MAINE STATE LEGISLATURE

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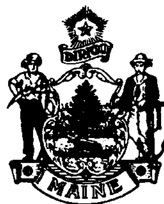


117th MAINE LEGISLATURE

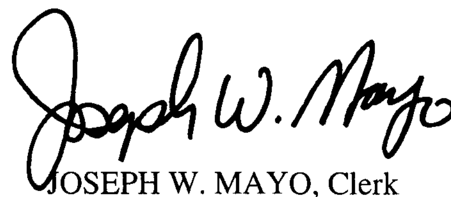
SECOND REGULAR SESSION-1996

Legislative Document **No. 1772**

H.P. 1289 House of Representatives, February 13, 1996

An Act to Create a Uniform Health Information System.

Reported by Representative FITZPATRICK for the Maine Health Care Reform Commission pursuant to Public Law 1993, chapter 707, Part AA, section 5.
Reference to the Joint Standing Committee on Human Resources suggested and printing ordered under Joint Rule 20.



JOSEPH W. MAYO, Clerk

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

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PART A

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Sec. A-1. 22 MRSA c. 1683 is enacted to read:

6

CHAPTER 1683

8

MAINE HEALTH DATA ORGANIZATION

10

§8701. Definitions

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

16 **1. Behavioral risk factor survey.** "Behavioral risk factor survey" means the behavioral risk factor survey conducted by the
18 federal Centers for Disease Control.

20 **2. Board.** "Board" means the Board of Directors of the Maine Health Data Organization established pursuant to section
22 8702.

24 **3. Carrier.** "Carrier" means a 3rd-party payor or an insurance administrator licensed pursuant to Title 24-A, chapter
26 18.

28 **4. Group purchaser.** "Group purchaser" means a person or organization that purchases health care coverage on behalf of an
30 identified group of persons, regardless of whether the cost of coverage is paid by the purchaser.
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5. Health care facility. "Health care facility" means a
34 public or private, proprietary or not-for-profit entity or institution providing health services, including but not limited
36 to a health care facility licensed under chapter 405, a home health care provider licensed under chapter 419, a residential
38 care facility licensed under chapter 1665, a community rehabilitation program licensed under Title 20-A, chapter 701, a
40 hospice provider licensed under chapter 1681, a state institution as defined under Title 34-B, chapter 1 and a mental health
42 facility licensed under Title 34-B, chapter 1.

44 **6. Health care practitioner.** "Health care practitioner" means an allopathic or osteopathic physician, a chiropractor, a
46 dentist, an optometrist, a podiatrist, a pharmacist, a psychologist, a nurse, a physical therapist, an occupational
48 therapist, an acupuncturist, a dental hygienist, a physician assistant, a social worker, a speech therapist or audiologist, a
50 dietitian, a substance abuse counselor, a respiratory care

practitioner, a counseling professional, a denturist, a dental radiographer, a chiropractic assistant, a medical radiation practitioner or any other person certified, registered or licensed to provide health services.

7. Health products. "Health products" means durable medical equipment, including but not limited to oxygen tents, hospital beds and wheelchairs, used in the patient's home or in an institution used as the patient's home.

8. Health product vendor. "Health product vendor" is a person or entity that sells health products to patients.

9. Health services. "Health services" means diagnostic, treatment, rehabilitative, therapeutic or other clinically related services and includes acute-care alcohol and drug abuse and mental health services, the sale of prescription drugs and the sale of health products.

10. Inpatient health services. "Inpatient health services" means health services rendered to a person who has been admitted to a health care facility as an inpatient.

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

12. Outpatient health services. "Outpatient health services" means health services rendered to a person who has not been admitted to a health care facility as an inpatient.

13. Patient. "Patient" means a person receiving health services from a provider, including a person purchasing prescription drugs from a pharmacist or a health product from a health product vendor.

14. Provider. "Provider" means a health care facility, health care practitioner or health product vendor.

15. Quality improvement research. "Quality improvement research" means research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition to determine the most appropriate and cost-effective means to prevent, diagnose, treat or manage the condition or to develop test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

16. Quality improvement foundation. "Quality improvement foundation" means a public or private sector entity designated by

the board under section 8703 that is engaged in quality improvement research.

17. Third-party payor. "Third-party payor" or "3rd-party payor" means a health insurer, health maintenance organization, nonprofit hospital or medical services organization licensed in this State.

§8702. Maine Health Data Organization; established

The Maine Health Data Organization is established as an independent, executive agency and referred to in this chapter as "organization."

1. Board of directors. The organization operates under the supervision of a board of directors, which consists of 15 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 resource matters and confirmation by the Legislature. The 13 board members appointed by the Governor must be selected in accordance with the following requirements.

(1) Two members must represent consumers. For the purposes of this section, "consumer" means a person who is not affiliated with or employed by a 3rd-party payor, a provider or an association representing payors or providers.

(2) Two members must represent employers.

(3) Two members must represent 3rd-party payors.

(4) Seven members must represent providers. Two provider members must represent hospitals and 2 provider members must be physicians. Three provider members must each represent a different provider type or discipline and may not represent a hospital or a physician. At least 2 of these provider members, including one physician, must provide services in a rural community.

