

(2) Medical information about any patient identified by name is not obtained without the consent of that patient except when the information sought pertains to verification or comparison of health data and the board finds that confidentiality can be adequately protected without patient consent;

(3) Those persons conducting the research or investigation do not disclose medical information about any patient identified by name to any other person without that patient's consent;

(4) Those persons gaining access to medical information about an identified patient use that information to the minimum extent necessary to accomplish the purposes of the research for which approval was granted; and

(5) The protocol for any research is designed to preserve the confidentiality of all medical information that can be associated with identified patients, to specify the manner in which contact is made with patients or health care practitioners, and to maintain public confidence in the protection of confidential information.

C. The board may not grant approval under this subsection if the board finds that the

proposed identification or contact with patients or health care practitioners would violate any state or federal law or diminish the confidentiality of medical information or the public's confidence in the protection of that information in a manner that outweighs the expected benefit to the public of the proposed investigation.

§ **TRANSITION**. The following provisions apply to the transfer of the health facilities data from the Maine Health Care Finance Commission to the Maine Health Data Organization:

1. The Maine Health Data Organization is the successor in every way to the Maine Health Care Finance Commission with respect to the authority to collect clinical, financial and restructuring data from health care facilities and providers of health care. All responsibilities, power and authority relative to the collection of such health care information, including but not limited to the authority to enforce the data requirements, that were formerly vested in the Maine Health Care Finance Commission, are transferred to the Maine Health Data Organization.

2. Notwithstanding the provisions of the Maine Revised Statutes, Title 5, all accrued expenditures, assets, liabilities, balances or appropriations, allocations, transfers, revenues or other available funds in an account or subdivision of an account of the Maine Health Care Finance Commission, must be transferred to the proper accounts of the Maine Health Data Organization by the State Controller upon the request of the Maine Health Data Organization when the organization is ready to assume its responsibilities under this chapter.

3. All rules and procedures in effect, in operation or adopted as of the effective date of this section by the Maine Health Care Finance Commission regarding data collection and enforcement provisions and requirements remain in effect until rescinded, revised or amended by the Maine Health Data Organization.

4. All contracts, agreements and compacts in effect on the effective date of this section in the former Maine Health Care Finance Commission remain in effect until rescinded, revised or amended by the Maine Health Data Organization.

5. All data required to have been filed with the Maine Health Care Finance Commission pursuant to Title 22, chapter 107 are transferred to the Maine Health Data Organization. In the event that any such data have not been filed with the Maine Health Care Finance Commission as of the effective date of this section, the Maine Health Data Organization shall direct such data to be filed with the Maine Health Data Organization.

6. All records, property and equipment previously belonging to or allocated for the use of the Maine Health Care Finance Commission necessary for performing the data collection activities are transferred to the Maine Health Data Organization.

Sec. 2 22 M.R.S.A. § 395-B (1), as enacted by PL 1995, c. 368, Pt. W-4 , is amended to read:

§ 395-B Charity Care

1. Charity care guidelines. The department shall adopt reasonable guidelines for policies to be adopted and implemented by hospitals with respect to the provision of health care services to patients who are determined unable to pay for the services received. The department shall adopt income guidelines that are consistent with the guidelines applicable to the Hill-Burton program established under 42 United States Code, Section 291, et seq. (1988). The guidelines and policies must include the requirement that upon admission or, in cases of emergency admission, before discharge of a patient, hospitals must investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. <u>The department shall promulgate rules to create a fair hearing mechanism to resolve disputes concerning the determination of eligibility of Maine citizens for charity care.</u>

STATEMENT OF FACT

The purpose of this bill is to establish the Maine Health Data Organization, an independent executive organization that will oversee and coordinate the collection and analysis of health care data. Section 1 of this bill enacts provisions to ensure that the Maine Health Data Organization has the authority to collect health data from all health care facilities, third party payers, managed care organizations, and practitioners providing health services, including pharmacists and health product manufacturers. This bill requires the Maine Health Data Organization to collect and analyze clinical, financial and restructuring data. This bill also provides for a mechanism of funding, including assessments and user fees, for the Maine Health Data Organization. Finally, this bill sets forth the transition provisions necessary to ensure continuation of the data collection and analysis functions of the Maine Health Care Finance Commission until such time as the new organization becomes operational, as determined by the board, or December 31, 1996, whichever is earlier.

Section 2 of this bill expressly requires the Department of Human Services to promulgate rules to create a fair hearing mechanism for resolution of disputes over eligibility determinations for charity care.