MAINE STATE LEGISLATURE

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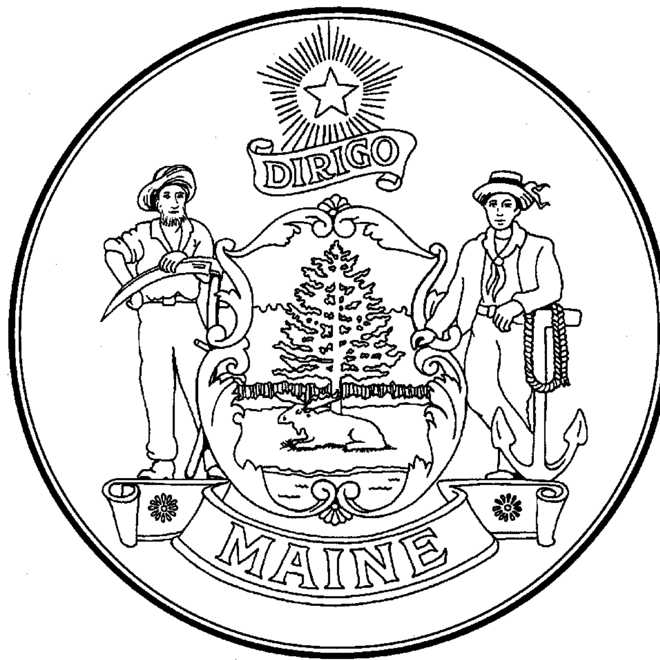

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117th MAINE LEGISLATURE

SECOND REGULAR SESSION-1996

Legislative Document	**No. 1803**
H.P. 1319	House of Representatives, February 20, 1996

An Act to Create a Single-payor System for Universal Health Care.

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

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

2

PART A

4

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

6

CHAPTER 1683

8

THE MAINE HEALTH CARE PLAN

10

§8801. Purpose

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It is the intent of the Legislature to make both primary and
14 preventive health care services available to all Maine residents
regardless of ability to pay; to reduce the rate of growth in the
16 cost of health care services; to promote the cost-efficient
delivery of services, develop appropriate standards of treatment
18 and quality for health care services, and eliminate excessive,
unnecessary practices; and to reduce waste and inefficiency in
20 the administration of health care services and health insurance.

22 **§8802. Definitions**

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

26

1. Administrator. "Administrator" means the entity
28 designated by the board pursuant to section 8808 to administer
the Maine Health Care Plan.

30

2. Authority. "Authority" means the Maine Health Care
32 Authority established by section 8803.

34 **3. Board.** "Board" means the board of directors of the
Maine Health Care Authority established by section 8803,
36 subsection 1.

38 **4. Carrier** "Carrier" means an insurer, health maintenance
organization or nonprofit hospital or medical service
40 organization licensed to do business in this State.

42 **5. Fund.** "Fund" means the Maine Health Care Trust Fund
established by section 8816.

44

6. Global budget. "Global budget" means a statewide
46 aggregate amount budgeted for the provision of all health care
services pursuant to section 8811.

48

7. Federally sponsored health plan. "Federally sponsored
50 health plan" means health care coverage provided pursuant to

federally sponsored programs, including the Medicare program, administered under the United States Social Security Act, Title XVIII; the Medicaid program, administered under the United States Social Security Act, Title V and Title XIX; the civilian health and medical program of the uniformed services; the health and medical program for veterans of the uniformed services; and the Federal Employee Health Benefit Plan.

8. Organization. "Organization" means the Maine Health Data Organization established pursuant to chapter 1681-A.

9. Participating provider. "Participating provider" means a provider agreeing to deliver health care services under the terms of the health plan as provided in sections 8807 and 8809.

10. Plan. "Plan" means the Maine Health Care Plan established by section 8805.

11. Provider. "Provider" means a person, organization, corporation or association that provides health care services and is authorized to provide those services under the laws of this State. "Provider" includes persons and entities that provide healing, treatment and care for those relying on a recognized religious method of healing as provided for in the federal Social Security Act, Title XVIII and permitted under state law.

12. Quality improvement foundation. "Quality improvement foundation" means the quality improvement foundation designated by the organization pursuant to chapter 1681-A.

13. Resident. "Resident" means a person who has met the residency requirements as defined by rules adopted by the board pursuant to section 8806.

14. State health resource plan. "State health resource plan" means the state health resource plan adopted by the board pursuant to section 8810.

§8803. Establishment

The Maine Health Care Authority is established as an independent executive agency. The authority has broad powers to carry out the purposes of this chapter.

1. **Board of directors.** The authority operates under the supervision of a board of directors that consists of 10 members.

A. Seven members are appointed jointly by the Governor, the President of the Senate and the Speaker of the House of Representatives, subject to review by the joint standing

committee of the Legislature having jurisdiction over insurance matters and confirmation by the Legislature, as follows:

(1) Two members must be providers;

(2) Two members must be business representatives; and

(3) Three members must be consumer representatives. For the purposes of this subparagraph, "consumer" means a person who is not affiliated with or employed by a 3rd-party payor, provider, or association representing those providers.

B. Three members shall serve ex officio as follows:

(1) The commissioner or the commissioner's designee;

(2) The Commissioner of Mental Health and Mental Retardation or the commissioner's designee; and

(3) The Director of the State Planning Office or the director's designee.

C. Persons eligible for appointment to the board must be knowledgeable about the organization, delivery and financing of health care.

D. A person may not be a board member if that person or a member of that person's household is currently employed as or by or is a consultant for, a member of the board of directors of, affiliated with, an agent of or a representative of, or otherwise has a personal financial interest in, a person or entity having a direct financial interest in board decisions distinct from the interest of the general public. Board members may not accept gifts or any other financial gain from any of these persons or entities. Notwithstanding this paragraph, the 2 provider members of the board may negotiate with and contract for payment from the administrator for medical services provided under the plan.

2. Terms of office. The terms of the appointed members are staggered. Of the initial appointees, 2 must be appointed for one year, 2 for 2 years and 3 for 3 years. No 2 representatives from the same group may be appointed for coextensive terms. All subsequent appointments are for 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.