B. Two members must be appointed by the commissioner to represent the department. One of these members must have medical and epidemiological credentials and expertise in public health.

2. Terms of office. For the initial appointed members of the board of directors, the terms of office are staggered as follows: Five members serve one-year terms; 5 members serve 2-year terms; and 5 members serve 3-year terms. Of the initial appointees, representatives of the same group may not have the same term length, except that 3 provider representatives may have the same term length. Thereafter, members serve 3-year terms, except that a member appointed to fill a vacancy in an unexpired term serves only for the remainder of that term. Members hold office until the appointment and confirmation of their successors. Board members may serve a maximum of 2 consecutive terms.

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

4. Legal counsel. The Attorney General and the several district attorneys within their respective counties, when requested, shall furnish any legal assistance, counsel or advice the organization requires in the discharge of its duties. The organization may also hire outside legal counsel at its discretion.

5. Quorum. Eight members of the organization constitute a quorum. No action of the organization is effective without the concurrence of at least 8 members.

6. Powers and duties. The board has the powers and duties set forth in section 8703.

7. Compensation. The board members are entitled to compensation according to the provisions of Title 5, chapter 379.

§8703. Powers and duties of the board

The board has the following powers and duties.

1. Collection of data. Consistent with the objectives set forth in section 8704, the board shall develop and implement data collection procedures as required under this chapter. The board is responsible for editing, processing and storing the collected data in a form suitable for public and private sector use.

2. Contracts for data collection. To the maximum extent feasible, the board shall contract with one or more qualified, independent 3rd-parties for services necessary to carry out the data collection activities required under this chapter. Unless permission is granted specifically by the board, a 3rd-party hired by the organization may not release, publish or otherwise use any information to which the 3rd-party has access under its

contract and shall otherwise comply with the requirements of this chapter.

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

4. Legal action. The board may sue or be sued, including taking any action necessary for securing legal remedies on behalf of or against the organization, any board member or any other party subject to this chapter.

5. Executive director; staff. The board shall appoint an executive director to serve as the chief operating officer of the organization and to perform those duties delegated to the executive director by the board. The executive director serves at the pleasure of the board. The executive director may employ other staff as needed, subject to the board's approval.

6. User fees. In order to fund the operation of the organization, the board may assess reasonable fees for the right to access and use the health data. The board shall waive user fees for public health research and health workforce planning research conducted by the department. The board shall establish a sliding scale of user fees. The board may waive or set lower fees for a user that is 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. Unless permission is granted specifically by the board, those users purchasing or granted the right to use the health data may not transfer or sell that right to other users and shall otherwise comply with the requirements of this chapter. Nothing in this subsection may be construed to limit the release, publication, use or sale of analyses, reports or compilations derived from the health data that otherwise comply with the requirements of this chapter. The board shall deposit all payments made pursuant to this section with the Treasurer of State. The deposits must be used for the sole purpose of paying the expenses of the organization.

7. Report on operations. The board shall prepare an annual report on the operations of the organization, which must include:

A. An annual accounting of all outside revenue received by the board; and

B. Summary statistics relating to the cost and quality of health care, the health status of the citizens of the State and the allocation of the health work force derived from the health data collected by the organization.

The board shall submit the annual report to the Governor and the joint standing committee of the Legislature having jurisdiction over human resource matters no later than January 15th of each year.

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

9. Rulemaking. In accordance with the Maine Administrative Procedure Act, the board shall adopt emergency and permanent rules implementing the requirements of this chapter.

10. Public hearings. In accordance with the Maine Administrative Procedure Act, the board may conduct any public hearings necessary and proper to carry out the requirements of this chapter.

11. Quality improvement foundation. The board shall designate a quality improvement foundation to conduct quality improvement research upon a finding that the quality improvement foundation conducts reliable and accurate research consistent with standards of health services and clinical effectiveness research and that the foundation has an established protocol acceptable to the board for safeguarding confidential or privileged information.

12. Unique identification numbers. The board shall adopt unique identification numbers to be used by providers filing the health data to identify providers, group purchasers, 3rd-party payors and patients. For patients, the unique identification number is the patient's social security number except when the patient does not have or refuses to provide a social security number, in which case the patient is identified according to an alternative numbering system developed by the board. The board shall adopt procedures for encoding the unique identification numbers to prevent identification of individual patients and health care practitioners.

13. Barriers to data collection. The board shall coordinate public and private sector efforts to eliminate technical and economic barriers to implementing the data collection requirements under this chapter.

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

§8704. Objectives

To the maximum extent feasible and consistent with the requirements of this chapter, the organization has the following objectives.

1. Use of existing data sources. The organization shall use and build upon existing data sources and measurement efforts and improve upon and coordinate these existing data sources and measurement efforts through the integration of data systems and the standardization of concepts.

