131st MAINE STATE LEGISLATURE
LEGISLATIVE COUNCIL

February 22, 2024
1:30 P.M.
AGENDA

Page	Item		Action
		CALL TO ORDER	
		ROLL CALL	
		SUMMARY OF THE JANUARY 9, 2024 MEETING OF LEGISLATIVE COUNCIL	**Decision**
		REPORTS FROM EXECUTIVE DIRECTOR AND STAFF OFFICE DIRECTORS	
		• Fiscal Report (Mr. Nolan)	**Information**
		• Legislative Studies Report (Ms. Fox)	**Information**
		REPORTS FROM COUNCIL COMMITTEES	
		• State House Facilities Committee	
		NEW BUSINESS	
	Item #1:	Consideration of Requests for After-Deadline Bills and Certain Joint Resolutions	**Roll Call Vote**
	Item #2:	Approval of the State House Emergency Plan Revision	**Decision**
	Item #3:	Request for waiver of *Legislative Council Policy on the Use of Capitol Park* (Senator Pouliot)	**Decision**
	Item #4:	Acceptance of the Eighteenth Annual Report of the Right to Know Advisory Committee (January 2024)	**Acceptance**

Item #5:	Acceptance of the Report of the Task Force to Study the Creation of a Comprehensive Career and Technical Education System (January 2024)	**Acceptance**
Item #6:	Acceptance of the Report of the Task Force to Study the Creation of a Comprehensive Career and Technical Education System (January 2024)	**Acceptance**
Item #7:	Acceptance of the Report of the Commission Regarding Foreign-trained Physicians Living in Maine (January 2024)	**Acceptance**
Item #8:	Acceptance of the Report of the Blue Ribbon Commission to Study Emergency Medical Services in the State (January 2024)	**Acceptance**
Item #9:	Acceptance of the Report of the Commission to Study Expansion of Public Preschool and Early Care and Education (January 2024)	**Acceptance**
Item #10:	Acceptance of the Report of the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities (January 2024)	**Acceptance**
Item #11:	Acceptance of the Report of the Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard-of-hearing Patients (January 2024)	**Acceptance**
Item #12:	Acceptance of the Report of the Task Force to Evaluate the Impact of Facility Fees on Patients (January 2024)	**Acceptance**
Item #13:	Acceptance of the Report of the Gagetown Harmful Chemical Study Commission (January 2024)	**Acceptance**
Item #14:	Acceptance of Annual Report of the Washington County Development Authority	**Acceptance**
Item #16:	Acceptance of Annual Report of the Midcoast Regional Redevelopment Authority	**Acceptance**

ANNOUNCEMENTS AND REMARKS

ADJOURNMENT

131ST MAINE STATE LEGISLATURE
LEGISLATIVE COUNCIL

LEGISLATIVE COUNCIL
MEETING SUMMARY
January 9, 2024

CALL TO ORDER

President Jackson called the January 9, 2024 meeting of the 131st Legislative Council to order at 2:30 p.m. in the Legislative Council Chamber.

ROLL CALL

Senators:	President Jackson, Senator Vitelli, Senator Daughtry, Senator Stewart, and Senator Keim
Representatives:	Speaker Talbot Ross, Representative Terry, Representative Cloutier, Representative Faulkingham, and Representative Arata
Legislative Officers:	Suzanne Gresser, Executive Director of the Legislative Council Darek Grant, Secretary of the Senate Rob Hunt, Assistant Clerk of the House Edward Charbonneau, Revisor of Statutes Danielle Fox, Director, Office of Policy and Legal Analysis Christopher Nolan, Director, Office of Fiscal and Program Review Nik Rende, Director, Office of Legislative Information Technology

President Jackson convened the meeting at 2:30 p.m. with a quorum of members present.

President Jackson asked if there was any objection to taking items out of order, and hearing no objection, the Chair then moved on to Item #1 under **New Business.**

NEW BUSINESS

Item #1: Consideration of After Deadline Bill Requests and Joint Resolutions

The Legislative Council proceeded to consider and vote on thirty-one (31) after deadline bill requests and two (2) Joint Resolutions. With respect to requests for after deadline bill requests, the Legislative Council accepted for introduction nineteen (19), rejected twelve (12), and tabled two

(2) request. In addition, the Council rejected two (2) requests for Joint Resolutions. The Legislative Council's action on the requests is attached to this meeting summary.

Following the Legislative Council's consideration of requests for after deadline bills and joint resolutions, the President returned to the printed agenda.

REPORTS FROM COUNCIL OFFICE DIRECTORS

Fiscal Report

Although a written fiscal report had not been included in the Council materials, President Jackson invited the Director of the Office of Fiscal and Program Review to provide an oral briefing to the Council regarding the appropriation limit and the most recent revenue projections. Director Nolan reported to the Legislative Council that: so far, the State is below the appropriation limit for both FY24 and FY25, but it is close to the limit for FY24; the December forecast had added $139.3 million for FY24 and $125.3 million for FY25, for a total of $264.6 million; and this re-projected amount, when added to the previously projected balance of $28.5 million, results in an estimated balance at the end of FY25 of $293.1 million. In response to questioning, Director Nolan further explained that while the estimated 2024-2025 General Fund balances are technically available to fund new initiatives, any additional appropriations in those initiatives would be limited by the appropriations limit, particularly in FY24.

REPORTS FROM COUNCIL COMMITTEES

State House Facilities Committee

Representative Terry reported that the State House Facilities Committee met on Friday, January 5th, to consider the following items.

1. Request for the Commissioning of Official Portraits and Overview of Policy

The committee considered a request from the Honorable Kevin Raye, former President of the Maine Senate, that the Legislative Council authorize the commissioning of official portraits of former United States Senators Olympia Snowe and William Cohen. The committee discussed the specifics of the request, as well as processes set out in the Legislative Council Policy on the Maine State House Portrait Collection, such as artist selection, sharing of portrait commission costs, and responsibility for the placement of portraits in the State House. Representatives of the Maine State Museum who were present at the meeting provided information to the committee. Following its discussion, the committee unanimously voted to recommend to the Legislative Council that it approve commissioning and adding to the Maine State House Portrait Collection the official portraits of former United States Senators Olympia Snowe and William Cohen.

2. Emergency Preparedness

The committee discussed emergency preparedness with Matthew Clancy, Chief of Maine Capitol Police. The committee requested that Chief Clancy provide the committee with a plan to enhance communications in emergency situations, including information on the costs that would be associated with implementing a type of public address system; and to work with the Clerk and the

Secretary on a date to provide training on active threat procedures to members of the Legislature and caucus office staff, in the House chamber.

Representative Terry reported that the at the end of its meeting, the committee went into executive session to receive information related to security plans and security procedures, and to discuss details of what an updated security system would look like. In response to a question from Sen. Stewart, Representative Terry confirmed that the plan for security screening in the CSOB would be similar to the security screening that currently exists in the State House. In response to a question from Speaker Talbot Ross, Director Gresser confirmed that the plan to move forward on security screening in the CSOB is not dependent on legislative action on LD 1100, which was carried over to the Second Regular Session from the First Regular Session.

Representative Terry returned to the topic of the Commissioning of Official Portraits, and offered the following motion:

> **Motion**: That, upon the unanimous recommendation of the Personnel Committee, the Legislative Council approve commissioning and adding to the Maine State House Portrait collection, official portraits of former United States Senators Olympia Snowe and William Cohen, and further that the Executive Director initiate the process of commissioning the portraits.
> Motion by Representative Terry. Second by Senator Stewart. **Motion passed unanimously (8-0-0-2,** with Senator Daughtry and Senator Keim absent).

OLD BUSINESS

Item #1: Council Actions Taken by Ballot

None

SUMMARY OF DECEMBER 21, 2023 MEETING OF LEGISLATIVE COUNCIL

> **Motion:** That the Meeting Summary for December 21, 2023 be accepted and placed on file. Motion by Senator Stewart. Second by Senator Vitelli. **Motion passed unanimously (8-0-0-1, with Senator Daughtry and Senator Keim absent)**.

ANNOUNCEMENTS AND REMARKS

With no other business to consider or further announcements, the Legislative Council meeting was adjourned at 5:28 p.m.

131st Second Regular Session
Maine State Legislature
Legislative Council Actions Taken
on Requests to Introduce
Legislation and Joint Resolutions
at Legislative Council Meeting Held on January 9, 2024

AFTER DEADLINE BILL REQUESTS

SPONSOR: **Rep. Poppy Arford**

LR #	Title	Action
3018	An Act to Require Health Insurance Coverage for Federally Approved Nonprescription Contraceptives	PASSED

SPONSOR: **Sen. Richard A. Bennett**

LR #	Title	Action
3000	An Act to Provide Assistance to Maine Households for the Costs of Home Heating	FAILED

SPONSOR: **Sen. Eric Brakey**

LR #	Title	Action
2979	An Act to Create a Lewiston Strong License Plate	FAILED

SPONSOR: **Rep. Dick Campbell**

LR #	Title	Action
3015	An Act to Change the Types of Rules That Are Subject to the Petition Process	TABLED

SPONSOR: **Rep. Nathan Michael Carlow**

LR #	Title	Action
2976	An Act to Address Violations of Confidentiality by School Board Members	WITHDRAWN

SPONSOR: **Rep. Kristen Sarah Cloutier**

LR #	Title	Action
2991	An Act to Ensure That Donations Received by Victims of the Mass Shooting in Lewiston Are Not Taxable	PASSED

SPONSOR:	**Rep. Scott Wynn Cyrway**	
LR #	Title	Action
3013	An Act to Require a Feasibility Study to Consider Alternative Transmission Technology for the Aroostook Renewable Gateway	PASSED
SPONSOR:	**Sen. Matthea Elisabeth Larsen Daughtry**	
LR #	Title	Action
2992	An Act to Protect Small Businesses from Fraudulent or Predatory Financial Settlements by Allowing Those Businesses Opportunities to Remove Barriers Associated with the Federal Americans with Disabilities Act of 1990	PASSED
2999	Resolve, to Rename the I-295 Overpass in the Town of Freeport the Matthew MacMillan Memorial Bridge	PASSED
SPONSOR:	**Rep. Jack Ducharme**	
LR #	Title	Action
2968	An Act to Ensure Collection of Damages by Increasing the Required Amount of Personal Liability Coverage	PASSED
SPONSOR:	**Sen. Brad Farrin**	
LR #	Title	Action
2977	Resolve, to Correct the Designation of a Bridge in Canaan to Be Named After Staff Sergeant Richard Gerald Salsbury	PASSED
SPONSOR:	**Sen. Matthew A. Harrington**	
LR #	Title	Action
3007	An Act to Improve Access to Affordable Wireless Communications	PASSED
SPONSOR:	**Sen. Craig V. Hickman**	
LR #	Title	Action
3012	An Act to Provide Relief to Retail Businesses Affected by the December 2023 Storm	PASSED
SPONSOR:	**Sen. Henry Ingwersen**	
LR #	Title	Action
3011	An Act to Implement Protections Against Deed Fraud	PASSED

SPONSOR: **Sen. Lisa Keim**

LR #	Title	Action
3010	An Act to Exempt from the State Income Tax Wages Earned by Hourly Law Enforcement Officers	FAILED

SPONSOR: **Rep. Laurel Libby**

LR #	Title	Action
2975	An Act to Increase Availability of Mental Health Care Facilities in Maine by Eliminating Certificate of Need Requirements for Mental Health Care Facilities	FAILED

SPONSOR: **Sen. James D. Libby**

LR #	Title	Action
2980	An Act Regarding the Use of Portable Toilets	PASSED

SPONSOR: **Rep. Reagan L. Paul**

LR #	Title	Action
2986	An Act to Require the Determination of Whether a Discriminatory Act Was Motivated by Antisemitic Intent	FAILED

SPONSOR: **Rep. Bill Pluecker**

LR #	Title	Action
3009	An Act to Relieve the Tax Burden of Wild Blueberry Growers Affected by Inflation	NO ACTION TAKEN

SPONSOR: **Rep. Katrina Smith**

LR #	Title	Action
2987	An Act to Prohibit the Acquisition of Title to Real Property by Certain Aliens or Foreign Entities	FAILED

SPONSOR: **Rep. Mike A. Soboleski**

LR #	Title	Action
3019	An Act Regarding Major Substantive Rules and Routine Technical Rules	FAILED
3020	An Act Regarding Automobile Emissions Rules	FAILED

SPONSOR: **Sen. Trey Stewart**

LR #	Title	Action
2969	An Act to Create the Savings Account Program for Small Businesses	FAILED
2981	An Act to Increase Reimbursement Rates for Outpatient Psychiatry	PASSED
2982	An Act to Attract and Retain Behavioral Health Clinicians	PASSED
2994	An Act to Clarify When a Wounded Game Animal May Be Dispatched by an Authorized Guide	PASSED
3002	Resolve, to Allow Ireland Farms to Sue the State	PASSED
3022	An Act to Support Veterans' Organizations and Other Nonprofits Across the State	PASSED
3023	An Act to Ensure Equitable Treatment in High School Sports	FAILED
3024	An Act Relating to State Closures	TABLED
3025	An Act Regarding Mental Health Crisis Response Regulations and Reimbursement	PASSED