3. Voting; chair. The 7 appointed members of the board may vote on all matters before the board. The 3 ex officio members do not have voting privileges. Four appointed board members constitute a quorum. The board may take action only by an affirmative vote of at least 4 appointed members. The voting members of the board shall elect a chair from among the board members.

4. Powers and duties. The board has the powers and duties regarding operation of the authority set forth in section 8804.

§8804. Powers and duties of the board

In addition to the powers granted to the board elsewhere in this chapter, the board is authorized to act as necessary to carry out the purposes of this chapter, including, but not limited to, the following.

1. Universal access. The board shall establish and maintain a system of universal access to medical care for all residents, as required by this chapter.

2. Administration. The board shall:

A. Solicit bids, negotiate contract terms and enter into contracts with the administrator as provided in section 8808;

B. Ensure that the administrator administer the plan consistent with the requirements of this chapter;

C. Coordinate its activities with the activities of the administrator to ensure the most efficient and effective use of resources in meeting the requirements of this chapter;

D. Develop a global budget and health resources plan as required in sections 8810 and 8811;

E. Consistent with section 8805, determine the health services covered under the plan. The board may implement cost containment strategies including, but not limited to, managed care techniques and utilization review;

F. Adopt quality assurance measures as required under section 8812 to monitor and improve the quality of health care delivered in the State;

G. Consistent with section 8806, establish standards and procedures for determining eligibility and enrollment under the plan;

H. Collect data consistent with the requirements of section 8813. The board shall implement, to the extent permitted by federal law, standardized claims and reporting methods;

I. Employ an executive director 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 to administer the authority, subject to the personnel policies set by the board;

J. Institute a system to coordinate the activities of the authority, the plan and the administrator with the health care programs of the federal, state and municipal governments; and

K. In cooperation with health care providers and plan members, institute a complaint resolution system to handle the complaints of health care providers and plan members.

3. Advisory committees. The board may appoint advisory committees to advise and assist the board. Members of those committees serve without compensation but may be reimbursed by the authority for necessary expenses while on official business of the committee.

4. Fees. The board may charge and retain fees to recover the reasonable costs incurred in reproducing and distributing reports, studies and other publications in responding to requests for information.

5. Studies and analyses. The board may conduct studies and analyses related to the provision of health care, health care costs and other matters it considers appropriate.

6. Contracts. The board may contract with anyone for services necessary to carry out the activities of the authority. Without the specific written authorization of the board, a party entering into a contract with the authority may not release, publish or otherwise use information made available to it under contracted responsibilities.

7. Audits. To the extent necessary to carry out its responsibilities, the authority, during normal business hours and upon reasonable notification, may audit, examine and inspect any records of any provider, the administrator or any other contractor.

8. Funding. The board shall determine the level of funding required to carry out the purposes of this chapter. It shall submit biennially to the Legislature for approval a proposed budget with levels of assessments and taxes to be collected in the fund. Funding for the authority's budget approved by the Legislature is paid from the fund.

9. Reports. On or before January 1st of each year the authority shall submit to the Governor and the Legislature an annual report of its operations and activities during the previous year. The report must include the funding, tax and budget requirements under the global budget for the health plan as established pursuant to section 8811. The report must include facts, suggestions and policy recommendations that the board considers necessary, and must include a report on access to health care under the plan, the economic impact of the plan on the State's gross state product, employment and per capita income and the quality of health care offered under the plan, with comparative statistics from comparable states. The authority may publish and disseminate information helpful to the residents of this State in making informed choices in obtaining health care, including the results of studies or analyses undertaken by the authority.

10. Grants. The board may solicit, receive and accept gifts, grants, payments and other funds and advances from any person and enter into agreements with respect to those gifts, grants, payments and other funds and advances, including agreements that involve the undertaking of studies, plans, demonstrations and projects. However, the board may not accept grants from any person or entity that has a financial interest in the decisions of the board distinct from the interest of the general public.

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

12. Rulemaking. The board may adopt, amend and repeal rules as necessary for the proper administration and enforcement of this chapter, subject to the Maine Administrative Procedure Act.

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

§8805. Maine Health Care Plan

The Maine Health Care Plan is established to provide health benefits to residents of the State as provided under this chapter beginning July 1, 1997.

1. Services covered. The plan must provide coverage for the following health care services, if the service is necessary or appropriate for prevention, diagnosis or treatment of, or maintenance or rehabilitation following, injury, disability or disease:

A. Inpatient services including:

(1) Medical, surgical, intensive and emergency care, including organ transplants that improve patient clinical status, as measured by medical condition, survival rates and other variables;

(2) Rehabilitation for disease or injury, excluding long-term, inpatient rehabilitation; and

(3) Skilled nursing facility care required for continued recovery after an acute inpatient hospitalization and excluding supportive activities of daily living care;

B. Outpatient and ambulatory services including coverage of diagnostic, surgical and emergency care and excluding:

(1) Nonemergent emergency room care;

(2) Ambulance services determined to be not medically necessary; and

(3) Random health screenings for specific conditions for which no risk factors or indicators exist;

C. Professional services at all sites, including all medically necessary professional services delivered by any licensed, certified or, registered health care practitioner within the practitioners legal scope of practice, with the following exclusions:

(1) Speech and occupational therapy for persons 5 years of age or older for chronic conditions;

(2) Physical, occupational and speech therapy for nonacute rehabilitation;

(3) Vision care services other than for the treatment of disease or injury;

2 (4) Counseling and health education services other than those integral to the care of an individual as a
4 result of illness, injury or other health condition;

6 (5) Chiropractic services provided as nonacute care;

8 (6) Podiatry services other than the equivalents to those provided by Medicare;

10

(7) Accredited Christian Science facilities' services
12 other than the equivalents to those provided by Medicare;

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(8) Acupuncture services provided as nonacute care; and

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(9) Massage therapy services provided as nonacute care;

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D. Mental health and substance abuse services, both
20 inpatient and outpatient, including detoxification and rehabilitation;