2. Linked information system. The organization shall coordinate the development of a linked public sector and private sector information system that:

A. Electronically transmits, collects, archives and provides users of data with the data necessary for their specific interests to promote a high quality, cost-effective, consumer-responsive health care system;

B. Provides the State, consumers, employers, providers and group purchasers with data for determining cost, health status, the appropriateness of health care, the effectiveness of cost-containment strategies and the distribution of health care practitioners and facilities and other health resources;

C. Provides employers with the capacity to analyze benefit plans and workplace health; and

D. Provides researchers and providers with the capacity to conduct health services and clinical effectiveness research.

3. Usefulness of data. The organization shall emphasize data that is useful, relevant and nonredundant of existing data while ensuring that the data collected is in the public domain.

4. Minimize burden. The organization shall minimize the administrative burden on carriers, health care providers and the health care delivery system and minimize any privacy concerns for patients and providers.

5. Reliability of data. The organization shall preserve the reliability, accuracy and integrity of the data collected pursuant to this chapter.

2 **§8705. Advisory committees**

4 The board shall appoint appropriate advisory committees to evaluate methods of data collection and to recommend methods of
6 data collection that minimize the administrative burden on providers, address data confidentiality concerns and meet the
8 needs of health service researchers. The board may appoint other advisory committees as necessary to carry out the purposes of
10 this chapter.

12 **§8706. Public access to data**

14 **1. Public access.** Any information, except privileged medical information, provided to the organization under this
16 chapter must be made available to any person upon request as long as individual patients or health care practitioners are not
18 directly identified.

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

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3. Public health and quality improvement studies. The
28 board, by rule or order, may allow, pursuant to subsection 1, exceptions to the rules adopted only to the extent authorized in
30 this subsection.

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

36 (1) The department;

38 (2) The quality improvement foundation; and

40 (3) Other researchers with established protocols approved by the board for safeguarding confidential or
42 privileged information.

44 B. The board shall adopt rules that ensure that:

46 (1) Identifying information is used only to gain access to medical records and other medical information
48 pertaining to public health or quality improvement research of substantial public importance;

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(2) Medical information about any patient identified by name is not obtained without the consent of that patient except when the information sought pertains only 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 organization shall establish or identify an institutional review board independent of the department, the quality improvement foundation or any other user of data with identifying information. The institutional review board is responsible for approving the protocol of the research, overseeing the conduct of the research to ensure consistency with the protocol and the board's rules and assessing both the scientific validity of the research and its effects upon patients. The institutional review board may endorse or accept the findings of other independent review boards.

D. The quality improvement foundation may publish a report identifying health care practitioners. The report may not be published unless it is approved by the board and follows a 30-day period during which any identified health care practitioner has an opportunity to review and respond to the report.

E. The board may not grant approval under this subsection if the board finds that the proposed identification of 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.

F. With respect to a health care practitioner, the board shall report to the relevant board of licensure identifying information and other data that the board reasonably believes to evidence incompetence in the practice for which the health care practitioner is licensed, certified or registered.

§8707. Utilization data

Consistent with the schedule of implementation developed in subsection 3, the board shall establish procedures, including rules that govern timing, form, medium and content, for filing utilization data as required in this section.

1. Inpatient health services. Each health care facility shall file with the organization as follows:

A. A completed uniform discharge data set or comparable information for each patient discharged from the facility; and

B. Scope-of-service information, including bed capacity, by service provided, special services, ancillary services, physician profiles in the aggregate by clinical specialties, nursing services and other scope-of-service information the board considers necessary for fulfillment of its objectives.

When more than one health care facility is operated by the reporting entity, the information required by this chapter must be reported for each health care facility separately.

2. Outpatient health services. For each encounter with a patient, each provider shall file with the organization a completed uniform data set or comparable information for all outpatient health services provided. When a provider operates in more than one location, the board may require that information be reported separately for each location.

3. Implementation of data collection requirements. Consistent with its objectives, the board shall implement the data collection requirements of this section in as timely a manner as practicable. The board shall develop a schedule of implementation that prioritizes the implementation of the data requirements for each type of provider based on the added administrative burden imposed by the data collection requirements, given the administrative resources and technical

and economic barriers to compliance typically faced by that type of provider, and based on the impact that the added administrative burden would typically have on that type of provider's ability to provide health services and the immediate need for the data to be collected. To the maximum extent feasible, the board shall assist providers in overcoming the technical and economic barriers to compliance with data collection requirements under this section.

4. Health outcomes data. The data collected may include, but is not limited to, information on health outcomes such as information on mortality and morbidity and patient functional status, quality of life, symptoms and satisfaction. The data collected must also include information necessary to measure and make adjustments for differences in the severity of patient illness and comorbidities across providers. The data may be obtained directly from the patient or the patient's medical records. The data must be collected in a way that allows comparisons between providers, 3rd-party payors, public programs and other entities.

5. Claims forms. To the extent permitted by federal law, the board shall implement standardized claims and reporting methods. The board shall solicit the cooperation of self-insured employers in adopting the standardized claim forms with a minimum amount of payor-specific codes.

§8708. Population and worksite surveys

The board shall establish procedures for the collection of population and worksite data as follows.