SPONSOR: **Spkr. Rachel Talbot Ross**

LR #	Title	Action
2998	An Act to Require Background Checks Prior to Certain Sales, Transfers or Exchanges of Firearms	WITHDRAWN
3005	An Act to Strengthen the Health, Well-being and Academic Success of Children and Their Families Through Community Support	PASSED
3006	Resolve, to Require the Chief Justice of the Supreme Judicial Court to Arrange the Constitution of Maine to Incorporate Amendments Approved in the November 2023 Referendum	PASSED

SPONSOR: **Rep. James L. White**

LR #	Title	Action
2988	An Act Relating to Prohibitions on Certain Firearms	NO ACTION TAKEN

JOINT RESOLUTIONS

SPONSOR: **Rep. Sally Jeane Cluchey**

LR #	Title	Action
3004	JOINT RESOLUTION MEMORIALIZING THE PRESIDENT OF THE UNITED STATES AND THE UNITED STATES CONGRESS TO PUBLISH AND AFFIRM THE EQUAL RIGHTS AMENDMENT	FAILED

SPONSOR: **Rep. Reagan L. Paul**

LR #	Title	Action
2984	JOINT RESOLUTION RECOGNIZING ISRAEL'S RIGHT TO USE DECISIVE FORCE IN DEFENDING ITS CITIZENS AND ELIMINATING TERRORIST THREATS, REAFFIRMING MAINE'S STRONG SUPPORT FOR ISRAEL AND URGING THE UNITED STATES TO PROVIDE ASSISTANCE TO ISRAEL	FAILED

Fiscal Briefing

February 22, 2024

Prepared by the Office of Fiscal & Program Review

1. General Fund Revenue Update (see attached)

Total General Fund Revenue - FY 2024 ($'s in Millions)

	Budget	Actual	Var.	% Var.	Prior Year	% Change
January	$529.8	$552.5	$22.8	4.3%	$507.0	9.0%
FYTD	$3,095.6	$3,143.6	$48.0	1.6%	$3,119.6	0.8%

General Fund revenue was over budget by $22.8 million (4.3%) for the month of January and by $48.0 million (1.6%) for the fiscal year to date. General Fund revenue for FY24 through January was 0.8% greater than FY23 General Fund revenue through January of 2023. Without the new automotive sales tax transfers totaling $107.5 million from the General Fund to the Highway Fund, FY24 General Fund revenue through January would be 4.2% greater than FY23 revenue through January of 2023.

Individual income tax revenue was under budget by $10.4 million (3.4%) for the month but over budget by $8.5 million (0.6%) for the fiscal year to date. Individual income tax withholding payments were below budget for the month and for the fiscal year to date, individual income tax final payments exceeded budget for the month and for the fiscal year to date and individual income tax refunds were above budget (negative general fund impact) for the month but remained below budget for the fiscal year to date. Corporate income tax revenue was $17.7 million above budget for January and $32.3 million (15.5%) above budget for the fiscal year to date. Sales and use tax revenue for January (December sales) was slightly above budget for the month and $2.7 million (0.2%) above budget for the fiscal year to date.

2. Highway Fund Revenue Update (see attached)

Total Highway Fund Revenue - FY 2024 ($'s in Millions)

	Budget	Actual	Var.	% Var.	Prior Year	% Change
January	$30.6	$38.4	$7.8	25.6%	$27.4	40.5%
FYTD	$333.6	$348.8	$15.2	4.5%	$208.8	67.1%

Highway Fund revenue was over budget by $7.8 million (25.6%) for the month of January and above budget by $15.2 million (4.5%) for the fiscal year to date. Highway Fund revenue for FY24 through January was 67.1% greater than FY23 revenue through January of 2023 largely because of the new sales tax transfers from the General Fund to the Highway Fund totaling $107.5 million and the liquor operations fund transfers of $36.7 million to date. Without these transfers, Highway Fund revenue through January would be 1.9% less than FY23 revenue through January of 2023.

Fuel tax revenue was $0.3 million (1.7%) above budget for the month and over budget by $1.1 million (0.8%) for the fiscal year to date. Motor vehicle registrations and fees were over budget by $3.2 million (7.8%) for the month and over budget by $5.7 million (10.9%) for the fiscal year to date. Highway Fund revenue for the fiscal year through January also included a positive variance of $8.7 million in the new liquor operations fund transfers.

3. Cash Balances Update

The average balance in the cash pool for January was $4,089.0 million, an increase of $101.1 million from December's average balance. Other Special Revenue Funds – Retaining Interest was the only fund category that showed a decrease in cash balances in January. The Highway Fund balance for January was $60.7 million, an increase of $1.7 million from December's balance of $59.0 million.

4. Revenue Forecast - Meeting

The Revenue Forecasting Committee (RFC) is scheduled to meet on February 28th to review and update the revenue forecast for its required March 1st report.

General Fund Revenue
Fiscal Year Ending June 30, 2024 (FY 2024)

Updated 2/12/24

January 2024 Revenue Variance Report

Revenue Category	January '24 Budget	January '24 Actual	January '24 Variance	Fiscal Year-To-Date Budget	Fiscal Year-To-Date Actual	Fiscal Year-To-Date Variance	Fiscal Year-To-Date Variance %	% Change from Prior Year	FY 2024 Budgeted Totals
Sales and Use Tax [1]	195,895,686	196,040,115	144,429	1,423,884,393	1,426,618,835	2,734,442	0.2%	3.6%	2,247,423,850
Service Provider Tax	4,166,707	3,909,677	(257,030)	29,860,757	29,809,066	(51,691)	-0.2%	-2.0%	49,110,044
Individual Income Tax	308,760,584	298,391,845	(10,368,739)	1,503,536,284	1,512,058,270	8,521,986	0.6%	2.1%	2,436,073,715
Corporate Income Tax	15,500,000	33,234,795	17,734,795	208,359,430	240,611,886	32,252,456	15.5%	16.7%	375,623,000
Cigarette and Tobacco Tax [2]	11,149,051	12,220,535	1,071,484	92,565,605	90,939,655	(1,625,950)	-1.8%	0.4%	153,348,622
Insurance Companies Tax	38,693	746,664	707,971	17,528,328	17,490,029	(38,299)	-0.2%	1.6%	118,460,000
Estate Tax	2,750,000	2,267,200	(482,800)	9,044,171	7,380,981	(1,663,190)	-18.4%	-67.0%	23,600,000
Other Taxes and Fees *	10,088,026	12,323,065	2,235,039	83,295,875	85,986,733	2,690,858	3.2%	8.2%	142,524,301
Fines, Forfeits and Penalties	1,121,537	821,453	(300,084)	8,822,105	5,128,214	(3,693,891)	-41.9%	-2.4%	14,954,289
Income from Investments	4,395,107	5,429,760	1,034,653	30,652,089	29,865,888	(786,201)	-2.6%	129.9%	49,891,282
Transfer from Lottery Commission	5,132,075	13,908,262	8,776,187	39,773,585	53,752,239	13,978,654	35.1%	18.8%	68,000,000
Transfers to Tax Relief Programs *	(10,357,254)	(3,822,788)	6,534,466	(75,334,915)	(74,277,765)	1,057,150	1.4%	0.6%	(81,730,000)
Transfers for Municipal Revenue Sharing	(21,958,862)	(23,187,193)	(1,228,331)	(158,557,165)	(159,785,497)	(1,228,332)	-0.8%	-1.6%	(261,429,468)
Other Revenue *	3,077,479	231,920	(2,845,559)	(117,843,934)	(121,997,614)	(4,153,680)	-3.5%	-727.2%	(86,326,237)
Totals	**529,758,829**	**552,515,308**	**22,756,479**	**3,095,586,608**	**3,143,580,920**	**47,994,312**	**1.6%**	**0.8%**	**5,249,523,398**

* Additional detail by subcategory for these categories is presented on the following page.

1 / Includes revenue from adult-use cannabis sales taxes of $2.1 million for January and $13.6 million for the fiscal year to date.

2 / Includes revenue from adult-use cannabis excise taxes of $1.2 million for January and $9.1 million for the fiscal year to date.

General Fund Revenue
Fiscal Year Ending June 30, 2024 (FY 2024)

Updated 2/12/24

January 2024 Revenue Variance Report

Revenue Category	January '24 Budget	January '24 Actual	January '24 Variance	Fiscal Year-To-Date Budget	Actual	Variance	Variance %	% Change from Prior Year	FY 2024 Budgeted Totals
Detail of Other Taxes and Fees:									
- Property Tax - Unorganized Territory	0	0	0	12,589,369	13,365,675	776,306	6.2%	7.4%	15,931,051
- Real Estate Transfer Tax	1,687,245	1,855,431	168,186	12,019,146	11,935,707	(83,439)	-0.7%	-14.6%	20,830,062
- Liquor Taxes and Fees	1,355,537	1,621,985	266,448	13,411,962	11,893,931	(1,518,031)	-11.3%	1.0%	22,093,824
- Corporation Fees and Licenses	433,943	575,529	141,586	3,929,210	4,555,045	625,835	15.9%	1.7%	11,913,649
- Telecommunication Excise Tax	2,500	32,116	29,616	87,484	117,100	29,616	33.9%	111.2%	100,000
- Finance Industry Fees	2,706,175	2,779,295	73,120	15,636,113	14,631,755	(1,004,358)	-6.4%	-4.2%	26,516,990
- Milk Handling Fee	(29,178)	79,311	108,489	717,853	881,466	163,613	22.8%	79.8%	833,650
- Racino Revenue	928,101	1,016,367	88,266	6,733,241	6,752,146	18,905	0.3%	5.3%	11,373,799
- Boat, ATV and Snowmobile Fees	410,227	379,726	(30,501)	2,082,649	1,751,208	(331,441)	-15.9%	3.9%	4,559,561
- Hunting and Fishing License Fees	1,511,700	2,439,269	927,569	10,394,790	13,803,407	3,408,617	32.8%	38.6%	15,996,984
- Other Miscellaneous Taxes and Fees	1,081,776	1,544,038	462,262	5,694,058	6,299,293	605,235	10.6%	57.5%	12,374,731
Subtotal - Other Taxes and Fees	**10,088,026**	**12,323,065**	**2,235,039**	**83,295,875**	**85,986,733**	**2,690,858**	**3.2%**	**8.2%**	**142,524,301**
Detail of Other Revenue:									
- Liquor Sales and Operations	985	5,474	4,489	7,010,339	7,040,487	30,148	0.4%	23102.2%	7,028,500
- Targeted Case Management (DHHS)	4,297	0	(4,297)	44,135	25,387	(18,748)	-42.5%	-30.3%	65,123
- State Cost Allocation Program	1,959,661	2,170,881	211,220	12,544,709	12,711,690	166,981	1.3%	10.5%	21,186,401
- Unclaimed Property Transfer	0	0	0	0	0	0	N/A	N/A	20,000,000
- Tourism Transfer	0	0	0	(24,202,942)	(23,457,942)	745,000	3.1%	-5.9%	(24,202,942)
- Transfer to Maine Milk Pool	0	(415,009)	(415,009)	(897,847)	(5,498,758)	(4,600,911)	-512.4%	N/A	(6,102,855)
- Transfer to Multimodal Transportation Fund	0	0	0	(15,151,926)	(15,151,926)	(0)	0.0%	-2.6%	(15,151,926)
- Highway Fund Sales Tax Transfer	0	0	0	(107,534,228)	(107,534,228)	(0)	0.0%	-628.2%	(107,534,228)
- Transfer to Adult-Use Cannabis Fund	(340,336)	(338,593)	1,743	(2,727,348)	(2,725,604)	1,744	0.1%	-125.7%	(4,596,984)
- Other Miscellaneous Revenue	1,452,872	(1,190,833)	(2,643,705)	13,071,174	12,593,280	(477,894)	-3.7%	18.8%	22,982,674
Subtotal - Other Revenue	**3,077,479**	**231,920**	**(2,845,559)**	**(117,843,934)**	**(121,997,614)**	**(4,153,680)**	**-3.5%**	**-727.2%**	**(86,326,237)**
Detail of Transfers to Tax Relief Programs:									
- Me. Resident Prop. Tax Program (Circuitbreak	0	0	0	0	424	424	N/A	-14.7%	0
- BETR - Business Equipment Tax Reimb.	(5,444,933)	(3,545,000)	1,899,933	(10,634,915)	(11,953,817)	(1,318,902)	-12.4%	-0.2%	(17,000,000)
- BETE - Municipal Bus. Equip. Tax Reimb.	(4,912,321)	(277,789)	4,634,532	(64,700,000)	(62,324,372)	2,375,628	3.7%	0.8%	(64,730,000)
Subtotal - Tax Relief Transfers	**(10,357,254)**	**(3,822,788)**	**6,534,466**	**(75,334,915)**	**(74,277,765)**	**1,057,150**	**1.4%**	**0.6%**	**(81,730,000)**
Inland Fisheries and Wildlife Revenue - Total	**2,015,450**	**2,951,282**	**935,832**	**13,006,384**	**16,094,828**	**3,088,444**	**23.7%**	**31.7%**	**21,503,431**

Highway Fund Revenue
Fiscal Year Ending June 30, 2024 (FY 2024)