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E. Preventive services as follows:

24

(1) Preventive medical services for both children and
26 adults in accordance with the United States Task Force on Preventive Services Guidelines, except that
28 screening mammograms must be provided in accordance with the guidelines of the American Cancer Society;

30

(2) Dental services for persons under 21 years of age,
32 including examinations, cleanings, fluoride treatments, sealants and education at 6-month intervals and
34 radiographs on an annual basis; and

36 (3) Dental services for persons 21 years of age and older, including examinations, cleanings, sealants,
38 fluoride treatments, cleaning and education covered on an annual basis;

40

F. Reproductive services, including coverage of prenatal,
42 delivery and postpartum care, the diagnosis and treatment of sexually transmitted disease and birth control procedures,
44 including sterilization, birth control devices and abortion;

46 G. Laboratory, radiology and special diagnostic procedures, when medically necessary and appropriate, including
48 electromyograms, nerve conduction studies, nuclear medicine procedures, pulmonary function studies and electrophysiology
50 studies;

H. Hospice and palliative care, only when medically necessary and appropriate, including medical supplies, drugs and medications, equipment and care for pain control and symptom management in the last 6 months of life;

I. Supplemental services as follows:

(1) Prosthetic devices when medically necessary and appropriate;

(2) Durable medical equipment when medically necessary and appropriate, including rental or purchase of necessary durable medical equipment for therapeutic use, oxygen equipment and hearing aids; and

(3) Medical transportation, as appropriate, to the nearest facility that can render necessary and appropriate emergency medical treatment; and

J. Prescription drugs, including prescription legend drugs, prescribed nonlegend drugs, insulin and diabetic syringes, but excluding:

(1) Experimental and investigational drugs unless prescribed as part of an established clinical trial and drugs prescribed as part of that trial that are covered by another financing mechanism; and

(2) Hair growth supplements, smoking deterrent agents, weight control drugs, nonroutine immunization agents, infertility treatments and nonprescription legend vitamins with the exception of those used to supplement the diets of pregnant women.

2. Excluded services. In addition to those exclusions listed in subsection 1, the following benefits are excluded from coverage under the plan:

A. Experimental diagnostic and treatment services other than those provided as part of an established clinical trial and services provided as part of that trial that are covered by another party;

B. Infertility diagnosis and treatment and reversal of sterilization;

C. Cosmetic surgery except for congenital anomalies and repair of injury resulting from an accident;

D. Nonacute ventilator support provided solely for the purposes of prolonging life;

E. Personal comfort items; and

F. Private rooms, except when medically necessary.

3. Expansion or substitution of covered services. The board may expand benefits beyond the minimum listed in subsection 1 upon a finding that the cost of the benefit is justified based upon the improvement in patient health outcomes resulting from the benefit and that there are sufficient funds to cover cost of providing the additional benefit. The board may substitute any service or benefit not previously covered under the plan for a listed service if the board determines that it is of equivalent therapeutic value or is a less costly treatment alternative to the listed service, and the service or benefit is delivered by a health care practitioner acting within the practitioner's scope of practice. In making a substitution or expansion under this subsection, the board shall consider the impact that the substitution or expansion will have on the public health goals of the Bureau of Health.

4. Delivery of services. Covered health care services must be provided to plan members by participating providers. The delivery of covered health care services to plan members is subject to the provisions of this subsection. The board shall adopt rules regarding benefit delivery by the plan that include but are not limited to the following provisions.

A. An eligible person may choose to receive services under the plan from any participating provider.

B. An eligible person may not be required to meet a deductible or copayment as a condition for receiving health care services covered by the plan by a participating provider, except that the eligible person may be required to make a copayment in an amount not to exceed $5 for each generic prescription drug and $10 for nongeneric drugs.

C. The plan must cover health care services provided to plan members while they are out of the State. The plan member must have been out of the State temporarily for reasons other than to obtain health care services, or the member must have obtained the health care services out of the State for compelling reasons related to the suitability of the services, the nature of the condition and personal circumstances. The board shall establish and operate a plan to pay for health care services provided to plan members while they are outside the State. The payments must be made

at the rates established by the board for comparable services provided by the plan in the State. Charges in excess of the payment rates established in accordance with this paragraph are the responsibility of the plan member. The board may establish rules governing out-of-state referrals including, but not limited to, requirements for preauthorization.

D. The plan must cover cash benefits paid to a provider or to a plan member for a reasonable amount charged for medically necessary, emergency health care services obtained by a plan member from a provider who is not a participating provider.

§8806. Eligibility; enrollment

Subject to the provisions of this section, all persons are eligible to receive the benefits specified in section 8805. The board shall adopt rules regarding application for a plan card and membership in the plan. The rules must provide for at least the following.

1. Residency requirement. A person not already covered under a federally sponsored health plan, who is a resident of this State for at least one month at the time of enrollment, is eligible to receive health care under the plan and may enroll in the plan. A dependent member of an eligible person's household is also eligible.

2. Nonresidents. A person who is not a resident of the State who maintains significant contact with the State, including employment or self-employment within the State or attendance at a college, university or other institution of higher education in the State, is eligible to receive health care under the plan. Eligibility extends to a person qualifying under this paragraph and to that person's spouse and dependents. The board shall adopt rules establishing criteria for eligibility for nonresidents and determine the premium to be paid and the method of payment.

3. Continued participation. A plan member who ceases to be eligible for the plan may elect, within 60 days of losing eligibility, to continue participation in the plan for up to 18 months. The board shall ensure that plan members who become ineligible for enrollment in the plan are promptly notified of the provisions of this subsection. The board shall adopt rules establishing the premium to be paid by persons eligible under this subsection and the method of payment.

4. Plan card. To establish eligibility, each person must apply for a plan card and satisfy the application requirements

established by the board. The board shall ensure that the applicant is issued a plan card within 30 days of receipt of a completed application or provided a written explanation for its denial or any restrictions placed on the applicant's participation. If good cause exists to believe that the applicant may not meet the eligibility requirements in this section, the board may extend the time period in this section for an additional 30 days.