1. Behavioral risk factor survey. The board shall advise, in consultation with its advisory committees and in cooperation with the Director of the Bureau of Health, the commissioner regarding the expansion of the behavioral risk factor survey. In making its recommendations, the board shall consider private sector and public sector health data needs, including, but not limited to, information relating to the following:

A. Health care quality, outcomes and satisfaction;

B. Access to health care, including insurance coverage and access to health care practitioners, health care facilities and other health resources;

C. Health status;

D. Health risk behaviors; and

E. The economic impact of poor physical or emotional health.

The board shall also consider the need to coordinate satisfaction and outcome surveys with the behavioral risk factor survey to provide a basis for comparing outcome and satisfaction data with statewide norms. The board shall also consider the need to expand the behaviorial risk factor survey to collect health data on children.

2. Worksite surveys. The organization may conduct worksite surveys to obtain statewide data relating to occupational health. The organization shall collect systematic information about the nature, extent, cost and outcomes of employer worksite programs in health promotion and stress reduction.

§8709. Workforce and health resource data

The board shall establish procedures for the collection of workforce and health resource data as follows.

1. Licensing boards. The following licensing boards shall cooperate with the organization in the collection of workforce and health resource data:

A. Board of Licensing of Dietetic Practice;

B. Board of Hearing Aid Dealers and Fitters;

C. Board of Examiners in Physical Therapy;

D. Board of Licensure of Podiatric Medicine;

E. State Board of Examiners of Psychologists;

F. Radiologic Technology Board of Examiners;

G. Board of Respiratory Care Practitioners;

H. State Board of Social Worker Licensure;

I. Board of Examiners on Speech Pathology and Audiology;

J. State Board of Substance Abuse Counselors;

K. Acupuncture Licensing Board;

L. Board of Commissioners of the Profession of Pharmacy;

M. Board of Chiropractic Licensure;

N. Board of Counseling Professionals Licensure;

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O. Board of Dental Examiners;

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P. Board of Licensure in Medicine;

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Q. State Board of Nursing;

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S. Board of Optometric Examiners;

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T. Board of Osteopathic Licensure; and

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U. Any other licensing board for health care practitioners.

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2. Workforce survey. In conjunction with the license
16 renewal process, each licensing board subject to this section
shall survey those health care practitioners within its
18 jurisdiction. The survey must be designed to collect workforce
data and be developed or approved by the organization. The
20 workforce data collected may include, but need not be limited to,
work setting, practice specialty and the amount of time spent
22 providing direct patient care. The licensing board has access to
the workforce data for health care practitioners within its
24 jurisdiction and may not be charged a user fee for that data.

26 **3. Workforce data collection.** The organization shall
collect, edit, process and store the workforce data in a manner
28 to ensure that the data is accurate and complete. In
consultation with its advisory committees and with the licensing
30 boards, the organization shall identify workforce data that may
be used by public and private sector users to identify regions of
32 the State with an insufficient supply of health care
practitioners, develop solutions to regional disparities, plan
34 health workforce educational programs and aid accurate statewide
health planning.

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§8710. Enforcement

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1. Fine. The failure to file data as required under this
40 chapter is a civil violation. Any provider who fails to file
data required under this chapter may be fined not more than
42 $1,000 a day if that provider is a health care facility or $500 a
day for all other providers, except that any fine imposed under
44 this section may not exceed $25,000 for health care facilities
for any one occurrence and $12,500 for all other providers for
46 any one occurrence. The board, or legal counsel of the board's
choice, may enforce the fine in a civil action brought in the
48 name of the board.

2. **License revoked.** Upon a finding that a provider has repeatedly and intentionally refused to comply with the requirements of this chapter, the board may file a complaint with the provider's licensing board seeking the revocation of the provider's license or other disciplinary action from the board.

3. **Court order.** If a provider refuses to file the data required, the board may obtain a court order requiring the provider to produce the data required.

§8711. Revenues and expenditures

1. **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 resource matters on its planned expenditures for the year and on its use of funds in the previous year.

2. **Expenditures.** The organization may use its revenues, including revenues from assessments and user fees, to defray the reasonable costs incurred by the organization pursuant to this chapter.

3. **Unexpended funds.** Any funds not expended at the end of a fiscal year may not lapse, but must be carried forward to the succeeding fiscal year.

§8712. Assessment for expense of maintaining the Maine Health Data Organization

The expense of maintaining the organization must be assessed annually by the board against each carrier in proportion to the respective number of persons in this State for whom the carrier either provides health-related coverage or on whose behalf the carrier administers health-related benefits during the year ending December 31st immediately preceding the fiscal year for which assessment is made. The annual assessment upon all carriers must be applied to the budget of the organization for the fiscal year commencing July 1st. The assessment must be in an amount not exceeding $1.50 per person covered by the carrier. In calculating the amount of the annual assessment, the board shall consider, among other factors, the staffing level required to administer the responsibilities of the organization as well as the expense of contracts for data management services.

1. **Number of persons covered.** For purposes of this section, "number of persons covered" means the number of persons for whom the carrier provides or administers health-related benefits. In the case of insurance administrators, the number of

persons covered refers to only those persons on whose behalf the insurance administrator administers benefits and whose health benefits are provided under a self-insured plan. On or before March 1st of each year, each carrier shall provide to the board a written report of the number of persons covered by the carrier in this State during the immediately preceding calendar year. In calculating the number of persons covered, the carrier shall add the number of persons covered in this State by the carrier in each month of the year for which the report is being made and divide that sum by 12. The result of this calculation is considered by the board to be the number of persons covered by the carrier in the calendar year for which the report is being made.