Updated 2/12/24

January 2024 Revenue Variance Report

Revenue Category	January '24 Budget	January '24 Actual	January '24 Variance	Fiscal Year-To-Date Budget	Fiscal Year-To-Date Actual	Fiscal Year-To-Date Variance	Fiscal Year-To-Date % Variance	% Change from Prior Year	FY 2024 Budgeted Totals
Fuel Taxes:									
- Gasoline Tax	15,832,797	15,792,721	(40,076)	120,045,684	121,131,835	1,086,151	0.9%	0.9%	193,503,075
- Special Fuel and Road Use Taxes	4,013,766	4,403,326	389,560	28,733,339	28,878,294	144,955	0.5%	-4.6%	49,212,136
- Transcap Transfers - Fuel Taxes	(1,996,632)	(2,029,615)	(32,983)	(14,974,156)	(15,035,551)	(61,395)	-0.4%	-36.0%	(24,382,318)
- Other Fund Gasoline Tax Distributions	(369,784)	(394,929)	(25,145)	(3,123,285)	(3,201,828)	(78,543)	-2.5%	-6.4%	(4,838,932)
Subtotal - Fuel Taxes	17,480,147	17,771,503	291,356	130,681,582	131,772,750	1,091,168	0.8%	-3.3%	213,493,961
Motor Vehicle Registration and Fees:									
- Motor Vehicle Registration Fees	4,249,853	5,929,601	1,679,748	37,490,727	40,644,934	3,154,207	8.4%	1.7%	69,019,954
- License Plate Fees	23,871	511,555	487,684	2,000,271	2,688,753	688,482	34.4%	19.4%	3,662,986
- Long-term Trailer Registration Fees	1,161,294	1,868,271	706,977	7,342,447	8,548,682	1,206,235	16.4%	-9.3%	14,134,523
- Title Fees	989,652	1,194,002	204,350	8,320,123	8,573,014	252,891	3.0%	-4.0%	14,279,501
- Motor Vehicle Operator License Fees	739,916	882,494	142,578	6,072,873	6,393,583	320,710	5.3%	-10.9%	10,158,098
- Transcap Transfers - Motor Vehicle Fees	0	0	0	(8,474,079)	(8,372,290)	101,789	1.2%	3.2%	(16,518,054)
Subtotal - Motor Vehicle Reg. & Fees	7,164,586	10,385,923	3,221,337	52,752,362	58,476,676	5,724,314	10.9%	-1.0%	94,737,008
Motor Vehicle Inspection Fees	265,215	410,782	145,567	1,656,505	1,155,255	(501,250)	-30.3%	-2.1%	2,982,600
Other Highway Fund Taxes and Fees	96,388	94,235	(2,154)	804,151	618,324	(185,827)	-23.1%	-32.8%	1,429,470
Fines, Forfeits and Penalties	35,549	61,216	25,667	371,307	548,181	176,874	47.6%	-19.4%	606,512
Interest Earnings	63,893	198,477	134,584	944,120	1,071,487	127,367	13.5%	346.3%	2,255,916
Highway Fund Sales Tax Transfer	0	0	0	107,534,228	107,534,228	0	0.0%	44692.0%	107,534,228
Liquor Operations Fund Transfer	5,000,000	8,037,671	3,037,671	28,000,000	36,658,244	8,658,244	30.9%	15169.5%	53,000,000
Other Highway Fund Revenue	505,536	1,489,499	983,963	10,868,468	10,949,728	81,260	0.7%	4.9%	13,755,823
Totals	**30,611,314**	**38,449,306**	**7,837,992**	**333,612,723**	**348,784,874**	**15,172,151**	**4.5%**	**67.1%**	**489,795,518**

131st Maine State Legislature
Second Regular Session

As of: 2/20/2024 10:14:04 AM

AFTER DEADLINE BILL REQUESTS

SPONSOR: **Sen. Richard A. Bennett**

LR #	Title	Action
3053	Resolve, to Name a Bridge in the Town of Mechanic Falls the Bill Dunlop Memorial Bridge	
3075	An Act to Require Department of Health and Human Services Rules Relating to the Operation of Youth Camps to be Major Substantive Rules	

SPONSOR: **Sen. Stacy Fielding Brenner**

LR #	Title	Action
3113	An Act to Authorize a Stop-work Order Regarding an Activity That is Creating a Substantial Adverse Impact to a Protected Natural Resource	

SPONSOR: **Sen. Brad Farrin**

LR #	Title	Action
3064	An Act to Increase the Debt Limit of the Anson and Madison Water District	
3111	An Act to Prohibit Requiring Compensation for Assisting a Person to Obtain Veterans Benefits	

SPONSOR: **Sen. Lisa Keim**

LR #	Title	Action
3106	An Act to Increase Rates for Certain Private Nonmedical Institution Homes	

SPONSOR: **Sen. Mark W. Lawrence**

LR #	Title	Action
3104	An Act to Clarify Permissible Election and Lobbying Expenditures by Consumer-owned Water Utilities	

SPONSOR:	**Rep. Bill Pluecker**	
LR #	Title	Action
3009	An Act to Relieve the Tax Burden of Wild Blueberry Growers Affected by Inflation	
SPONSOR:	**Rep. Ronald B. Russell**	
LR #	Title	Action
3047	An Act to Fully Fund the Property Tax Stabilization Program for Senior Citizens	
SPONSOR:	**Rep. Heidi H. Sampson**	
LR #	Title	Action
3081	An Act to Establish the Maine Election Transparency, Accountability and Inclusion Act	
SPONSOR:	**Rep. David Sinclair**	
LR #	Title	Action
3073	An Act to Establish a Minimum Value Threshold for the Class C Crime of Theft	
3074	An Act to Require Incarceration of a Person Convicted of Operating Under the Influence	
SPONSOR:	**Sen. Trey Stewart**	
LR #	Title	Action
3080	An Act to Increase the Tax Deduction Amount for In-home Day Care Businesses	
SPONSOR:	**Sen. Jeff Timberlake**	
LR #	Title	Action
3114	An Act to Allow School Administrative District No. 52 to Issue Temporary Notes for a Wastewater Treatment Project	
SPONSOR:	**Sen. Michael Tipping**	
LR #	Title	Action
3087	An Act to Create the Lincoln Mill Facilities District	In Ballot Status

SPONSOR: **Rep. James L. White**

LR #	Title	Action
2988	An Act Relating to Prohibitions on Certain Firearms	

LATE-FILED MAJOR SUBSTANTIVE RULES

SPONSOR:

LR #	Title	Action
3056	Resolve, Regarding Legislative Review of Chapter 213: Rules for the Salmonella Enteritidis Risk Reduction and Surveillance Program for Commercial Egg-type Flocks, a Late-filed Major Substantive Rule of the Department of Agriculture, Conservation and Forestry	In Ballot Status
3068	Resolve, Regarding Legislative Review of Portions of Chapter 80: Reduction of Toxics in Packaging, a Late-filed Major Substantive Rule of the Department of Environmental Protection	In Ballot Status
3120	Resolve, Regarding Legislative Review of Chapter 255: Workers' Compensation Fronting Companies, a Late-filed Major Substantive Rule of the Department of Professional and Financial Regulation, Bureau of Insurance	

JOINT RESOLUTIONS

SPONSOR: **Sen. Trey Stewart**

LR #	Title	Action
3102	JOINT RESOLUTION, URGING THE UNITED STATES CONGRESS TO ENACT MUCH-NEEDED REFORMS TO FEDERAL PERMITTING POLICIES TO ACCELERATE DEPLOYMENT OF NEW ENERGY INFRASTRUCTURE	

TABLED BY THE LEGISLATIVE COUNCIL

AFTER DEADLINE BILL REQUESTS

SPONSOR: **Rep. Dick Campbell**

LR #	Title	Action
3015	An Act to Change the Types of Rules That Are Subject to the Petition Process	Tabled 01/10/24

SPONSOR: **Sen. Trey Stewart**

LR #	Title	Action
3024	An Act Relating to State Closures	Tabled 01/10/24

Emergency Plans for the Maine State House

Maine Legislative Council

***Date of Adoption*, 2024**

Table of Contents

STATE HOUSE
BUILDING EMERGENCY PLANS

I. INTRODUCTION

This plan describes the procedures for full or partial evacuation, lockdown, or active threat response for the Maine State House in the event of an emergency within the State House or in the immediate vicinity of the State House.

For the purposes of this plan, the terms "complete evacuation" or "partial evacuation" applies to emergency situations occurring within the State House and that require the immediate exit of all persons from the State House to designated meeting areas, in accordance with this plan. The term "lock-down" applies to an emergency situation in the immediate outside vicinity of the State House and may include a full or partial lock-down of the State House to protect the safety of the State House occupants from the outside emergency situation. The term "active threat" applies to an emergency situation occurring within the State House that requires all persons in the State House to comply with active threat procedures to protect the safety of the State House occupants. During any evacuation, lock-down, or active threat event, the Executive Director of the Legislative Council, Chief of Capitol Police, Secretary of the Senate, Clerk of the House, or the Senior Group Leaders, or the designees of these individuals, will provide instructions to occupants of the State House in an appropriate manner.

II. PLAN OBJECTIVES

In the event of an emergency inside the State House, it may be necessary to evacuate all occupants of the State House from the building, or to invoke active threat procedures, in a rapid and safe manner.

In the event of an emergency outside of the State House, to protect the occupants of the building from harm, it may be necessary to secure (lock-down) the building.

Goals. This plan is intended to achieve the following goals.

A. The protection of the life and safety of individuals is the paramount goal.

B. All exits will be kept fully operational and clear of obstructions in all weather conditions.

C. Fire escapes will meet all applicable safety codes and will be used as backup routes of egress.

D. State House personnel will be identified to perform various functions during an emergency and provided with the appropriate training.

E. State House personnel taking part in the functions described in this plan will take no actions that place their personal safety in jeopardy.

III. INCIDENTS REQUIRING COMPLETE BUILDING EVACUATION

The following are some examples of emergencies that may require the immediate and complete evacuation of the State House, in accordance with this plan:

- Smoke or fire;
- Chemical or gas leak or spill inside the State House;
- Terrorist or bomb threat/detonation;
- Violence or threat of violence with a weapon;
- Civil disturbance; or
- Earthquake

IV. INCIDENTS REQUIRING PARTIAL EVACUATION OR LOCKDOWN

The following are some examples of emergencies that may require partial evacuation of the State House or a full or partial lock-down of the State House to protect the safety of the State House occupants from the outside emergency situation:

- Unauthorized presence or discharge of weapons in the immediate vicinity of the State House;
- Chemical or gas leak or spill in the immediate vicinity of the State House;
- Violence or threat of violence with a weapon;
- Civil disturbance in the immediate vicinity of the State House; or
- Law enforcement activity in the immediate vicinity of the State House in response to terrorism or civil disturbance.

V. INCIDENTS REQUIRING ACTIVATION OF ACTIVE THREAT PROTOCOLS

The following are some examples of emergencies that may require activation of active threat protocols within the State House to protect the safety of the State House occupants from the emergency situation:

- Unauthorized presence or discharge of weapons inside or in the immediate vicinity of the State House; or
- Violence or threat of violence with a weapon inside the State House.

VI. EXITS, FIRE ESCAPES, ELEVATORS, WAITING AREAS: LOCATIONS

On a busy day, there may be well over 1000 people in the State House, including members of the Legislature, the Governor, State employees, groups of school children, members of the public, lobbyists and others. Awareness of all exits from the State House and any congestion issues that may pertain to those exits is important, since many people in the State House on any day, particularly visitors, may be unfamiliar with the layout of the building and specific evacuation plans.

❖ PRIMARY EXITS

There are six primary exits from the State House immediately to ground level.

First Floor. There are four exits on the first floor of the State House:

- (1W) the West Wing (Main) entrance (disability accessible);
- (1NW) the service entrance on the north side of the West Wing (disability accessible) (controlled access; not recommended for use during emergency evacuation procedures);
- (1S) the South Wing Exit (stairs) that faces the legislative parking area (Parking Lot A), and the Cultural Building, and
- (1N) the North Wing Exit (stairs) that faces the Blaine House.

Second Floor. There are two exits on the second floor of the State House:

- (2E) The East side entrance (stairs) facing Capitol Park; and
- (2N) The "Leadership/Governor's Entrance" (stairs) on the north side of the West Wing.

Third Floor. There are no direct exits to ground elevation from the third floor. Exiting the third floor requires traveling to lower elevations using either the north, south or west wing stairways or, if necessary, the outside fire escapes, as further described in this plan.

Fourth Floor. There are no direct exits to ground elevation from the fourth floor. Exiting the fourth floor requires traveling to lower elevations using either the north or the south stairways or, if necessary, the outside fire escapes, as further described in this plan.

Fifth Floor. Access to the fifth floor is restricted to maintenance and other authorized personnel. It is not open to the public, legislators or most staff. There are no direct exits to ground elevation from the fifth floor. Exiting the fifth floor requires traveling to lower elevations using one of 2 stairways to the fourth floor.

Note the following potential areas of congestion around certain exits:

- The two disability-accessible entrances to the State House, (1W) and (1NW), lead to areas that may be used by emergency responders and their vehicles.