5. Presumed eligibility. A person is presumed eligible if:

A. The person is unconscious, comatose or otherwise unable because of the physical or mental condition to document eligibility or to act in the person's own behalf;

B. The person is a minor; or

C. The person is involuntarily committed to an acute psychiatric facility or to a hospital with psychiatric beds.

A provider shall provide care to a person presumed eligible as if the person were eligible. In the event that the person does not otherwise meet the eligibility standards established pursuant to this section, the board shall pay the provider for services provided and shall seek reimbursement from the person served.

6. Enrollment. The board shall establish an enrollment procedure to ensure that all eligible persons are aware of their right to health care and are formally enrolled.

§8807. Provider participation

1. Participation. A provider may participate in the plan if the provider is licensed, certified or registered to provide services covered under the plan, has agreed to accept no reimbursement for services offered under the plan other than the reimbursement set pursuant to section 8809 and has agreed to accept other terms of participation established pursuant to section 8809. A participating provider may not charge a plan member or a 3rd-party for covered health services. The provider shall charge persons not eligible for enrollment in the plan the same reimbursement levels established pursuant to section 8809, except for services reimbursed by federally sponsored health plans, other than the Federal Employees Health Benefit Plan.

2. Reimbursement. The board shall ensure that the administrator establishes a reimbursement system to promptly and appropriately reimburse participating providers for services rendered.

3. Association; representation. The board shall recognize professional associations to represent categories of licensed, certified or registered health care professionals in negotiations with the administrator. Pursuant to rules established by the board, the professional association must be chosen by majority vote of the appropriate category of providers.

4. Discrimination. A participating provider may not refuse to provide services to a plan member on the basis of race, religious creed, color, national origin, ancestry, physical or mental disability, health status, medical condition, marital status, gender, sexual orientation, age, wealth or any other basis prohibited by the laws of this State. This subsection may not be construed to require a provider to perform a particular service if the particular service is outside the provider's scope of practice or if the provider asserts a religious or conscientious objection to providing the particular service.

5. Provision of information by participating providers. A participating provider must make information available to the board and permit examination of the provider's records by the board as necessary for the purposes of this chapter.

6. Nonparticipating providers. Except as provided in section 8805, providers not participating in the plan may not be reimbursed by the plan.

§8808. Health plan administrator

Pursuant to rules adopted by the board, the board shall solicit bids from companies or nonprofit organizations to act as the administrator for the plan. The board shall select the administrator based on the price and quality of the administrator's proposal, including the administrator's ability to implement the health plan in accordance with the requirements of this chapter. The board may not enter into a contract with the administrator for a term longer than 5 years.

1. Duties. Consistent with the requirements of this chapter, the administrator has the following duties:

A. To administer the health plan for all claims for services covered under the plan;

B. To provide for timely payments to providers as required under this chapter;

C. To solicit bids for prescription drug contracts in order to achieve the lowest possible cost for drugs covered under the plan;

D. To negotiate with providers and provider associations to set reimbursement levels and other terms of participation in the plan;

E. When appropriate, to implement reimbursement schedules based upon the federal resource-based, relative-value scale, augmented as necessary to meet the needs of the plan; and

F. To fulfill all other duties delegated to it pursuant to its contract with the authority.

2. Audit. For each year of the contract with the authority, the administrator shall prepare a report on the operations of the administrator, including an annual internal and independent audit and an accounting of all revenues received and disbursed. The administrator shall submit the report to the authority, the Governor, the joint standing committee of the Legislature having jurisdiction over insurance matters and the State Auditor no later than January 15th of each year.

3. Administrative costs. The administrator's administrative budget is a matter of contract negotiated by the authority and the administrator.

§8809. Reimbursement for providers

In accordance with this section, the administrator shall impose standards for participation by providers and negotiate with providers to establish reimbursement levels for services provided under the plan.

1. Goals and strategies. Based on the state health resource plan, the global budget and the cost containment and quality assurance goals adopted by the authority, and subject to the board's advice and approval, the administrator shall:

A. Establish sector-wide budgets, for appropriate categories of providers;

B. Develop reimbursement strategies to promote desirable utilization and practice patterns;

C. Develop reimbursement strategies to promote access for underserved populations;

D. Develop incentive programs to promote desirable capital expenditures; and

E. Establish standards of quality that must be met by providers wishing to participate in the plan.

2. Negotiation with providers. Negotiations between the administrator and providers are subject to the provisions of this subsection.

A. The administrator shall negotiate with providers or provider associations to determine reimbursement rates for services covered under the plan. As appropriate, the administrator shall use the federal resource-based, relative-value scale as a fee schedule, adjusted as appropriate for the plan. The administrator may not agree to reimburse providers at a rate that, based upon projections approved by the authority, would cause health care expenditures to exceed the global budget set by the authority pursuant to section 8811;

B. All professional provider associations may participate in reimbursement negotiations. All providers within a category are bound by the results of the negotiations between the administrator and the association representing that category of provider recognized by the authority pursuant to section 8807; and

C. In the event that negotiations with providers are not concluded in a timely manner, the authority may set rates, fees and prices for services reimbursed under the plan. A provider aggrieved by a rate, fee or price set by the authority pursuant to this subsection, upon the production of credible evidence that the rate, fee or price is confiscatory, is entitled to a hearing as provided under section 8814.

3. Caps on reimbursement. Notwithstanding the provisions of subsection 2, the administrator shall establish a limit on the aggregate annual payment to an individual provider. An individual provider whose billing volume or distribution suggests the possibility of impropriety is subject to investigation by the administrator or the board, and may be subject to exclusion or other penalties.

4. Prior year expenditures. The administrator shall reduce total reimbursement to providers by the amount that the prior year's total expenditures exceeded the global budget or increase total reimbursement to providers by the amount that the prior year's total expenditures were less than the global budget. For the purposes of this subsection, "prior year" means the most recent year for which the board can determine total expenditures. The administrator may reduce or increase

reimbursement pursuant to this section on a sector-by-sector basis, as appropriate.