2. Minimum assessment. In any year in which a carrier has no health-related contracts in force in this State or in which the number of persons covered by the carrier is not sufficient to produce at the rate prescribed an amount equal to or in excess of $100, the minimum assessment payable by any carrier is $100.

3. Notification of assessment. On or before July 1st of each year, the board shall notify each carrier, in writing, of the assessment due.

4. Time of payment. Payment must be made on or before August 10th.

5. Revocation or suspension. Upon a finding by the board that a carrier has failed to comply with the requirements of this chapter, the board may file a complaint with the superintendent seeking a revocation of the carrier's license or certificate of authority to transact business in this State.

6. Recalculation of assessment. Immediately following the close of the fiscal year ending June 30, 1997 and at the close of each 2nd succeeding fiscal year, the board shall recalculate the assessment made against each carrier after giving recognition to the actual expenditures of the organization during the preceding biennial period. On or before October 1st, the board shall render to each carrier assessed a statement showing the difference between the respective recalculated assessment and the amount paid with respect to the preceding biennium. Any overpayment of annual assessment resulting from complying with the requirements of this chapter must be refunded or, at the option of the assessed carrier, applied as a credit against the assessment for the succeeding fiscal year. Any overpayment of $100 or less must be applied as a credit against the assessment for the succeeding fiscal year.

7. Deposit with Treasurer of State. The board shall deposit all payments made pursuant to this section with the Treasurer of State. The money must be used for the sole purpose of paying the expenses of the organization.

8. Applicability. This section applies to fiscal years commencing on or after July 1, 1996.

§8713. Interim hospital assessment

1. Assessment. Every hospital is subject to an assessment of not more than .075% of its gross patient service revenue. The organization shall determine the assessment annually prior to July 1st, October 1st, January 1st and April 1st of each year.

2. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Gross patient service revenue" means a hospital's gross patient service revenue calculated by the department as required under Public Law 1995, chapter 368, Part W, section 10, subsection 2.

B. "Hospital" means any acute care institution required to be licensed pursuant to chapter 405 or its successor, with the exception of the Cutler Health Center and the Dudley Coe Infirmary.

3. Repeal. This section is repealed June 30, 1998.

Sec. A-2. PL 1995, c. 368, Pt. W, §12, sub-§5 is amended to read:

5. The task force shall report its findings and recommendations concerning the statutory and rule changes necessary to further implement the elimination of the regulatory functions of the Maine Health Care Finance Commission, including any necessary implementing legislation in completed form, to the Legislature no later than December 15, 1995. Any necessary implementing legislation concerning the elimination of regulatory functions ~~or replacement~~ of the Maine Health Care Finance Commission must be drafted so as to take effect no later than July 1, 1996. Any implementing legislation concerning the elimination of the Maine Health Care Finance Commission must be drafted so as to take effect no later than 120 days after confirmation or appointment of the 13th member of the board of the Maine Health Data Organization or December 31, 1996, whichever is earlier.

Sec. A-3. Appointments. The Governor shall appoint the board members of the Maine Health Data Organization, as required under the Maine Revised Statutes, Title 22, section 8702, subsection 1, no later than 30 days after the effective date of this Part.

Sec. A-4. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1996-97
MAINE HEALTH DATA ORGANIZATION	
Positions - Other Count	(4.0)
Personal Services	$189,724
All Other	405,964
Capital Expenditures	35,170
MAINE HEALTH DATA ORGANIZATION TOTAL	$630,858

Sec. A-5. 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 inpatient and outpatient health care information from health care facilities and providers of health care. All responsibilities, power and authority relating to the collection of such health care information 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 and liabilities and any balances, 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 State Budget Officer and with the approval of the Governor.

3. All rules and procedures in effect, in operation or adopted on the effective date of this Part by the Maine Health Care Finance Commission regarding data collection 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 Part 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 data have not been filed with the Maine Health Care Finance Commission as of the effective date of this Part, the Maine Health Data Organization shall direct that data 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.

PART B

Sec. B-1. 10 MRSA §8002, sub-§§7 and 8, as enacted by PL 1995, c. 502, Pt. H, §9, is amended to read:

7. Delegate authority. Authorize the heads of bureaus, offices, boards and commissions within the department to carry out the commissioner's duties and authority; ~~and~~

8. Adequate resources. Ensure that each bureau, office, board and commission has adequate resources to carry out regulatory functions and that the department's expenditures are equitably apportioned~~.~~; and

Sec. B-2. 10 MRSA §8002, sub-§9 is enacted to read:

9. Coordinated data collection. Cooperate with the Maine Health Data Organization in planning and coordinating the health data collection activities of the licensing boards within and affiliated with the department as they relate to the Maine Health Data Organization's duties. The commissioner shall direct the cooperation of the internal and affiliated licensing boards.