- The "Leadership/Governor's Entrance" on the second floor (2N) also leads to the Leadership/Governor's parking lot (Parking Lot G) that is used by emergency responders and emergency vehicles.

- The Leadership/Governor's parking lot (Parking Lot G), adjacent to the Leadership/Governor's Entrance (2N), is the only area allowing ready access to the building for heavy equipment. This area must be kept clear for responding personnel and emergency response equipment. Those evacuating the building

must make every effort to keep out of this area and to stay clear of responding emergency vehicles.

❖ FIRE ESCAPES

There are three outside fire escapes available for use when the primary exits are not useable. Fire escapes should be used only when there is no other safe option of exiting the building. Examples of this include smoke conditions, visible flame, fire blocked exits and sprinkler activation.

The fire escapes are located in the North Wing, South Wing, and West Wing. Access to the outside fire escapes is as follows:

- Second Floor: Rooms 204 (Law Library), 226 (OFPR) and Governor's office (restricted access)
- Third Floor: House Chamber, Senate Chamber, Room 300 (Clerk's office mezzanine), Room 332 (House Republican Office)
- Fourth Floor: House Gallery, Room 424 (Senate President's staff office) and Room 436 (CJPS Committee)

❖ ELEVATORS

Elevators do not operate during a fire alarm. Upon activation of the alarm, the elevator cars will immediately travel to the ground floor and remain there with the doors open.

VII. PROCEDURES FOR REPORTING AN EMERGENCY SITUATION

❖ Employee. If an employee discovers an emergency situation, that person must notify the Maine Capitol Police at 287-HELP (287-4357) or dial 911 immediately to report the incident. The person must then notify his or her supervisor and, when time permits, the Office of the Executive Director at 287-1615. If the emergency warrants, e.g. in the case of fire, the person should pull the nearest fire alarm box. If none of those options are available, the employee must notify Building Control Center at 287-4154.

❖ Supervisor. When a supervisor is notified by any person that an emergency situation exists in the State House, the supervisor must confirm that the Maine Capitol Police or the 911 response center has been notified and, if appropriate, that a fire alarm has been activated. The supervisor must then immediately contact the Executive Director at 287-1615 and brief the director on the situation, site, and actions taken.

❖ Executive Director. Once notified of an emergency situation, the Executive Director or the Executive Director's designee must notify the Chief of Capitol Police if Capitol Police has not already been notified. Although, depending on the precise nature of the specific emergency circumstance, it may not always be possible to provide the desired

level of information to all parties at the outset of the situation, if time and circumstances permit, the Executive Director shall also notify the Governor's Office, the Secretary of the Senate, the Clerk of the House, and the chiefs of staff (or designees) of each Senate and House caucus office. The Executive Director may activate the emergency plan or consult first with the Presiding Officers, or their designees, and the Bureau of Capitol Police, depending on the urgency of the situation.

VIII. INCIDENT MANAGEMENT

The Chief of Capitol Police will ordinarily direct emergency activities and responses, including but not limited to evacuation, partial evacuation, lockdown, and response to an active threat.

❖ EVACUATION, AND PARTIAL EVACUATION:

With respect to evacuation procedures, the State House Emergency Evacuation Team is composed of the Senior Group Leader, Group Leaders, Office Captains, Emergency Wardens, Special Needs Buddies (or "Buddies"), the Secretary of the Senate, the Clerk of the House, the Executive Director and the Bureau of Capitol Police. Group Leaders report directly to the Senior Group Leader who reports to the Executive Director. Emergency Wardens and Office Captains report to their Group Leaders. Buddies report to their Emergency Warden. Capitol Police works closely with the Senior Group Leader and the response agencies. Team members should wear legislature-issued vests during an emergency to visually identify themselves as State House Emergency Evacuation Team members.

Senior Group Leaders. Senior Group Leaders are responsible for the overall coordination and communications during an incident, and work closely with the Executive Director and Capitol Police to coordinate communications amongst the members of the State House Emergency Response Team. Senior Group Leaders meet up with their groups at their designated assembly areas. Senior Group Leaders will wear yellow vests.

Group Leaders. Group Leaders meet with their groups at their designated assembly areas for a head count, to record reports from emergency wardens and office captains as received, and note any problems or concerns. They frequently report these items to the Senior Group Leader. Group Leaders remain in charge of their groups until the emergency is discontinued. Group Leaders will wear yellow vests.
Office Captains. Office Captains evacuate with their own office and must account for individuals of their particular office group. Concerns and discrepancies are reported to the respective Group Leader immediately.

Emergency Wardens. Emergency Wardens begin at their respective ends of the hallway and check every office, restroom and lounge (including those in the West Wing) to ensure they are vacated. They report to their Group Leaders on the completion of their evacuation assignments, noting any problems or unusual incidents. There are two teams

for every floor: one team composed of staff members from offices located in the north wing of that floor, and one team composed of two staff members from offices located in the south wings. They also provide assistance and guidance to those in the halls. They will continue to work as monitors for their Group Leader and carry out assignments until the termination of the event. Emergency Wardens will wear yellow vests.

Buddies. Buddies report the safe evacuation of their evacuee to their Group Leader. They also report any special needs or problems that develop during the emergency period.

Committee Clerks. Upon activation of an emergency alarm, committee clerks will inform members of the committee and the public that an emergency exists and direct them to the designated exit.

Stairway Monitors. Stairway monitors are members of the staff assigned to take up positions near the stairways on the 2nd, 3rd and 4th floors. Stairway monitors will also take up positions near the stairways on the 1st floor south and on the 1st floor north. They guide individuals entering and exiting the stairways, keep the exit process moving and to provide brief reminders of assembly points. Stairway monitors on each floor and wing should remind their group of their primary exit door. Monitors on the first floor will direct people to the (1W) West exit if necessary to avoid or mitigate congestion at the North or South exits. Stairway monitors will wear yellow vests.

If there is no immediate need to initiate building evacuation, the Senior Group Leader, Emergency Wardens, Office Captains, and Group Leaders are to be notified and placed on standby.

Complete evacuation decision. If a decision is made for immediate evacuation, Legislators, staff and members of the public in the State House will be notified through the activation of an alarm broadcast throughout the State House.

Partial evacuation or lock-down. If a decision is made to initiate a partial evacuation or a building lock down, building occupants will be notified through the activation of an automated notification process.

The Governor, the President of the Senate, and the Speaker of the House must be evacuated immediately to predetermined locations.

For safety reasons, maintenance and trades crews must be authorized or accompanied by a Capitol Police officer or other on-site response personnel in order to proceed to the site of alarm activation during a building evacuation. If entry is authorized, they must wear red response vests.

Parking Lot G adjacent to the Leadership/Governor's entrance is the only area allowing ready access to the building by emergency vehicles and other heavy equipment. This area must

be kept clear for the emergency equipment, etc. Those evacuating the building must make every effort to keep out of this area and stay clear of responding emergency vehicles.

If the situation does not intensify, Team Members will be notified of the situation conclusion.

Evacuation routes may change depending on the location and nature of the emergency. Follow the instructions of the Stairway Monitors when exiting.

All measures are based on the presumption that they will not place a person's life in danger. Such actions as closing windows and checking empty rooms should be weighed against the imminent danger to the person involved. Actions unable to be taken are reported to the Group Leader. The Group Leader forwards the information through channels to the Incident Commander who will make any necessary decisions.

The State House Emergency Evacuation Team is charged with responsibility to carry out the evacuation measures as described in this plan. No legislator, employee or visitor, no matter how well intentioned, may interfere with evacuation of the building or countermand instructions given by the State House Emergency Evacuation Team for such evacuation.

❖ ACTIVE THREAT

As described in the training regarding active threat responses presented to Legislators and staff, in the instance of an active threat incident, the following procedures should be followed in the following sequence:

1. If a person is able to safely leave the area, the person should leave their belongings and quickly and safely **run** away from the threat. Legislators and staff who are able to safely leave the area go directly to their designated assembly areas.

2. If a person is unable to leave due to the physical proximity of the active threat, the person should **hide**, and observe lockdown procedures by securing the location, silencing their electronic devices, and remaining quiet; and

3. If a person is in danger of being harmed, the person, as a last resort, should **fight** by working with others to take active defensive steps, such as improvising weapons and coordinating an ambush**.**

IX. TERMINATION/CONTINUATION OF EVENT

The Presiding Officers (or their designees) or the Executive Director, after consultation with Capitol Police, the Senior Group Leader and the Incident Commander, informs the Senior Group Leader regarding re-entry to the building, relocation of business, or dismissal of employees and closure of business. If the building has been evacuated, no one will be allowed to

re-enter the building until authorized by the Emergency Evacuation Team who receives re-entry instructions from the Senior Group Leader.

The Group Leaders circulate the information, using the Office Captains and Emergency Wardens. Upon the termination of the event, whether it is an evacuation, partial evacuation or lockdown, or active threat event, notice to all staff and legislators will be provided via an automated notification process; in addition, supplemental communications aids will be used as available.

If dismissal with an undetermined return is necessitated, the form of notification of resumption of business will be communicated via an automated notification process.

When reentering the State House after the termination of an event, Legislative Council rules regarding security screening protocols must be followed. Persons without access cards or access rights through another entrance or the priority screening lane must be rescreened. Those with access to the priority screening lane must use their cards to approve access as they would entering the State House for the first time. If other entrances are used, only those using their cards are allowed to enter and they are prohibited from allowing other persons to enter with them unless they have their own individual card access.

X. TRAINING

Safety Trainings. At the beginning of each biennium, Legislators and staff will be presented with a safety training that includes training regarding responding to active threat situations.

Emergency Evacuation Trainings. Staff members who are on the State House Emergency Evacuation Team and the directors of legislative offices will receive annual training regarding the State House evacuation routes, the designated assembly areas, and the specific tasks performed by each evacuation team role.

XI. DEVELOPMENT OF OFFICE-SPECIFIC SAFETY PLANS

Each Leader together with their Chief of Staff, and each legislative Office Director shall annually establish, or review and revise, a safety plan that is specific to their office's physical space and staff configuration, and that incorporates plans and procedures to be implemented in the event of an evacuation, lock-down, or active threat event.

XII. SAFETY DRILLS

The Executive Director, the Secretary of the Senate, and the Clerk of the House will together schedule and hold two annual safety drills in consultation with the presiding officers. One drill will be held during a regular session of the Legislature, and a second drill will be held in the fall.

XIII. PERIODIC REVIEW OF PLAN

This plan is maintained by Office of the Executive Director and will be reviewed each biennium by the Legislative Council or its State House Facilities Committee and revised as necessary.

This Plan as revised supersedes all previous versions.

BY: _____
Suzanne M. Gresser
Executive Director of the Legislative Council

Adopted February 24, 2005
Revised effective May 9, 2007
Revised effective March 28, 2008
Revised effective April 4, 2011
Revised effective April 2, 2013
Revised effective January 25, 2018
Revised effective February 28, 2019
Revised effective (date of adoption 2024)

State of Maine
131st Legislature

Eighteenth Annual Report of the Right to Know Advisory Committee

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE

Eighteenth Annual Report of the Right to Know Advisory Committee

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EXECUTIVE SUMMARY

This is the eighteenth annual report of the Right to Know Advisory Committee (RTKAC or Advisory Committee). The Advisory Committee was created by Public Law 2005, chapter 631 as a permanent advisory council with oversight authority and responsibility for a broad range of activities associated with the purposes and principles underlying Maine's freedom of access laws. The members are appointed by the Governor, the Chief Justice of the Supreme Judicial Court, the Attorney General, the President of the Senate and the Speaker of the House of Representatives.

As in previous annual reports, this report includes a brief summary of the legislative actions taken in response to the Advisory Committee's January 2023 recommendations and a summary of relevant Maine court decisions from 2023 related to the freedom of access laws. This report also summarizes several topics discussed by the Advisory Committee that did not result in a recommendation or further action.

For its eighteenth annual report, the Advisory Committee makes the following recommendations:

- ❒ **Amend certain provisions of law in Title 22 relating to previously-enacted public records exceptions**

- ❒ **Provide an explanation to the Blue Ribbon Commission to Study Emergency Medical Services in the State of why the RTKAC did not recommend amending Title 32, section 98, to establish a public records exception for financial information provided by applicants for Emergency Medical Services Stabilization and Sustainability Program grants**

- ❒ **Reinforce the importance of following the statutory requirements applicable to public bodies and agencies going into executive session**

- ❒ **Request that the Public Access Ombudsman include more guidance regarding the Freedom of Access Act's (FOAA) requirements for public bodies and agencies going into executive session on the Maine Freedom of Access Act website**

- ❒ **Send a letter to Maine School Management Association confirming that FOAA allows a public body to create an internal form for responding to public records requests and that the Public Access Ombudsman can assist in the development of such a form**

- ❒ **Solicit from entities within the State responsible for responding to public records requests examples of burdensome public records requests and situations that the entity believes represent an abuse of the FOAA process, as well as suggested statutory changes, for consideration by the Advisory Committee next year**

- ❒ **Send a letter to Maine Chiefs Police Association requesting that it coordinate with the Maine Sheriffs Association, Maine State Police, Maine Office of the Attorney General, Maine Press Association and Maine Association of Broadcasters to convene a meeting**

to share information among stakeholders regarding the pressures and constraints experienced by both members of the media and law enforcement when reporting on or releasing information related to public safety incidents and ongoing criminal investigations

- ❒ **Propose that the Joint Standing Committee on Judiciary report out a bill in the Second Regular Session of the 131st Legislature to create a legislative study group to develop recommendations related to public employee disciplinary records, taking into consideration progressive discipline structures and employee incentives across different types of public employment**

In 2024, the Right to Know Advisory Committee will continue to discuss the unresolved issues identified in this report, including issues related to burdensome public records requests and to the development of recommendations to increase collaboration between law enforcement and the media to ensure the public has access to timely, reliable information about significant public safety incidents and criminal investigations. The Advisory Committee will also continue to provide assistance to the Joint Standing Committee on Judiciary relating to proposed legislation affecting public access. The Advisory Committee looks forward to another year of activities working with the Public Access Ombudsman, the Judicial Branch and the Legislature to implement the recommendations included in this report.