§8810. State health resource plan

The board shall, before January 15, 1997 and every 2nd year thereafter, adopt a state health resource plan in accordance with the United States Public Health Services Act. The plan must identify the health care, facility and human resource needs in the State, the resources available to meet those needs and priorities for addressing those needs on a statewide basis.

1. Data; supporting information. In developing the state health resource plan, the board shall use the best and most recent data describing the current supply and distribution of health care, facility and human resources. The board shall consult with relevant state agencies and may establish advisory committees that include consumer groups, health care providers, insurance and health benefit carriers and other 3rd-party payors, as considered necessary to carry out the purposes of this chapter.

2. Plan components. The state health resource plan must include:

A. A statement of principles used in the allocation of resources and in establishing priorities for health services;

B. Identification of the current supply and distribution of hospital, nursing home and other inpatient services; home health and mental health services; treatment services for alcohol and substance abuse; emergency care; ambulatory care services including primary care resource; human resources; major medical equipment; and health screening and early intervention;

C. A determination of the appropriate supply and distribution of resources and services identified in paragraph B and mechanisms that encourage the appropriate integration of these services on a local or regional basis. In making this determination, the board shall consider the following factors: the needs of the population on a statewide basis; the needs of particular geographic areas of the State; the use of facilities in this State by out-of-state residents; the use of out-of-state facilities by residents of this State; the needs of populations with special health care needs; the desirability of providing high-quality services in an economical and efficient manner including the appropriate use of mid-level practitioners; and the cost impact of these requirements on health care expenditures; and

D. A component that addresses health promotion and disease prevention prepared by the Bureau of Health in a format established by the board.

3. Public hearings. Prior to adopting the state health resource plan, the board shall conduct public hearings in different regions of the State on the proposed state health resource plan. Interested persons must be given the opportunity to submit oral and written testimony. Not less than 30 days before each hearing, the board shall publish in a newspaper of general circulation in the region the time and place of the hearing, the place where interested persons may review the state health resource plan in advance of the hearing and the place to which and period during which written comments may be directed to the board.

4. Funds. The board is authorized to accept and expend federal funds allotted or otherwise made available under the United States Public Health Services Act to states for the purposes of the Act in accordance with the Act, and the applicable state laws, rules or fiscal policies or practices.

5. Health workforce forum. The board shall convene at least annually a health workforce forum to discuss health workforce issues. The forum must include representatives from health professionals and health education programs. The forum shall:

A. Develop an inventory of present health workforce and education programs;

B. Develop research and analytical methods for understanding population-based health care needs on an ongoing basis; and

C. Determine the appropriateness of forming a federation of licensing boards to facilitate communication across medical disciplines.

Through the forum, the board shall serve as a clearinghouse for information relating to health workforce issues. The board shall use the information gathered through the forum to inform its health policy and planning decisions authorized under this chapter.

§8811. Global budget

The board shall before January 1st of each year prepare a global budget for all health care expenditures under the plan.

The global budget must include the cost of all services and benefits provided under the plan, administrative costs, data gathering and other activities and revenues deposited in the fund. The board shall determine an appropriate rate of increase for the global budget based upon the quality of care under the plan, access to care under the plan, the economic impact of the plan on gross state product, employment and per capita income and the projected revenues to be deposited in the fund. Beginning January 1, 1997 and through December 31, 1998, the board shall allow a rate of increase for the global budget not to exceed the rate of increase in the gross state product plus 2 percent.

§8812. Quality and affordable health care

In coordination with the administrator, the board shall ensure that the health plan enrollees receive quality and affordable health services.

1. Quality assurance. The board shall develop methods of quality analysis for analyzing the data to determine the quality and cost-effectiveness of the care provided by participating providers. The board may consult the quality improvement foundation designated by the Maine Health Data Organization pursuant to chapter 1681-A, to assist it in this process.

2. Cost containment. In order to control costs and ensure that funds are used for maximum service delivery, the board shall, to the maximum extent feasible:

A. Eliminate administrative and other costs that do not contribute to health care;

B. Identify and eliminate wasteful and unnecessary care that is of no benefit to patients receiving that care;

C. Identify and foster those measures that prevent disease and maintain health;

D. Identify and implement managed care techniques that contain costs and improve the quality of care; and

E. Take other steps as necessary to ensure that the rate or increase allowed by the global budget is not exceeded.

§8813. Data collection and monitoring

1. Data collection. The board shall advise and assist the data collection activities of the Maine Health Data Organization.

2. Analysis of data. The board shall conduct analyses of data necessary for the functioning of the plan, including, but not limited to, the review of access to care, quality, efficiency and appropriateness of care and services, provider participation, population-based health outcomes and geographic distribution of health care resources.

3. Standard measurements. In cooperation with the Maine Health Data Organization, the board shall establish a standard set of indicators and methods to be used to assess the effectiveness of the plan in implementing and fulfilling the requirements of this chapter.

§8814. Proceedings generally

1. Actions before the board. Pursuant to this section, a person or entity aggrieved by an act or decision of the administrator or the authority may seek redress before the board. Proceedings before the board are subject to the Maine Administrative Procedure Act and any further rules established by the board consistent with the Maine Administrative Procedure Act. In all actions arising under this chapter, the burden of proof is upon the party seeking to set aside any determination, requirement, direction or order of the board.

2. Appeals. Any person aggrieved by a final determination of the board may appeal to the Superior Court in accordance with the Maine Administrative Procedure Act.

§8815. Private insurance

A person, insurer, health maintenance organization or nonprofit hospital or medical service organization may not sell or offer for sale in this State a health insurance policy or contract or a health care contract or plan that offers benefits that duplicate the health care benefits offered by the plan. A violation of this section constitutes an unfair and deceptive trade practice under Title 24-A, section 2152.

A licensed insurer, health maintenance organization or nonprofit hospital or medical service organization may sell or offer for sale in this State a health insurance policy or contract or a health care contract or plan that offers coverage and benefits that are supplemental to and do not duplicate covered health care benefits offered by the plan.