Sec. B-2. 22 MRSA §257 is enacted to read:

§257. Coordinated data collection

The commissioner shall cooperate with the Maine Health Data Organization in planning and coordinating the health data collection activities within the department as they relate to the Maine Health Data Organization's duties. To the extent

practicable and consistent with federal and state law, the commissioner shall implement the recommendations of the Maine Health Data Organization as they relate to the data collection activities within the department.

PART C

Sec. C-1. 5 MRSA §12004-G, sub-§14-B is enacted to read:

14-B. Health	Maine Health Data Organization	Expenses Only	22 MRSA §8702

PART D

Sec. D-1. 32 MRSA §503-A, sub-§2, ¶H, as amended by PL 1993, c. 600, Pt. A, §46, is further amended to read:

H. A violation of this chapter or a rule adopted by the board; ~~or~~

Sec. D-2. 32 MRSA §503-A, sub-§2, ¶I, as enacted by PL 1983, c. 378, §4, is amended to read:

I. Engaging in false, misleading or deceptive advertising~~.~~; or

Sec. D-3. 32 MRSA §503-A, sub-§2, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-4. 32 MRSA §557, sub-§§2 and 3, as enacted by PL 1991, c. 884, §1, are amended to read:

2. Nonsupervision. Perform other than at the direction and under the supervision of a chiropractor licensed by the board; ~~or~~

3. Inadequate training. Perform a task that they have not been trained or are not clinically competent to perform~~.~~; or

Sec. D-5. 32 MRSA §557, sub-§4 is enacted to read:

4. Data requirements. Repeatedly and intentionally fail to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-6. 32 MRSA §1077, sub-§2, ¶H, as amended by PL 1993, c. 600, Pt. A, §62, is further amended to read:

H. A violation of this chapter or a rule adopted by the board; ~~or~~

Sec. D-7. 32 MRSA §1077, sub-§2, ¶I, as enacted by PL 1983, c. 378, §7, is amended to read:

I. Engaging in false, misleading or deceptive advertising~~.~~; or

Sec. D-8. 32 MRSA §1077, sub-§2, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-9. 32 MRSA §1100-Q, sub-§1, ¶¶E and F, as amended by PL 1993, c. 600, Pt. A, §99, are further amended to read:

E. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or that relates directly to the practice of dental radiography or conviction of a crime for which incarceration for one year or more may be imposed; ~~or~~

F. A violation of this chapter or a rule adopted by the board~~.~~; or

Sec. D-10. 32 MRSA §1100-Q, sub-§1, ¶G is enacted to read:

G. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-11. 32 MRSA §1658-N, sub-§6, as repealed and replaced by PL 1983, c. 413, §80, is amended to read:

6. Violations. ~~For any~~ Any violation of this chapter or the rules; ~~or~~

Sec. D-12. 32 MRSA §1658-N, sub-§7, as enacted by PL 1983, c. 413, §80, is amended to read:

7. Conviction of a criminal offense. Conviction of a crime, subject to the limitations of Title 5, chapter 341~~.~~; or

Sec. D-13. 32 MRSA §1658-N, sub-§8 is enacted to read:

8. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-14. 32 MRSA §2105-A, sub-§2, ¶H, as amended by PL 1993, c. 600, Pt. A, §116, is further amended to read:

H. A violation of this chapter or a rule adopted by the board; ~~or~~

Sec. D-15. 32 MRSA §2105-A, sub-§2, ¶I, as enacted by PL 1983, c. 378, §21, is amended to read:

I. Engaging in false, misleading or deceptive advertising~~.~~; or

Sec. D-16. 32 MRSA §2105-A, sub-§2, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-17. 32 MRSA §2286, sub-§2, ¶¶C and D, as enacted by PL 1983, c. 746, §2, are amended to read:

C. Subject to the limitations of Title 5, chapter 341, conviction of a crime ~~which~~ that involves dishonesty or false statement or ~~which~~ that relates directly to the practice for which the licensee is licensed or conviction of any crime for which imprisonment for one year or more may be imposed; ~~or~~

D. Any violation of this chapter or rules adopted by the board~~.~~; or

Sec. D-18. 32 MRSA §2286, sub-§2, ¶E is enacted to read:

E. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-19. 32 MRSA §2431-A, sub-§2, ¶O, as amended by PL 1987, c. 439, §16 and c. 542, Pt. K, §§16 and 20, is further amended to read:

O. Failure to display a diagnostic or therapeutic drug license issued under section 2419-A or 2425; ~~or~~

Sec. D-20. 32 MRSA §2431-A, sub-§2, ¶P, as amended by PL 1993, c. 600, Pt. A, §160, is further amended to read:

P. Splitting or dividing a fee with an individual not an associate in conformance with section 2434, or giving or accepting a rebate from an optician or ophthalmic dispenser.; or

Sec. D-21. 32 MRSA §2431-A, sub-§2, ¶Q is enacted to read:

Q. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-22. 32 MRSA §2591-A, sub-§2, ¶L, as amended by PL 1989, c. 291, §2, is further amended to read:

L. Division of professional fees not based on actual services rendered; or

Sec. D-23. 32 MRSA §2591-A, sub-§2, ¶M, as enacted by PL 1989, c. 291, §3, is amended to read:

M. Failure to comply with the requirements of Title 24, section 2905-A.; or

Sec. D-24. 32 MRSA §2591-A, sub-§2, ¶N is enacted to read:

N. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-25. 32 MRSA §2594-D, sub-§1, ¶D is enacted to read:

D. Repeatedly and intentionally fails to comply with the data collection requirements established under Title 22, chapter 1683;

Sec. D-26. 32 MRSA §3117-A, sub-§§6 and 7, as enacted by PL 1983, c. 413, §139, are amended to read:

6. Criminal conviction. Subject to the limitations of Title 5, chapter 341, conviction of a Class A, B or C crime or of a crime which that, if committed in this State, would be punishable by one year or more of imprisonment; or

7. Violation. Any violation of this chapter or any rule adopted by the board.; or

Sec. D-27. 32 MRSA §3117-A, sub-§8 is enacted to read:

8. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-31. 32 MRSA §3270-C, sub-§1, ¶¶C and D, as amended by PL 1993, c. 600, Pt. A, §207, are further amended to read:

C. Been delegated and performed a task or tasks beyond the physician assistant's competence; ~~and~~

D. Administered, dispensed or prescribed a controlled substance otherwise than as authorized by law~~.~~; or

Sec. D-32. 32 MRSA §3270-C, sub-§1, ¶E is enacted to read:

E. Repeatedly and intentionally failed to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-28. 32 MRSA §3282-A, sub-§2, ¶K, as amended by PL 1989, c. 291, §4, is further amended to read:

K. Failure to report to the secretary of the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee; ~~or~~

Sec. D-29. 32 MRSA §3282-A, sub-§2, ¶L, as enacted by PL 1989, c. 291, §5, is amended to read:

L. Failure to comply with the requirements of Title 24, section 2905-A~~.~~; or

Sec. D-30. 32 MRSA §3282-A, sub-§2, ¶M is enacted to read:

M. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-33. 32 MRSA §3655-A, sub-§2, ¶I, as enacted by PL 1983, c. 378, §59, is amended to read:

I. Engaging in false, misleading or deceptive advertising; ~~or~~

Sec. D-34. 32 MRSA §3655-A, sub-§2, ¶K, as enacted by PL 1993, c. 600, Pt. A, §248, is amended to read:

K. Prescribing narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes~~.~~; or

Sec. D-35. 32 MRSA §3655-A, sub-§2, ¶L is enacted to read:

L. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-36. 32 MRSA §3837, sub-§8, as enacted by PL 1983, c. 413, §157, is amended to read:

8. Negligence. Negligence in the performance of ~~his~~ duties; ~~or~~

9. Violations. Violating any provision of this chapter or any rule of the board~~.~~; or

Sec. D-37. 32 MRSA §3837, sub-§10 is enacted to read:

10. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-38. 32 MRSA §6026, sub-§4, as amended by PL 1983, c. 413, §205, is further amended to read:

4. Conviction of a criminal offense. Subject to the limitations of Title 5, chapter 341, being convicted of a felony in any court of this State or the United States if the acts for which ~~she or he~~ that person is convicted are found by the board to have a direct bearing on whether ~~she or he~~ that person should be entrusted to serve the public in the capacity of a speech pathologist or audiologist; ~~or~~

Sec. D-39. 32 MRSA §6026, sub-§4-A is enacted to read:

4-A. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683; or

Sec. D-40. 32 MRSA §6217-A, sub-§6, as repealed and replaced by PL 1983, c. 413, §218, is amended to read:

6. Criminal conviction. Subject to the limitations of Title 5, chapter 341, conviction of a Class A, B or C crime or of a crime ~~which~~ that, if committed in this State, would be punishable by one year or more of imprisonment; ~~or~~

Sec. D-41. 32 MRSA §6217-A, sub-§6-A, as enacted by PL 1991, c. 456, §29, is amended to read:

6-A. Incompetence in the practice of counseling. Any incompetence in the practice of counseling such as engaging in conduct that evidences a lack of ability or fitness to discharge the duty owed by the counselor to a client or engaging in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which that person is licensed, certified or registered; ~~or~~

Sec. D-42. 32 MRSA §6217-A, sub-§6-B is enacted to read:

6-B. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683; or

Sec. D-43. 32 MRSA §7059, sub-§1, ¶F, as enacted by PL 1983, c. 413, §229, is amended to read:

F. Subject to the limitations of Title 5, chapter 341, conviction of a Class A, B or C crime or of a crime ~~which~~ that, if committed in this State, would be punishable by one year or more of imprisonment; ~~or~~

Sec. D-44. 32 MRSA §7059, sub-§1, ¶G, as amended by PL 1985, c. 736, §18, is further amended to read:

G. Violation of any provision of this chapter or any rule of the board~~.~~; or

Sec. D-45. 32 MRSA §7059, sub-§1, ¶H is enacted to read:

H. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-46. 32 MRSA §9713, sub-§2, ¶¶C and D, as enacted by PL 1985, c. 288, §3, are amended to read:

C. Subject to the limitations of Title 5, chapter 341, conviction of a crime ~~which~~ that involves dishonesty or false statement or ~~which~~ that relates directly to the practice for which the licensee is licensed or conviction of any crime for which imprisonment for one year or more may be imposed; ~~or~~