I. INTRODUCTION

This is the eighteenth annual report of the Right to Know Advisory Committee. The Right to Know Advisory Committee was created by Public Law 2005, chapter 631 as a permanent advisory council with oversight authority and responsibility for a broad range of activities associated with the purposes and principles underlying Maine's freedom of access laws. The Advisory Committee's authorizing legislation, located at Title 1, section 411, is included in Appendix A.

More information on the Advisory Committee, including meeting agendas, meeting materials and summaries of meetings and its previous annual reports can be found on the Advisory Committee's webpage at http://legislature.maine.gov/right-to-know-advisory-committee. The Office of Policy and Legal Analysis provides staffing to the Advisory Committee when the Legislature is not in regular or special session.

The Right to Know Advisory Committee has 18 members. Currently, there is one vacancy. The chair of the Advisory Committee is elected by the members. Current Advisory Committee members are:

Rep. Erin Sheehan, Chair	*House member of Judiciary Committee, appointed by the Speaker of the House*
Sen. Anne Carney	*Senate member of Judiciary Committee, appointed by the President of the Senate*
Amy Beveridge	*Representing broadcasting interests, appointed by the President of the Senate*
Jonathan Bolton	*Attorney General's designee*
Vacant	*Representing a statewide coalition of advocates of freedom of access, appointed by the Speaker of the House*
Justin Chenette	*Representing the public, appointed by the President of the Senate*
Lynda Clancy	*Representing newspaper and other press interests, appointed by the President of the Senate*
Linda Cohen	*Representing municipal interests, appointed by the Governor*

Julia Finn	*Representing the Judicial Branch, designated by the Chief Justice of the Supreme Judicial Court*
Betsy Fitzgerald	*Representing county or regional interests, appointed by the President of the Senate*
Chief Michael Gahagan	*Representing law enforcement interests, appointed by the President of the Senate*
Kevin Martin	*Representing state government interests, appointed by the Governor*
Judy Meyer	*Representing newspaper publishers, appointed by the Speaker of the House*
Tim Moore	*Representing broadcasting interests, appointed by the Speaker of the House*
Kim Monaghan	*Representing the public, appointed by the Speaker of the House*
Eric Stout	*A member with broad experience in and understanding of issues and costs in multiple areas of information technology, appointed by the Governor*
Cheryl Saniuk-Heinig	*A member with legal or professional expertise in the field of data and personal privacy, appointed by the Governor*
Victoria Wallack	*Representing school interests, appointed by the Governor*

The complete membership list of the Advisory Committee is included in **Appendix B**.

By law, the Advisory Committee must meet at least four times per year. During 2023, the Advisory Committee met five times: on September 18, October 2, October 23, November 6 and December 4. In accordance with the Advisory Committee's remote participation policy, Advisory Committee meetings were conducted in a hybrid manner. Meetings were remotely accessible to the public through the Legislature's website.

II. COMMITTEE DUTIES

The Right to Know Advisory Committee was created to serve as a resource and advisor about Maine's freedom of access laws. The Advisory Committee's specific duties include:

❒ Providing guidance in ensuring access to public records and public proceedings;

- ❒ Serving as the central source and coordinator of information about Maine's freedom of access laws and the people's right to know;

- ❒ Supporting the provision of information about public access to records and proceedings via the Internet;

- ❒ Serving as a resource to support training and education about Maine's freedom of access laws;

- ❒ Reporting annually to the Governor, the Legislative Council, the Joint Standing Committee on Judiciary and the Chief Justice of the Supreme Judicial Court about the state of Maine's freedom of access laws and the public's access to public proceedings and records;

- ❒ Participating in the review and evaluation of public records exceptions, both existing and those proposed in new legislation;

- ❒ Examining inconsistencies in statutory language and proposing clarifying standard language; and

- ❒ Reviewing the collection, maintenance and use of records by agencies and officials to ensure that confidential records and information are protected and public records remain accessible to the public.

In carrying out these duties, the Advisory Committee may conduct public hearings, conferences, workshops and other meetings to obtain information about, discuss and consider solutions to problems concerning access to public proceedings and records.

The Advisory Committee may make recommendations for changes in statutes to improve the laws and may make recommendations to the Governor, the Legislature, the Chief Justice of the Supreme Judicial Court and local and governmental entities with regard to best practices in providing the public access to records and proceedings and to maintain the integrity of the freedom of access laws. The Advisory Committee is pleased to work with the Public Access Ombudsman, Brenda Kielty. Ms. Kielty is a valuable resource to the public and public officials and agencies.

III. RECENT COURT DECISIONS RELATED TO FREEDOM OF ACCESS ISSUES

By law, the Advisory Committee serves as the central source and coordinator of information about Maine's freedom of access laws and the people's right to know. In carrying out this duty, the Advisory Committee believes it is useful to include in its annual reports a digest of recent developments in case law relating to Maine's freedom of access laws. For this annual report, the Advisory Committee has identified and summarized the following Maine Supreme Judicial Court decisions related to freedom of access issues. In addition, the Advisory Committee includes a summary of an October 2022 Superior Court decision related to a Title 22 exception that the Advisory Committee has recommended be amended in this report.

Human Rights Defense Center v. Maine County Commissioners Association Self-Funded Risk Management Pool

In this case, *Human Rights Defense Center v. Maine County Commissioners Association Self-Funded Risk Management Pool,* the Maine County Commissioners Association Self-Funded Risk Management Pool appealed the Superior Court's decision finding that the risk pool wrongfully refused to release documents requested by the Human Rights Defense Center (HRDC) from the risk pool related to the settlement of a case against Kennebec County and that the risk pool did so in bad faith, warranting award of attorney's fees. HRDC sought records showing payments disbursed related to a settlement. In response to the request, the risk pool stated that counsel for Kennebec County had already provided a release document and that the settlement amount was $30,000, but failed to produce any documentation supporting payment for that amount. When an additional request was made, the risk pool provided a link to a newspaper article quoting a representative of the risk pool about the settlement. No documentation showing an actual payment was produced. The Superior Court found that the risk pool used the clarification process to avoid disclosing responsive documents and failed to adequately respond to the request. Further, the Superior Court found that the risk pool acted in bad faith because it used the clarification process to invent a pretext to justify the refusal to disclose responsive documents. While the court was not able to find any other case of attorney's fees being granted in the FOAA context, the Superior Court granted the HRDC's request for reasonable attorney's fees pursuant to 1 MRSA section 409, subsection 4.

The Law Court affirmed the Superior Court's decision and, in a case of first impression, upheld the awarding of attorney's fees because the risk pool acted in bad faith in its refusal to fully comply with HRDC's request for records. The Law Court determined that, based on the facts cited by the Superior Court, the risk pool deliberately withheld access to payment-related documents in its possession that clearly were responsive to the request and should have been disclosed.

Fairfield v. Maine State Police

In this case, *Fairfield v. Maine State Police*, the plaintiff, Mr. Fairfield appealed a Superior Court order that affirmed the Maine State Police's (MSP) refusal to produce documents sought pursuant to a FOAA request. Mr. Fairfield requested records relating to: (1) documentation of MSP Crime Laboratory protocols including standing operating procedures; (2) DNA contamination logs; (3) quality assurance records; and (4) quality assurance manuals dating back to 2008. The Maine State Police produced certain documents responsive to the request, but withheld other documents that were determined to be confidential by statute, citing the Intelligence and Investigative Record Information Act, the DNA Data Base and Data Bank Act and personnel records provisions applying to state employees (Maine State Police). Maine State Police provided approximately 6,800 pages of requested materials in full, as well as 40 partially redacted pages. The MSP withheld approximately 2,700 pages on the basis that the records were confidential. Mr. Fairfield appealed and contended that the DNA contamination logs and quality assurance records were not confidential.

For the first time, the Law Court set forth the standard for review in cases that appeal a trial court's determination that a large number of requested documents are confidential. The Law Court outlined a 2-part analysis; first, the court must analyze de novo whether the trial court has created a sufficient factual record upon which it can determine whether the withheld documents are confidential, and second, the court independently reviews the factual record, including any documents submitted for in camera review, to ensure that the trial court did not commit clear error in its description and categorization of the withheld document. The Law Court noted that its review is completed by spot-checking a random selection of any withheld documents submitted for *in camera* review and reviewing other components of the factual record. In this case, the trial court conducted an *in camera* review of the records and also reviewed briefs submitted by the parties, affidavits submitted by the parties and an exceptions log prepared by the MSP as the factual record. Based on its independent review of the record, the Law Court affirmed the trial court's order, finding that there was no error when it determined that DNA contamination logs and quality assurance records were confidential and therefore not subject to disclosure under FOAA.

Feltis v. Frey

In this case, *Feltis v. Frey*, the plaintiff, Mr. Feltis, requested records from the Office of the Attorney General (OAG) related to his son's (Roger Feltis) death. Mr. Feltis's son died during an altercation and his death was investigated as a criminal matter. Although two individuals were presented to the Grand Jury, the Grand Jury returned a No Bill for both individuals. The OAG denied the request for records contained in the OAG investigative file and Mr. Feltis appealed. The Superior Court rejected the OAG argument that the investigative file as a whole was confidential because it contained confidential information that, if redacted, would render the information in the file unintelligible. The Superior Court analyzed the information asserted as confidential to determine if the information was confidential based on application of a specific statute and ordered the release of the records, stating that any redactions made by the OAG should be made consistent with the rulings made by the court with regard to the application of each confidentiality exception. Of particular interest to the Advisory Committee, one of the specific confidentiality statutes cited by the OAG that protected information in the investigative file from disclosure was 22 MRSA §3022. The OAG asserted that this provision designated autopsy photographs as confidential. The statute provides that certain records "in the possession or custody of a medical examiner or the Office of Chief Medical Examiner are not public records .... " 22 MRSA §3022(8). The court determined that these records were not in the custody of a medical examiner or the Office of Chief Medical Examiner, but were in the custody of the OAG so the statute, by its express language, did not apply. Further, although the photographs may implicate the privacy interests of Roger Feltis and his family under other confidentiality provisions in the Intelligence and Investigative Records Information Act, 16 MRSA §804(3), those privacy interests did not warrant a refusal to release the records given the death of Roger Feltis.

IV. ACTIONS RELATED TO COMMITTEE RECOMMENDATIONS CONTAINED IN SEVENTEENTH ANNUAL REPORT

The Advisory Committee made the following recommendations in its Seventeenth Annual Report. The legislative actions taken in 2023 as a result of those recommendations are summarized below.

Recommendation:	**Action:**
Amend certain provisions of law in Titles 23, 24 and 24-A relating to previously-enacted public records exceptions	LD 1207, *An Act to Implement the Recommendations of the Right To Know Advisory Committee Concerning Public Records Exceptions*, was enacted as Public Law 2023, ch. 123.
Recommendation: Enact legislation to revise the membership of the Archives Advisory Board to include a member representing journalists, newspapers, broadcasters and other news media interests	**Action:** LD 133 was enacted as Public Law 2023, ch. 24, *An Act to Include a Representative of Newspaper and Other Press Interests on the Archives Advisory Board and to Require the Member Representing a Historical Society to Have Expertise in Archival Records*. As enacted, the law requires that the existing board member representing a state or local historical society have expertise in archival records and that the new member proposed by RTKAC have expertise in journalism.
Recommendation: For FOAA training purposes, recommend that the Public Access Ombudsman review the Freedom of Access website and FOAA training materials to include guidance on best practices for conducting remote meetings to optimize public participation	**Action** Staff communicated this recommendation to the Public Access Ombudsman.
Recommendation: Encourage the Maine Municipal Association, the Maine County Commissioners Association and the Maine School Management Association to develop guidance documents related to remote meetings	**Action:** Staff shared a copy of the 17th Annual Report with representatives of these organizations.
Recommendation: Enact legislation to amend the law related to remote participation	**Action:** LD 1322, *An Act to Implement the Recommendations of the Right To Know Advisory Committee Concerning*

	Remote Participation, was enacted as Public Law 2023, ch. 158. In addition, LD 1425, *An Act to Strengthen Freedom of Access Protections by Allowing Remote Meetings to Be Recorded*, was also enacted as Public Law 2023, ch. 185. This law requires that members of the public be allowed to record a meeting with remote participation using the electronic platform used to conduct the meeting, as long as additional costs are not incurred and the recording does not interfere with the orderly conduct of the proceeding.
Recommendation: Recommend that the Legislature direct funding to provide grants and technical assistance to all public bodies authorized to adopt remote participation policies, including counties, municipalities, school boards and regional or other political subdivisions	**Action:** No specific action taken by the Legislature during the First Regular Session or the First Special Session.
Recommendation: Recommend a statutory change and the revision of the record retention schedules applicable to state, county and municipal employee personnel records (1 member opposed; 1 member abstained)	**Action:** LD 1397, *An Act to Implement the Recommendations of the Right To Know Advisory Committee Concerning Records of Disciplinary Actions Against Public Employees*, included the language recommended by RTKAC that would prevent a collective bargaining agreement or employment contract from overriding the records retention schedule established by the State Archivist and would require that records related to disciplinary actions be retained for a period of 20 years, with potentially shorter retention periods for less serious conduct and potentially longer retention periods for law enforcement disciplinary actions reflecting on the credibility of the officer. But, these provisions were each removed before the bill was enacted as Public Law 2023, chapter 159.
Recommendation: Enact legislation to amend state and county employee personnel records statutes to align with the municipal employee personnel record statute	**Action:** The enacted version of LD 1397, *An Act to Implement the Recommendations of the Right To Know Advisory Committee Concerning Records of Disciplinary Actions Against Public Employees*, Public Law 2023, chapter 159, implements this recommendation.