This section takes effect on July 1, 1997 and applies to all policies, contracts and plans executed, delivered, issued for delivery, continued or renewed in this State, on or after July 1, 1997. For purposes of this section, all policies, contracts and

plans are deemed renewed no later than the next yearly anniversary of the contract date.

This chapter may not be construed to prohibit the following types of insurance: accident, disability, credit, long-term care or nursing home care, Medicare supplement, specified disease, vision, coverage issued as a supplement to liability insurance, workers' compensation, automobile medical payment or insurance under which benefits are payable with or without regard to fault and that is required by statute to be contained in any liability insurance policy or equivalent self-insurance.

This chapter may not be construed to prohibit the sale of insurance to persons not covered by the plan.

§8816. Maine Health Care Trust Fund

1. Establishment of the fund. The Maine Health Care Trust Fund is established to finance the plan pursuant to this chapter. Deposits to the fund must be made pursuant to this section and to rules adopted by the board to carry out the purposes of this chapter. All money in the fund is commingled and undivided. The fund consists of:

A. All payments collected under this section;

B. Interest earned upon any money in the fund;

C. Property or securities acquired through the use of money belonging to the fund and all earnings of the property or securities; and

D. All other money received for the fund from any other source.

The fund does not lapse, but carries forward from one fiscal year to the next.

2. Use of the fund. All revenue paid into the fund is available to the board and must be expended solely for the purpose of defraying the cost of administering the plan, including, but not limited to, payments to the administrator for administering the plan. The board shall adopt rules setting the requirements for expenditures from the fund. The board shall perform quarterly reviews of expenditures within the plan to determine whether expenditures are within the global budget.

3. Payment to the fund. Payments are deposited to the fund from the following sources:

A. Payments equal to 9.14% of the state liquor tax collected pursuant to Title 28-A, section 1651;

B. Payments equal to 50% of the excise tax on malt liquor, low-alcohol spirit products, fortified wines and wine collected pursuant to Title 28-A, section 1652;

C. Payments of the sales tax collected pursuant to Title 36, section 1811, as follows:

(1) An amount equalling 34.88% of the sales tax on the value of liquor sold in licensed establishments;

(2) An amount equalling 28.2% of the sales tax on the value of rental of living quarters in a hotel, rooming house, tourist or trailer camp;

(3) An amount equalling 23.03% of the sales tax collected on the value of rental for a period of less than one year of an automobile;

(4) An amount equalling 24.8% of the sales tax collected on the value of prepared food sold in establishments that are licensed for on-premises consumption of liquor; and

(5) An amount equalling 38.46% of the sales tax on the value of the all other tangible personal property and taxable services;

D. Payment of the payroll tax collected pursuant to Title 36, section 2870;

E. Payment equal to 65% of the personal income tax collected pursuant to Title 36, section 5111; and

F. Payment equal to 30% of the corporate income tax collected pursuant to Title 36, section 5200.

Sec. A-2. Effective date. This Part takes effect January 1, 1997

PART B

Sec. B-1. Waivers for Medicaid and Medicare. The Department of Human Services and the Maine Health Care Authority shall conduct a joint study of the provision of health care services under the Medicaid and Medicare programs to determine the best method of coordinating benefit delivery and compensation

under those programs and the reorganization of State Government necessary to achieve the objectives of the authority, and any other changes in law needed to carry out the purposes of the Maine Revised Statutes, Title 22, chapter 1683. The Department of Human Services shall apply for all waivers necessary to allow the State to incorporate the Medicaid program into the Maine Health Care Plan to the maximum degree possible. The Maine Health Care Authority shall apply for all waivers required to coordinate the benefits of the Maine Health Care Plan and the Medicare program. The Department of Human Services and the Maine Health Care Authority shall report their actions taken pursuant to this section to the Legislature no later than January 1, 1997 and shall include necessary legislation in the report.

Sec. B-2. Effective date. This Part takes effect July 1, 1996.

PART C

Sec. C-1. 22 MRSA §253, as amended by PL 1981, c. 470, Pt. A, §§55 and 56, is repealed.

Sec. C-2. 22 MRSA c. 103, as amended, is repealed.

Sec. C-3. Effective date. This Part takes effect July 1, 1997.

PART D

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

14-B. Health	Maine Health Care Authority	Expenses Only	22 MRSA §8803

PART E

Sec. E-1. 5 MRSA §285, as amended by PL 1995, c. 368, Pt. G, §§1 to 4, is repealed.

Sec. E-2. 5 MRSA §286, as amended by PL 1991, c. 780, Pt. Y, §§26 and 27, is repealed.

Sec. E-3. 5 MRSA §286-A, as amended by PL 1991, c. 780, Pt. Y, §28, is repealed.

Sec. E-4. Effective date. This Part takes effect July 1, 1997.

PART F

Sec. F-1. Transition. The following provisions apply to the implementation of the Maine Health Care Plan as it relates to insurance regulation under the Maine Revised Statutes, Title 24 and Title 24-A. The Maine Health Care Authority and the Superintendent of Insurance shall study the coordination of the delivery of health benefits under the Maine Health Care Plan and the regulation of insurers, health maintenance organizations and nonprofit hospital and medical organizations. The study must consider the repeal of unnecessary statutes and regulations and the elimination of unnecessary functions within the Bureau of Insurance. By January 1, 1997, the Maine Health Care Authority, with the assistance of the Superintendent of Insurance, shall submit to the Legislature all legislation necessary to coordinate the functions of the Bureau of Insurance with the implementation of the Maine Health Care Plan, including amendments of statutes, reallocation of funds and transitional language, as needed.

Sec. F-2. Effective date. This Part takes effect July 1, 1996.

PART G

Sec. G-1. 28-A MRSA §1651, sub-§1, as amended by PL 1993, c. 615, §5, is further amended to read:

1. State liquor tax. Except as provided in subsection 2, the commission shall determine and set the price at which to sell all spirits and fortified wine that will produce a state liquor tax of not less than ~~65%~~ 70% based on the delivered case cost F.O.B. liquor warehouse.