D. Any violation of this chapter or rules adopted by the board~~.~~; or

Sec. D-47. 32 MRSA §9713, sub-§2, ¶E is enacted to read:

E. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683;

Sec. D-48. 32 MRSA §9860, sub-§7, as enacted by PL 1983, c. 524, is amended to read:

7. Conviction of certain crimes. Subject to the limitations of Title 5, chapter 341, conviction of a crime ~~which~~ that involves dishonesty or false statement or ~~which~~ that relates directly to the practice for which the licensee is licensed, or conviction of any crime for which incarceration for one year or more may be imposed; ~~or~~

Sec. D-49. 32 MRSA §9860, sub-§7-A is enacted to read:

7-A. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683; or

Sec. D-50. 32 MRSA §9910, sub-§2, ¶C, as amended by PL 1987, c. 313, §6, is further amended to read:

C. Subject to the limitations of Title 5, chapter 341, conviction of a crime ~~which~~ that involves dishonesty or false statement or ~~which~~ that relates directly to the practice for which the individual is licensed or convicted of any crime for which imprisonment for one year or more may be imposed; ~~or~~

Sec. D-51. 32 MRSA §9910, sub-§2, ¶D, as enacted by PL 1985, c. 389, §28, is amended to read:

D. Any violation of this chapter or rules adopted by the board~~.~~; or

Sec. D-52. 32 MRSA §9910, sub-§2, ¶E is enacted to read:

E. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683.

Sec. D-53. 32 MRSA §12413, sub-§5, as enacted by PL 1987, c. 488, §3, is amended to read:

5. Criminal conviction. Subject to the limitations of Title 5, chapter 341, conviction of a Class A, Class B or Class C

crime or of a crime ~~which~~ that, if committed in this State, would be punishable by one year or more of imprisonment; ~~or~~

Sec. D-54. 32 MRSA §12413, sub-§6, as enacted by PL 1987, c. 488, §3, is amended to read:

6. Good cause. Any other good cause~~,~~ relevant to qualifications to practice~~.~~; or

Sec. D-55. 32 MRSA §12413, sub-§7 is enacted to read:

7. Data requirements. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683;

Sec. D-56. 32 MRSA §13742, sub-§2, ¶¶H and I, as enacted by PL 1987, c. 710, §5, is amended to read:

H. Engaging in false, misleading or deceptive advertising; ~~or~~

I. Any violation of this Act or of any rule adopted by the board~~.~~; or

Sec. D-57. 32 MRSA §13742, sub-§2, ¶J is enacted to read:

E. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683;

Sec. D-58. 32 MRSA §13861, sub-§1, ¶H, as amended by PL 1989, c. 895, §17, is further amended to read:

H. The licensee or registrant has had any professional or occupational license revoked for disciplinary reasons, or any application rejected for reasons relating to untrustworthiness, within 3 years of the date of application; ~~or~~

Sec. D-59. 32 MRSA §13861, sub-§1, ¶I, as enacted by PL 1989, c. 465, §3, is amended to read:

I. Violation of any provisions of this chapter or any rule of the board~~.~~; or

Sec. D-60. 32 MRSA §13861, sub-§1, ¶J is enacted to read:

J. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683;

Sec. D-61. 32 MRSA §14308, sub-§1, ¶¶F and G, as enacted by PL 1991, c. 403, §1, are amended to read:

F. Revocation in any state of a professional or occupational license, certification or registration for disciplinary reasons, or rejection of any application for reasons related to untrustworthiness, within 3 years of the date of application; ~~and~~

G. Violating any provisions of this chapter or any rule of the department~~.~~ ; or

Sec. D-62. 32 MRSA §14308, sub-§1, ¶H is enacted to read:

H. The repeated and intentional failure to comply with the data collection requirements established under Title 22, chapter 1683;

STATEMENT OF FACT

Part A establishes the Maine Health Data Organization, an independent state agency that will oversee and coordinate health collection activities and collect, edit and store statewide health data resources. Part A grants the Maine Health Data Organization authority to collect health data from all health care facilities and practitioners providing health services, including pharmacists and health product vendors. It requires the Maine Health Data Organization to collect utilization data, coordinate population surveys with the needs of both public and private sectors and oversee the collection of workforce data through surveys conducted by licensing boards. Part A also assesses carriers and insurance administrators as a mechanism for funding the Maine Health Data Organization.

Part B requires the Commissioner of Professional and Financial Regulation to cooperate with the Maine Health Data Organization's data collection activities and to require the cooperation of the health care practitioner licensing boards within and affiliated with the Department of Professional and Financial Regulation. Part B also requires the Commissioner of Human Services to cooperate with the Maine Health Data Organization's data collection activities.

Part C allows the board members for the Maine Health Data Organization to be reimbursed for their expenses.

Part D amends the licensing statutes for all health care practitioners to provide that repeated and intentional failure to

comply with the data collection requirements imposed under the
2 Maine Revised Statutes, Title 22, chapter 1683 is grounds for
terminating a health care practitioner's license.

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