Recommendation: Enact legislation to ensure that responses to FOAA requests for "personnel records" include records that have been removed from the personnel file and are otherwise retained	**Action:** LD 1397, *An Act to Implement the Recommendations of the Right To Know Advisory Committee Concerning Records of Disciplinary Actions Against Public Employees*, included the language recommended by RTKAC to implement this recommendation, but, this language was removed before the bill was enacted as Public Law 2023, chapter 159.
Recommendation: Recommend that the State Archivist, the Maine Archives Advisory Board and legislative proposals use standardized language related to record retention in schedules developed for public bodies and consider the inclusion of definitions of terms such as "remove," "purge" and "destroy" when they are used in record retention schedules	**Action:** LD 1397, *An Act to Implement the Recommendations of the Right To Know Advisory Committee Concerning Records of Disciplinary Actions Against Public Employees*, included the language recommended by RTKAC to implement this recommendation. Although this language was removed before the bill was enacted as Public Law 2023, chapter 159, the State Archivist indicated a willingness to continue working on this issue.
Recommendation: Request information from municipal, county and state law enforcement agencies regarding the prevalence and frequency of use of encrypted radio channels	**Action:** Staff requested that municipal, county and state law enforcement agencies participate in a survey regarding the prevalence and frequency of the use of encrypted radio channels. Several responses were received, each indicating that the responding law enforcement agencies were not using encryption. Anecdotal evidence suggests that encrypted radio channels have been used only in the Lewiston/Auburn area.
Recommendation: Recommend that the Judiciary Committee, in consultation with the Criminal Justice and Public Safety Committee, continue to discuss providing expanded access to participation in the legislative process by residents of correctional facilities, including the barriers that must be resolved to allow participation	**Action:** No action taken by the Judiciary Committee during the First Regular Session or the First Special Session.

V. COMMITTEE PROCESS

In 2023, the Advisory Committee formed 3 subcommittees to assist in its work: the Public Records Exceptions Subcommittee, the Public Records Process Subcommittee and the Law Enforcement Records Subcommittee. Each subcommittee discussed its assigned topics and issues thoroughly and determined whether to make recommendations for consideration by the full Advisory Committee. More information on the subcommittee activities, including meeting agenda and materials, can be found on the Advisory Committee's webpage at http://legislature.maine.gov/right-to-know-advisory-committee.

The deliberations of each subcommittee are summarized below. Part VI of this report contains the specific recommendations from the subcommittees that were adopted by the full Advisory Committee. Unless otherwise noted, subcommittee recommendations were unanimously approved by those subcommittee members present.

Public Records Exceptions Subcommittee

The Public Records Exceptions Subcommittee was chaired by Kim Monaghan. Jonathan Bolton, Lynda Clancy and Cheryl Saniuk-Heinig served as members of the Subcommittee. The Subcommittee met 4 times: on October 23, November 9, November 28 and December 4. On December 4, the Subcommittee made its report and recommendations to the Advisory Committee.

The focus of the Public Records Exceptions Subcommittee is to review and evaluate public records exceptions as required of the Advisory Committee pursuant to 1 MRSA, section 433, subsection 2-A. The guidelines in the law require the Advisory Committee to review all public records exceptions in Titles 22, 23, 24 and 24-A by 2025. In 2022, the Subcommittee completed its review of the exceptions in Titles 23, 24 and 24-A. During 2023, the Subcommittee reviewed the public records exceptions in Title 22 and, at the Advisory Committee's request, also considered whether to recommend a new proposed public records exception to protect from public disclosure certain information included in grant applications under the Emergency Medical Services Stabilization and Sustainability Program, enacted as part of the biennial budget law, Public Law 2023, chapter 412, Part GGGGG. The Emergency Medical Services Stabilization and Sustainability Program was enacted by the Legislature to provide financial assistance to emergency medical services entities based in the State that are facing immediate risk of failing and leaving their communities without access to adequate emergency medical services.

- *Review of exceptions in Title 22*

As a first step to the review of existing public records exceptions, the Subcommittee reached out to state agencies for information, comments and suggestions with respect to the relevant public records exceptions administered by that body. Subcommittee members reviewed the agency responses to the questionnaires and also had available a chart that included the following information: the statutory citation for each exception and links to the statutory language; the

agency that is responsible for administering each exception; and each agency's recommendation whether to continue, amend or repeal the exception.

The Subcommittee reviewed 79 exceptions in Title 22. While the members agreed that most of the exceptions under review were appropriate and did not need to be discussed further, the members did cull out certain exceptions for discussion before making their recommendation as to whether the exception should continue without change, should be amended or should be repealed. Of the 79 exceptions originally identified for review, 14 exceptions were subsequently repealed so Subcommittee review was not necessary. The Subcommittee recommended that there be no changes to 62 exceptions and that 3 exceptions be amended.

The Advisory Committee unanimously approved these recommendations, which are discussed in Part VI of this report. *See also the list of existing exceptions recommended to continue without change provided in Appendix F and the proposed amendments to existing exceptions in Appendix E.*

- *Consideration of new proposed public records exception to protect from public disclosure certain information included in grant applications under the Emergency Medical Services Stabilization and Sustainability Program*

At the request of the Advisory Committee, the Subcommittee was asked to consider recommending that a new public records exception be added to protect as confidential financial statements required to be included in grant applications for funding under the Emergency Medical Services Stabilization and Sustainability Program. This program was enacted by the Legislature as part of the biennial budget law, Public Law 2023, chapter 412, Part GGGGG, and established to provide financial assistance to emergency medical services entities based in the State that are facing immediate risk of failing and leaving their communities without access to adequate emergency medical services. The request originated from Advisory Committee member, Sen. Anne Carney, after a discussion with staff in the Speaker's Office. Under the law as currently written, emergency medical services entities applying for financial assistance must submit a financial statement for the most recent year.

While members of the Subcommittee recognized that certain emergency medical services entities may have concerns about releasing this information to the public because it may create a competitive disadvantage to those entities, the Subcommittee concluded that there is no need for a public records exception at this time given that this financial information is already public for many emergency medical services entities. The Subcommittee felt that there should be a level playing field between municipal emergency medical services programs which are funded by taxpayers and whose records are public and other non-profit or for-profit entities who are competing for these grants. These organizations regularly share information about their financial position with the public and disclosure of that information is not protected under the Freedom of Access Act. Further, financial information related to nonprofit entities is also available to the public. The Subcommittee members also noted that there is an existing public records exception that protects trade secrets as confidential; emergency medical services entities applying for grants that are concerned about the public disclosure of their financial statements may invoke that exception when submitting records with any grant application. Because financial assistance

will be provided by Maine taxpayers, the members believed that the public interest in the information provided to support an application for assistance outweighs any proprietary business interest in maintaining the confidentiality of that information.

The Subcommittee members agreed to not recommend legislation to enact a public records exception for these financial records.

Public Records Process Subcommittee

The Public Records Process Subcommittee was chaired by Victoria Wallack. Representative Sheehan, Julie Finn, Judy Meyer, Kevin Martin and Eric Stout served as members of the Subcommittee. The Subcommittee met three times: on October 23, November 6 and December 4. On December 4, the Subcommittee made its report and recommendations to the Advisory Committee.

The Subcommittee was formed to consider 7 specific topics associated with the process requirements of FOAA described and discussed below. Several of the topics were suggested for Advisory Committee review in a June 29, 2023 letter sent to the RTKAC from the Joint Standing Committee on Judiciary; these topics related to proposals considered by the Judiciary Committee in the First Regular and First Special Sessions of the 131st Legislature. A copy of this letter is included in **Appendix C**. The Subcommittee also considered additional topics suggested by Advisory Committee members at the first Advisory Committee meeting.

- *Require body or agency to cite the reason for going into executive session*

This topic was raised for consideration by Rep. Sheehan at the first Advisory Committee meeting based on concerns shared with her by a member of the public regarding the appropriateness of a public body going into executive session. The Subcommittee started its discussion by reviewing the relevant statute, 1 MRSA §405, which requires, among other things, that a motion to go into executive session include the precise nature of the business of the executive session and a citation of one or more sources of statutory or other authority that permits an executive session for that business. Subcommittee members noted that they have seen situations in which motions for executive session are incomplete, and they discussed the remedies available to a member of the public if they believe the public body or agency does not have authority to move into executive session, including appealing to superior court, raising their concerns during a public comment period or submitting a letter to the body or agency. Brenda Kielty, the Public Access Ombudsman, added that it is also the responsibility of the members of a public body or agency to object to the motion if the reasons for the executive session are not sufficiently clear. Ms. Kielty noted that there is tension between needing to provide sufficient detail in the motion to go into executive session while maintaining the confidentiality of the matters that are to be discussed. The members discussed the origin of the language in section 405, subsection 4, and several commented that, in their recent experience, public bodies are including a citation in the motion to go into executive session, but failing to include the "precise nature of the business." The members specifically considered two of the permitted reasons for an executive session: section 405, subsection 6, paragraph C, related to real and personal property, and section 405, subsection

6, paragraph E, related to the presence of the attorney for the body or agency. Ms. Kielty provided some examples of the types of business a public body might be discussing in which paragraph C could be appropriately used for an executive session, but noted that much more information would be necessary to evaluate the propriety of a specific situation. The members considered whether additional guidance or education related to the appropriate use of executive sessions is necessary, and Ms. Kielty reviewed the current guidance provided in three of the frequently asked questions posted on the Maine Freedom of Access Act website, https://www.maine.gov/foaa/.

The members agreed to recommend that the Advisory Committee send a letter providing an overview of the Subcommittee's discussions regarding public bodies and agencies going into executive session and asking the recipients to remind their members of the importance of including in the motion both the precise nature of the business of the executive session and a citation of one or more sources of statutory or other authority that permits an executive session for that business. The letter would be distributed to the state agency FOAA contacts, the Maine School Management Association, Maine Municipal Association, Maine County Commissioner's Association, the Maine Town and City Manager Association and the Maine Town and City Clerks' Association as well as the RTKAC interested parties list. The members also agreed to recommend that the Public Access Ombudsman update the frequently asked questions on the Maine Freedom of Access Act website to include more guidance regarding FOAA's requirements for executive sessions, with particular focus on the need to identify the precise nature of the business of the executive session.

The Advisory Committee unanimously approved these recommendations, which are discussed in Part VI of this report.

- *Use of a standard form for FOAA requests*

This topic was suggested to the Advisory Committee by the Judiciary Committee, as a proposal for a form for submission of public records requests was included in LD 1649. The Subcommittee identified two contexts in which the use of a standard form could be implemented: a form used by a requestor to access public records and a form used internally by a responding entity to facilitate a FOAA response. Although it was noted that a form for use by a requestor could be useful for ensuring that a public records request is complete and may make providing records easier for responders, some members expressed concern that a form could create a barrier to members of the public seeking public records, especially for those with lower reading abilities. Several members also described the importance of the conversations and negotiations that are involved in refining a FOAA request that could be negatively impacted by the use of a standard form. At the request of the Subcommittee, Ms. Kielty prepared and shared with the members an example of a form that could be provided by requestors when making a request under FOAA for public records. In discussing the form example, the Subcommittee members noted that FOAA does not require a request for public records to be made in writing and, in fact, public records requests may be made anonymously, so a form would need to be carefully drafted to ensure readability and to not create the impression that a form is required or that all fields must be filled out. The Subcommittee learned that schools have been receiving broad public records requests and a requestor form, such as that proposed in LD 1649, was a possible

mechanism for narrowing the scope of these requests. The members agreed that creating a template form to be used by individuals requesting public records raises many issues and decided to focus their discussions instead on forms that could be used internally by a responding entity. The members reviewed a form shared by Eric Stout that is intended for internal use by agencies and others to document and track a public records request after it has been made. Mr. Stout also shared a document with search tips that may be useful for an entity that is responding to a public records request, but noted that responding entities would need different resources due to differences in the technology used by the entities. Ms. Kielty added that she is willing to assist agencies that are interested in creating a form.