C. The commission shall add any cost to the State related to handling containers returned for refund pursuant to Title 32, section 1863-A to the established price without markup.

Sec. G-2. 28-A MRSA §1652, sub-§1, as repealed and replaced by PL 1987, c. 342, §116, is amended to read:

1. Excise tax on malt liquor. An excise tax is imposed on the privilege of manufacturing and selling malt liquor in the State. The Maine manufacturer or importing wholesale licensee shall pay an excise tax of ~~25¢~~ 50¢ per gallon on all malt liquor sold in the State.

Sec. G-3. 28-A MRSA §1652, sub-§1-A, as amended by PL 1993, c. 462, §7, is further amended to read:

1-A. Excise tax on low-alcohol spirits products and fortified wines. An excise tax is imposed on the privilege of manufacturing and selling low-alcohol spirits products and fortified wines in the State. The Maine manufacturer or importing wholesale licensee shall pay an excise tax of ~~$1~~ $2 per gallon on all low-alcohol spirits products and fortified wines manufactured in or imported into the State.

Sec. G-4. 28-A MRSA §1652, sub-§2, as amended by PL 1987, c. 623, §16, is further amended to read:

2. Excise tax on wine. An excise tax is imposed on the privilege of manufacturing and selling wine in the State. The Maine manufacturer or importing wholesale licensee shall pay an excise tax of ~~30¢~~ 60¢ per gallon on all wine other than sparkling wine manufactured in or imported into the State and ~~$1~~ $2 per gallon on all sparkling wine manufactured in or imported into the State.

Sec. G-5. 36 MRSA §1811, first ¶, as amended by PL 1993, c. 701, §6 and affected by §10, is further amended to read:

A tax is imposed on the value of all tangible personal property and taxable services sold at retail in this State. The rate of tax is ~~7%~~ 10.75% on the value of liquor sold in licensed establishments as defined in Title 28-A, section 2, subsection 15, in accordance with Title 28-A, chapter 43; ~~7%~~ 9.75% on the value of rental of living quarters in any hotel, rooming house, tourist or trailer camp; ~~10%~~ 13% on the value of rental for a period of less than one year of an automobile; ~~7%~~ 10.75% on the value of prepared food sold in establishments that are licensed for on-premises consumption of liquor pursuant to Title 28-A, chapter 43; and ~~6%~~ 9.75% on the value of all other tangible personal property and taxable services. Value is measured by the sale price, except as otherwise provided.

Sec. G-6. 36 MRSA §2870 is enacted to read:

§2870. Payroll tax on employers

Each employer, as defined in Title 26, section 1043, for each calendar year, shall pay a payroll tax at the rate of 4.75% of aggregate total wages, as defined in Title 26, section 1043, paid by the employer in the State for that calendar year. These contributions are due and paid by each employer in accordance with regulations as the State Tax Assessor may prescribe and may

not be deducted, in whole, or in part, from the wages of individuals in the employers employ. In the payment of any contribution, a fractional part of a cent must be disregarded unless it amounts to 1/2¢ or more, in which case it must be increased to 1¢.

Sec. G-7. 36 MRSA §5111, sub-§1-A, as enacted by PL 1991, c. 591, Pt. YY, §2 and affected by §7, is repealed and the following enacted in its place:

1-A. Single individuals and married persons filing separate returns. For single individuals and married persons filing separate returns:

If Maine taxable income is:	The tax is:
Less than $4,050	5.504% of the Maine taxable income
At least $4,050 but less than $8,100	$81 plus 12.384% of the excess over $4,050
At least $8,100 but less than $16,200	$263 plus 19.264% of the excess over $8,100
$16,200 or more	$830 plus 23.392% of the excess over $16,200

Sec. G-8. 36 MRSA §5111, sub-§2-A, as enacted by PL 1991, c. 591, Pt. YY, §4 and affected by §7, is repealed and the following enacted in its place:

2-A. Heads of households. For unmarried individuals or legally separated individuals who qualify as heads of households:

If Maine taxable income is:	The tax is:
Less than $6,100	5.504% of the Maine taxable income
At least $6,100 but less than $12,150	$122 plus 12.384% of the excess over $6,100
At least $12,150 but less than $24,300	$394 plus 19.264% of the excess over $12,150

$24,300 or more	$1,245 plus 23.392% of the excess over $24,300

Sec. G-9. 36 MRSA §5111, sub-§3-A, as enacted by PL 1991, c. 591, Pt. YY, §6 and affected by §7, is repealed and the following enacted in its place:

3-A. Individuals filing married joint return or surviving spouses. For individuals filing married joint returns or surviving spouses permitted to file a joint return:

If Maine taxable income is:	The tax is:
Less than $8,100	5.504% of the Maine taxable income
At least $8,100 but less than $16,200	$162 plus 12.384% of the excess over $8,100
At least $16,200 but less than $32,400	$527 plus 19.264% of the excess over $16,200
$32,400 or more	$1,661 plus 23.392% of the excess over $32,400

Sec. G-10. 36 MRSA §5200, as amended by PL 1985, c. 675, §§1 and 5, is further amended to read:

§5200. Imposition and rate of tax

A tax is imposed upon the Maine net income of taxable corporations for each taxable year at the following rates:

If the Maine net income is:	The tax is:
Not over $25,000	~~3.5%~~ 7.25% of Maine net income
$25,000 but not over $75,000	$875 plus ~~7.93%~~ 11.43% of excess over $25,000
$75,000 but not over $250,000	$4,840 plus ~~8.33%~~ 11.83% of excess over $75,000
$250,000 or more	$19,417 plus ~~8.93%~~ 12.43% of excess over $250,000

In the case of an affiliated group of corporations engaged

in a unitary business, the respective preferential rates provided in this section ~~shall-be-applied~~ only apply to the first $250,000 of Maine net income of the entire group and ~~shall~~ must be apportioned equally among the taxable corporations unless those taxable corporations jointly elect a different apportionment. The balance of the Maine net income of the entire group ~~shall-be~~ is taxed at ~~8.93%~~ 12.43%.