The Subcommittee agreed to recommend that the Advisory Committee send a letter to the Maine School Management Association confirming that a public body or agency is free to create an internal form to facilitate efficient responses to public records requests and that the Public Access Ombudsman is a resource for best practices and assistance in developing such a form.

The Advisory Committee unanimously approved this recommendation, which is discussed in Part VI of this report.

- *Allow prioritization of certain FOAA requests based on the type of requestor*

This topic was suggested to the Advisory Committee by the Judiciary Committee, as a proposal for prioritizing public records requests for certain types of requestors, specifically residents of the State or journalists acting in a journalistic capacity, and was included in LD 1203. Rep. Sheehan shared that when the Judiciary Committee considered prioritization of certain types of requestors as proposed in LD 1203, members were concerned about making these kinds of distinctions and several Subcommittee members noted that there would be ways to circumvent such prioritization efforts. The Subcommittee members agreed to not recommend legislation or other action related to this issue.

- *Responding entity to provide notice to individual who is the subject of a Freedom of Access request*

This topic was suggested to the Advisory Committee by the Judiciary Committee, as a proposal for requiring notice to a school employee who is the subject of a FOAA request was included in LD 1649. Members discussed potential issues associated with providing notice to the subject of a public records request, including the lack of recourse for the subject once they receive such notice and the risk that providing notice could create an impression that the subject has the ability to influence the production of records. One member observed that providing notice to an individual named in a public records request could be a best practice implemented by a responding entity and does not need to be in statute. The Subcommittee discussed "weaponized" public records requests (i.e., requests that appear intended to be harassment or to target specific individuals) and the available remedy of an action in Superior Court, as well as whether school employees should be treated differently than public employees generally. Subcommittee members recognized the strain that FOAA requests place on school boards and school officials, but expressed concern about a mandatory notice requirement when the subject of the FOAA request would have no authority to stop the public disclosure of the records. A majority of the

Subcommittee members agreed that they would not recommend legislation or other action related to this issue.

- *Define "burdensome" request as used in 1 MRSA §408-A(4)*
- *Repeat requestors and incomplete/delayed public records request responses*
- *Give the Public Access Ombudsman authority to waive an agency response requirement under certain circumstances*

The Subcommittee considered the above three topics together, as each relates to challenges faced by entities responding to public records requests. The first two topics were raised in Advisory Committee discussions at the first meeting and the third was suggested to the Advisory Committee by the Judiciary Committee, as a proposal for allowing the Public Access Ombudsman to relieve an agency or official of its obligation to provide records pursuant to FOAA was included in LD 1649. The Subcommittee considered various ways in which a "burdensome" request could be defined and agreed that what is considered a burdensome request would vary by situation, including the type of entity responding to the request, and may be subjective in nature. The members discussed the possibility of identifying specific metrics that could be included in statute, such as the number of hours involved to produce the records or the cost to the requestor, for classifying a request as burdensome. Some members believed this approach might be too broad given that some responding entities have significant resources and others do not; the members agreed that resource limitations contribute to whether a request is burdensome to a responding entity. Kevin Martin suggested that there is a distinction between a burdensome request and a request that could be considered an abuse of the FOAA process, and he shared examples of situations in which he believed a FOAA request was designed for reasons other than accessing records.

The Subcommittee also considered how the Public Access Ombudsman could assist responding entities with burdensome requests. Ms. Kielty pointed out that her involvement in a FOAA dispute would create an extra step in the process and a determination would need to be made quickly. In her role, she does not have a structure for implementing an adjudicatory process and would need additional resources. She also noted that such a structure would be necessary to ensure that members of the public are not losing their rights to access public records without appropriate consideration. The members struggled with how to best approach providing clear guidance for responding entities while maintaining the policy goal of FOAA to make records available. Members agreed that additional time and information would be necessary to fully consider this topic, including examples of what responders believe are burdensome requests and situations in which the FOAA process is abused.

The Subcommittee agreed to recommend that the Advisory Committee consider these topics again next year. To assist the Advisory Committee, the Subcommittee also recommended that RTKAC staff send a survey to the state agency FOAA contacts, the Maine School Management Association, Maine Municipal Association, Maine County Commissioner's Association, the Maine Town and City Manager Association and the Maine Town and City Clerks' Association requesting examples of burdensome public records requests and situations the responder believes represent an abuse of the FOAA process as well as any recommended statutory changes.

The Advisory Committee unanimously approved this recommendation, which is discussed in Part VI of this report.

Law Enforcement Records Subcommittee

The Law Enforcement Records Subcommittee was chaired by Senator Carney. Amy Beveridge, Jonathan Bolton, Julia Finn, Betsy Fitzgerald, Chief Michael Gahagan, Judy Meyer, Tim Moore and Cheryl Saniuk-Heinig served as members of the Subcommittee. The Subcommittee met two times: on October 23 and November 13. On December 4, the Subcommittee made its report and recommendations to the Advisory Committee. The Subcommittee was formed to consider two topics, described and discussed below.

- *Amending the Intelligence and Investigative Record Information Act*

The Subcommittee considered whether to recommend amending the Intelligence and Investigative Record Information Act (IIRIA), 16 MRSA §804(3). This topic was suggested for Advisory Committee review in the June 29, 2023 letter sent to the RTKAC from the Joint Standing Committee on Judiciary, as the Judiciary Committee considered a bill during the First Special Session, LD 1203, which among other things, would have amended provisions of the IIRIA. A copy of this letter is included in **Appendix C**. Specifically, the proposal in LD 1203 would authorize a Maine criminal justice agency to disclose intelligence and investigative records—despite a reasonable possibility that the public disclosure would constitute an unwarranted invasion of personal privacy—with either the consent of the individual who is the subject of the record or, if that individual is deceased, incapacitated or a minor, with the consent of the individual's "family or household member" as defined in the State's protection from abuse laws. The Judiciary Committee did not move forward with the bill and instead requested that the Advisory Committee study the issue further to determine: whether to authorize an individual whose personal privacy might be invaded to consent to release of the record; whether the individual's status as a suspect, victim, witness or bystander should affect their authority to consent; whether each individual whose personal privacy might be invaded must consent to the record's release; and who, if anyone, should have the authority to consent to release of the record if the individual whose personal privacy is implicated has died or is incapacitated.

The Subcommittee began its consideration of this topic by reviewing background information on the IIRIA, the proposal from LD 1203 and research it had requested reviewing the history of the confidentiality provisions for investigative and intelligence record information in the IIRIA. This research demonstrated the parallels between the state IIRIA and the federal Freedom of Information Act (FOIA); specifically that the language of the provision of the IIRIA rendering intelligence and investigative record information confidential if there is a reasonable probability release of the information would constitute an unwarranted invasion of personal privacy, 16 MRSA §804(3), closely tracks the provision of federal law exempting law enforcement records and information from FOIA if production of those materials could reasonably be expected to constitute an unwarranted invasion of personal privacy. Maine Courts have therefore viewed caselaw interpreting FOIA as persuasive, albeit not binding, when interpreting this provision of the IIRIA.

The Subcommittee solicited input from various groups, including the Office of the Attorney General, law enforcement and the media. It received written and oral comments from the Department of Corrections and the Maine Coalition Against Sexual Assault (MeCASA) which cautioned against amending the IIRIA as proposed in LD 1203. Law enforcement stakeholders and MeCASA observed that in many instances multiple individuals' personal privacy is at stake with the release of a record such as a video recording, including the suspect or suspects, victim or victims, witnesses and potential bystanders. In addition, law enforcement emphasized several additional procedural and resource challenges that would be present if consent forms were required from every individual whose personal privacy might be implicated by that record, including how to identify who must provide consent and who is responsible for the identification process and obtaining consent. It was noted that requiring law enforcement officers to identify and locate all affected individuals in response to a public records request would place a large burden on already strained law enforcement resources. The members also considered the difficulties associated with determining who has the authority to consent when the individual whose privacy interests might be implicated by release of information protected by the IIRIA is deceased, a minor or incapacitated. Both law enforcement stakeholders and MeCASA urged the Subcommittee not to craft a proposal that might grant a parent suspected of abducting or abusing a minor, who as the subject of the investigation does not have the right to access intelligence and investigative information under current law, to nevertheless obtain access to those records by consenting to the record's release on behalf of their child. Similar concerns arise if family members have the authority to consent to the release of intelligence and investigative information on behalf of deceased or incapacitated victims of domestic violence. Members also considered whether the law should recognize residual privacy protections for a person who has died, rather than allowing the deceased person's family members to consent to the release of embarrassing information the person would presumably want to keep private, were they alive.

The Subcommittee also discussed that there are numerous, sometimes overlapping, criteria under the IIRIA for rendering intelligence and investigation information confidential in addition to the potential for an invasion of privacy. Members of the Subcommittee representing media interests expressed frustration that these criteria have been broadly interpreted, resulting in the media not receiving adequate information in a timely manner. As an example they cited experiences when law enforcement uses the personal privacy interests provision of the IIRIA to justify denying public access to a dashcam video recording of an incident occurring on a public street. These members shared that their primary concern involves the way law enforcement interprets section 804, subsection 1 of the IIRIA, which renders otherwise public records confidential if they might interfere with law enforcement investigations as this provision has been used to deny public access to records including video recordings of incidents occurring in public places, accident reports, portions of police reports and other records based solely on whether an investigation is ongoing. For this reason, amendments to the personal privacy provision of the IIRIA may not have much impact on the prompt release of information during the early stages of an investigation.

Law enforcement stakeholders added that individuals seeking access to intelligence and investigative records that implicate personal privacy have the ability under current law to seek court orders for access to those records under §805(4) of the IIRIA. This process allows the court to redact sensitive information before releasing the records and craft orders limiting further

dissemination of information that invades personal privacy which may make amending this provision of the IIRIA unnecessary.

After a thoughtful discussion, the Subcommittee agreed to not recommend legislation or other action related to this issue.

- *Release by law enforcement of information about a critical public safety incident or criminal investigation, without the delays incident to submitting formal FOAA requests*

The Subcommittee considered ways to facilitate prompt release by law enforcement of information about a critical public safety incident or criminal investigation, without submitting formal FOAA requests that may have a delayed response. This topic was raised in Advisory Committee discussions at the Advisory Committee's first meeting. The Subcommittee solicited input from various groups, including the Office of the Attorney General, law enforcement and the media. The Subcommittee received written and oral public comments from Maine State Police Staff Attorney Paul Cavanaugh, the Maine Chiefs of Police Association and Stanford resident Sarah Johnson. The Subcommittee reviewed copies of media relations policies adopted by the Auburn Police Department, a relatively large law enforcement agency in the State, and the Presque Isle Police Department, a smaller law enforcement agency in the State. Staff noted that, while current law requires the chief administrative officer of each law enforcement agency to adopt written policies regarding procedures to respond to public records requests and to designate a person trained to respond to such requests on behalf of the agency, 25 MRSA §2803-B(1)(M), the law does not require law enforcement agencies to adopt broader media relations policies governing media access to information outside of the public records request process or to designate media relations officers.

After reviewing these materials, Subcommittee members discussed both the difficulties and benefits of amending the law to require law enforcement agencies to adopt media relations policies. While larger police departments and agencies with ample resources are more likely to have media relations policies and designated public relations officers, many smaller law enforcement agencies do not, in part because of the statewide shortage of certified law enforcement officers. Although many smaller departments maintain positive relationships with local media, if the chief of police who serves as the primary contact for media inquiries must patrol the streets due to staff vacancies, delays may occur in responding to media requests. Members of the Subcommittee representing media interests noted the critical role played by the media in the aftermath of important public safety incidents and, while these members are not necessarily advocating for a requirement that police departments designate media relations officers, they emphasized that currently information is not disseminated by law enforcement as quickly as it should be, especially when incidents occur on the weekend. Even a 48-hour delay in the release of information can have serious negative effects, especially given the advent of social media and the ability for misinformation to spread quickly in the immediate aftermath of an incident. Once misinformation has been spread, it is difficult to correct the record with the public: people remember what they learned immediately after an incident, even if it is later shown to be incorrect.

Subcommittee members agreed that more information should be gathered before deciding whether legislative action should be recommended on this issue. While Subcommittee members agree on the importance of public access to critical information during and immediately after certain incidents, it is not clear whether the release of information should be required and, if a requirement is imposed, how to define the types of information that law enforcement must release. Nor is it clear what the appropriate timeframe should be for the release of different types of critical information and how staffing and other resource shortages should be considered in making these decisions. Ultimately, Subcommittee members decided to accept the offer made by the Maine Chiefs of Police Association in its written comment dated November 7, 2023, to partner with members of the media to increase understanding between the members of the law enforcement and media communities regarding each other's concerns in an effort to enhance collaboration with regard to these issues.

The Subcommittee agreed to recommend that the Advisory Committee send a letter to Maine Chiefs Police Association requesting that it coordinate with the Maine Sheriffs Association, Maine State Police, Maine Office of the Attorney General, Maine Press Association and Maine Association of Broadcasters to convene a meeting to share information among stakeholders regarding the pressures and constraints experienced by both members of the media and law enforcement when reporting on or releasing information related to public safety incidents and ongoing criminal investigations. The letter will ask the parties to develop recommendations for increasing collaboration between law enforcement agencies and representatives of the media in a way that will ensure the public has access to timely, reliable information about significant public safety incidents and criminal investigations.