PART H

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

CHAPTER 1683

MAINE HEALTH DATA ORGANIZATION

§8701. Definitions

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

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

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

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

4. Group purchaser. "Group purchaser" means a person or organization that purchases health care coverage on behalf of an identified group of persons, regardless of whether the cost of coverage is paid by the purchaser.

5. Health care facility. "Health care facility" means a public or private, 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. Health care practitioner. "Health care practitioner" means an allopathic or osteopathic physician, a chiropractor, a dentist, an optometrist, a podiatrist, a pharmacist, a psychologist, a nurse, a physical therapist, an occupational therapist, an acupuncturist, a dental hygienist, a physician assistant, a social worker, a speech therapist or audiologist, a 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.

§8705. Advisory committees

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

§8706. Public access to data

1. Public access. Any information, except privileged medical information, provided to the organization under this chapter must be made available to any person upon request as long as 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 adopt procedures to afford affected health care practitioners notice and opportunity to comment in response to requests for information that may be considered privileged.

3. Public health and quality improvement studies. The board, by rule or order, may allow, pursuant to subsection 1, exceptions to the rules adopted only 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;

(2) The quality improvement foundation; and

(3) 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 or quality improvement research of substantial public importance;

(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.

2 E. The board may not grant approval under this subsection if the board finds that the proposed identification of or
4 contact with patients or health care practitioners would violate any state or federal law or diminish the
6 confidentiality of medical information or the public's confidence in the protection of that information in a manner
8 that outweighs the expected benefit to the public of the proposed investigation.

10

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

18 **§8707. Utilization data**

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

24

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

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

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

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

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

48

3. Implementation of data collection requirements.
50 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;

O. Board of Dental Examiners;

P. Board of Licensure in Medicine;

Q. State Board of Nursing;

S. Board of Optometric Examiners;

T. Board of Osteopathic Licensure; and

U. Any other licensing board for health care practitioners.

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

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

§8710. 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 $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 this section may not exceed $25,000 for health care facilities for any one occurrence and $12,500 for all other providers for any one occurrence. The board, or legal counsel of the board's choice, may enforce the fine in a civil action brought in the 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
2 the expense of contracts for data management services.

4 **1. Number of persons covered.** For purposes of this section, "number of persons covered" means the number of persons
6 for whom the carrier provides or administers health-related benefits. In the case of insurance administrators, the number of
8 persons covered refers to only those persons on whose behalf the insurance administrator administers benefits and whose health
10 benefits are provided under a self-insured plan. On or before March 1st of each year, each carrier shall provide to the board a
12 written report of the number of persons covered by the carrier in this State during the immediately preceding calendar year. In
14 calculating the number of persons covered, the carrier shall add the number of persons covered in this State by the carrier in
16 each month of the year for which the report is being made and divide that sum by 12. The result of this calculation is
18 considered by the board to be the number of persons covered by the carrier in the calendar year for which the report is being
20 made.

22 **2. Minimum assessment.** In any year in which a carrier has no health-related contracts in force in this State or in which
24 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
26 $100, the minimum assessment payable by any carrier is $100.

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

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

34

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

40

6. Recalculation of assessment. Immediately following the
42 close of the fiscal year ending June 30, 1997 and at the close of each 2nd succeeding fiscal year, the board shall recalculate the
44 assessment made against each carrier after giving recognition to the actual expenditures of the organization during the preceding
46 biennial period. On or before October 1st, the board shall render to each carrier assessed a statement showing the
48 difference between the respective recalculated assessment and the amount paid with respect to the preceding biennium. Any
50 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. H-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. H-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. H-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. H-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 I

Sec. I-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. I-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. I-3. 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 J

Sec. J-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 K

Sec. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-28. 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. K-29. 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. K-30. 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. K-31. 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. K-32. 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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-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. K-57. 32 MRSA §13742, 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. K-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. K-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. K-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. K-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. K-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.

PART L

Sec. L-1. Submission of legislation. The Department of Human Services, by July 1, 1996, shall submit to the Legislature legislation to amend the statutes to correct cross-references and make any other technical changes necessitated by this Act.

STATEMENT OF FACT

Part A of the bill creates the Maine Health Care Authority. The Authority is required to administer the Maine Health Care Plan, a universal health care plan for all Maine residents. Part A requires the authority to contract with an administrator for the administration of the Maine Health Care Plan. It also assigns to the Maine Health Care Authority the tasks of creating a comprehensive state health resource plan, establishing a global budget and ensuring the quality and affordability of health care in the State.

Part B requires the Maine Health Care Authority and the Department of Human Services to coordinate the Maine Health Care Plan with the health benefits provided under the Medicaid and Medicare programs. The department is required to apply for all

waivers necessary to integrate the Medicaid program with the
2 Maine Health Care Plan.

4 Part C eliminates the requirement for the Department of Human Services to create a health resource plan. This Part also
6 repeals the certificate of need program.

8 Part D allows the members of the board of the Maine Health Care Authority to be paid for expenses incurred by them.

10

Part E repeals the statutes creating the State Employee
12 Health Commission and the Health Insurance Plan for State Employees. State employees will be insured under the Maine
14 Health Care Plan.

16 Part F requires the Bureau of Insurance and the Maine Health Care Authority to study the statutes and regulations enforced by
18 the bureau and report to the Legislature regarding any statutory changes needed to coordinate the role of the bureau with the
20 implementation of the Maine Health Care Plan.

22 Part G imposes the taxes necessary to pay for the Maine Health Care Plan.

24

Part H establishes the Maine Health Data Organization, an
26 independent state agency that will oversee and coordinate health collection activities and collect, edit and store statewide
28 health data resources.

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

38

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

42 Part K amends the licensing statutes for all health care practitioners to provide that repeated and intentional failure to
44 omply with the data collection requirements imposed under the Maine Revised Statutes, Title 22, chapter 1683 is grounds for
46 terminating a health care practitioner's license.

48 Part L requires the Department of Human Services to submit legislation to make technical corrections to the statutes
50 necessitated by this Act.