Full Advisory Committee Discussions

The Advisory Committee also discussed a number of topics and issues as a full Advisory Committee. The Advisory Committee made recommendations related to one of these issues, access to public employee disciplinary records, which is discussed in Part VI of this report. The Advisory Committee decided not to recommend further action with respect to the remaining topics and issues which are described below.

- *Inclusion of records of certain tax-exempt, nonprofit organizations in public record definition*

This topic was suggested to the Advisory Committee by the Judiciary Committee, as a proposal for including in the definition of public records the records of tax-exempt, nonprofit organizations that receive at least 50% of their annual revenue from federal, state or municipal sources was included in LD 1699. The members discussed the legal issues associated with this proposal, such as the First Amendment rights of nonprofit entities, and noted that it would need significant time to explore these issues. The Advisory Committee members agreed to take no further action with respect to this topic at this time.

- *Use of radio encryption by law enforcement*

The issue of the use of radio encryption by law enforcement was discussed by a RTKAC Subcommittee last year and it was determined at that time that additional information was needed regarding the scope of its use. In accordance with the recommendation of the Advisory Committee in the 17th Annual Report, RTKAC staff sent a survey to police departments and the Executive Director of the Maine Chiefs of Police Association to obtain information regarding the use of radio encryption by law enforcement in the State. The responding law enforcement agencies advised that they were not using encryption and the Executive Director of the Maine Chiefs of Police Association indicated that he was not aware of any county or municipal police department using radio encryption other than the Lewiston and Auburn police departments. Although there were fewer responses to the survey than had been hoped for, the Advisory Committee decided that because there appears to be no statewide use of radio encryption, they agreed to take no further action with respect to this issue at this time.

- *Grants and technical assistance to all public bodies authorized to adopt remote participation policies*

Justin Chenette, who chaired the Subcommittee on Remote Participation last year, suggested that the Advisory Committee should focus on its recommendation to provide guidance and information about remote participation through the Ombudsman's website before pursuing a recommendation for more funding from the Legislature. The Advisory Committee members agreed to take no further action with respect to this issue at this time.

- *Participation in the legislative process by residents of correctional facilities*

The Judiciary Committee did not take any action to develop a working group to continue discussion of this issue as recommended by the Advisory Committee in its 17th Annual Report. Chair Sheehan advised that she would discuss informal study options with RTKAC staff, and the Advisory Committee did not make any recommendations for further action at this time.

VI. RECOMMENDATIONS

The Advisory Committee makes the following recommendations. Unless otherwise noted, the following recommendations were unanimously approved by those members present.

❒ Amend certain provisions of law in Title 22 relating to previously-enacted public records exceptions

The Advisory Committee recommends that the following public records exceptions reviewed in 2023 be amended:

- Title 22, section 3022, subsection 8, relating to medical examiner information; *(Vote: 11- 4[1]; 1 abstention)*

[1] Those Advisory Committee members voting in opposition to the recommendation, Amy Beveridge, Lynda Clancy, Judy Meyer and Tim Moore, expressed discomfort with the full implications of this proposal, not just for the media

- Title 22, section 5409, subsections 1 and 2, relating to records held by the Maine Health Insurance Marketplace;
- Title 22, section 3294, subsection 3, relating to confidential information provided to professional and occupational licensing boards; and
- Title 22, section 2454-A, subsection 12, relating to applications and supporting information submitted by patients, caregivers and providers under the Maine Medical Use of Marijuana Act. [Note: this recommendation is to amend the existing public records exception with specific language to be developed by the Judiciary Committee or during the committee process.]
  (Vote: 15 - 0, 1 abstention)

See recommended legislation in Appendix E and a list of public records exceptions for which no amendments are recommended in Appendix F.

❒ **Provide an explanation to the Blue Ribbon Commission to Study Emergency Medical Services in the State of why the RTKAC did not recommend amending Title 32, section 98, to establish a public records exception for financial information provided by applicants for Emergency Medical Services Stabilization and Sustainability Program grants**

The Advisory Committee recommends sending a letter to the Blue Ribbon Commission to Study Emergency Medical Services providing an explanation for why it did not recommend creating a public records exception for financial information provided by applicants for Emergency Medical Services Stabilization and Sustainability Program grants.

See correspondence in Appendix D.

❒ **Reinforce the importance of following the statutory requirements applicable to public bodies and agencies going into executive session**

The Advisory Committee recommends sending a letter to the state agency FOAA contacts, the Maine School Management Association, Maine Municipal Association, Maine County Commissioner's Association, the Maine Town and City Manager Association and the Maine Town and City Clerks' Association as well as the RTKAC interested parties list explaining that the Advisory Committee discussed concerns surrounding public bodies and agencies going into executive session and asking the recipients to remind their members of the importance of including in the motion both the precise nature of the business of the executive session and a citation of one or more sources of statutory or other authority that permits an executive session for that business.

See correspondence in Appendix D.

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and the press but also for families of victims and were concerned with the timing of the Chief Medical Examiner's Office request to amend the statute.

❒ **Request that the Public Access Ombudsman include more guidance regarding the Freedom of Access Act's (FOAA) requirements for public bodies and agencies going into executive session on the Maine Freedom of Access Act website**

The Advisory Committee recommends that the Public Access Ombudsman update the Maine Freedom of Access Act website's frequently asked questions to include more guidance regarding the requirements for public bodies and agencies going into executive session.

❒ **Send a letter to Maine School Management Association confirming that FOAA allows a public body to create an internal form for responding to public records requests and that the Public Access Ombudsman can assist in the development of such a form**

The Advisory Committee recommends sending a letter to the Maine School Management Association confirming that FOAA allows a public body or agency to create an internal form for responding to public records requests and that the Public Access Ombudsman can assist in the development of such a form.

See correspondence in Appendix D.

❒ **Solicit from entities within the State responsible for responding to public records requests examples of burdensome public records requests and situations that the entity believes represent an abuse of the FOAA process, as well as suggested statutory changes, for consideration by the Advisory Committee next year**

The Advisory Committee recommends continuing its consideration of defining a "burdensome" request, giving the Public Access Ombudsman authority to waive the obligation to produce records in accordance with FOAA under certain circumstances and issues related to repeat requestors and incomplete and delayed public record request responses. To assist in its discussions, the Advisory Committee will distribute a survey seeking examples of burdensome public records requests and situations that a responding entity believes represent an abuse of the FOAA process, as well as suggested statutory changes, for consideration by the Advisory Committee next year. The survey will be sent to state agency FOAA contacts, the Maine School Management Association, Maine Municipal Association, Maine County Commissioner's Association, the Maine Town and City Manager Association and the Maine Town and City Clerks' Association.

See correspondence in Appendix D.

❒ **Send a letter to Maine Chiefs Police Association requesting that it coordinate with the Maine Sheriffs Association, Maine State Police, Maine Office of the Attorney General, Maine Press Association and Maine Association of Broadcasters to convene a meeting to share information among stakeholders regarding the pressures and constraints experienced by both members of the media and law enforcement when reporting on or releasing information related to public safety incidents and ongoing criminal investigations**

The Advisory Committee recommends sending a letter to the Maine Chiefs Police Association requesting that it coordinate with the Maine Sheriffs Association, Maine State Police, Maine Office of the Attorney General, Maine Press Association and Maine Association of Broadcasters to convene a meeting to share information among stakeholders regarding the pressures and constraints experienced by both members of the media and law enforcement when reporting on or releasing information related to public safety incidents and ongoing criminal investigations. The parties should develop recommendations for increasing collaboration between law enforcement agencies and representatives of the media in a way that will ensure the public has access to timely, reliable information about significant public safety incidents and criminal investigations. The Advisory Committee's letter will ask for a report on the meeting, including any recommendations that are developed by meeting participants, when the Advisory Committee reconvenes next year.

See correspondence in Appendix D.

- ❒ **Propose that the Joint Standing Committee on Judiciary report out a bill in the Second Regular Session of the 131st Legislature to create a legislative study group to develop recommendations related to public employee disciplinary records, taking into consideration progressive discipline structures and employee incentives across different types of public employment**

In its most recent Annual Report, the Advisory Committee made several recommendations related to disciplinary records of public employees including statutory changes which were proposed in LD 1397. As noted in Section IV of this report, language related to all but one recommendation was removed before LD 1397 was enacted as Public Law 2023, chapter 159. The Advisory Committee agreed that it would reconsider the issues raised by the provisions in LD 1397 which were not enacted. These issues included: accessing records of disciplinary actions located outside of personnel files, shorter retention periods for final written decisions relating to disciplinary action involving less serious conduct and the effect of collective bargaining agreements on retention schedules.

To assist in its consideration of these issues, the Advisory Committee requested additional comment on the proposals in LD 1397 from various entities, including those that testified at the public hearing for the bill. The Advisory Committee also solicited public comment at each of its five meetings, with two comment periods specific to the issue of disciplinary records of public employees.

The Maine Education Association (MEA) encouraged the Advisory Committee to address concerns about police disciplinary records through legislation focused on law enforcement instead of public employees generally. MEA explained that LD 1397 as printed is too broad and could undermine labor relations at municipal, county and state levels and deter people from entering or staying in public employment. The Maine Association of Police expressed support for a consistent policy with respect to all public employees, but agreed with MEA's concerns regarding the impact greater disclosure could have on attracting and retaining employees. The Maine Service Employees Association (MSEA) shared the concerns voiced by other about how the policies in LD 1397 as printed would affect attracting and retaining public employees and

added that disciplinary records could be weaponized against workers, with consequences that are felt for the remainder of an individual worker's career. MSEA discouraged the Advisory Committee from recommending legislation that has the potential to override collective bargaining agreements. On behalf of the Maine State Archives' Advisory Board, State Archivist Kate McBrien addressed the changes to state and local government personnel records record retention schedules that were proposed in section 5 of LD 1397. Ms. McBrien shared that the Board believes 5 years is a sufficient period of time to retain written decisions concerning public employees and disciplinary action; however, law enforcement disciplinary records represent a unique case given this group of state employees' close interaction with members of the public and their responsibility for public safety. The Board's recommendation is to consult with the Department of Public Safety to create an individual agency record retention schedule to address the final written decision of a disciplinary action of law enforcement officers. The Board recommends that this record retention schedule be for 15-20 years, a longer period than the 5-year retention period for disciplinary decisions of other state employees. The Advisory Committee also received information from the Maine State Police (MSP) which emphasized that issues regarding law enforcement disciplinary records are incredibly complicated and noted that law enforcement disciplinary records, unlike those of public employees generally, may be used as *Brady/Giglio* materials and are not subject to a statute of limitations. This issue was also raised by Attorney Marcus Wraight who submitted written comments for the Advisory Committee's consideration. Attorney Wraight urged the Advisory Committee to establish retention periods in statute for disciplinary records for law enforcement as well as state employees who may be called as witnesses to ensure that such records are consistently retained and not subject to collective bargaining agreements.

The Advisory Committee focused the majority of its discussions on how they might define "less serious" misconduct subject to a shorter retention period. Kate McBrien shared with the members that the Archives Advisory Board has also discussed this issue and recommends that records retention schedules include clear guidance so that the determination of what is "less serious" is not at discretion of individual agencies or supervisors. The members approached the definition of "less serious" in two ways: 1) with a focus on the type of misconduct, for example longer retention for more serious misconduct; and 2) the type of discipline imposed, with longer retention schedules applicable with more serious disciplinary sanctions under a progressive discipline model.

In considering a focus on the underlying conduct, the members reviewed various statutes in Titles 10, 20-A and 25 enumerating the types of misconduct that may form the basis for professional discipline—including license or certificate denial, nonrenewal, modification, suspension or termination—for public educators, law enforcement officers and licensed professionals. Members also reviewed the statutory definition of the types of misconduct that disqualify someone from receiving unemployment benefits.

In considering a focus on the severity of discipline imposed on a public employee, the members sought additional information regarding progressive discipline that may be imposed on employees from the Maine Municipal Association (MMA) and the State Bureau of Human Resources (BHR), as well as additional information about how collective bargaining agreements affect both the types of discipline that may be imposed and the time periods for retention of those

disciplinary records. Both MMA and BHR shared information regarding progressive discipline and the effect of collective bargaining agreements on the retention of disciplinary records. MMA noted that even when discipline may not be used for internal progressive discipline, municipal law enforcement is working to ensure that those records are retained elsewhere and disclosed to other law enforcement agencies considering hiring the individual. BHR explained that for most state employers, once the records are removed from the employee's file under pursuant to a collective bargaining agreement, it is destroyed; however, in some cases additional reporting of discipline to Maine Criminal Justice Academy is required by law. The members discussed the lack of a standard process or timeframe for requesting the removal of a disciplinary record from a person's file and uncertainty regarding whether, if the disciplinary record is removed from the personnel file but retained by the agency, the records remain publicly accessible.

Kate McBrien also explained that existing state and local government records retention schedules currently provide that a collective bargaining agreement creating a shorter retention period for employee discipline records takes precedence over the period set forth in the retention schedules. Several members pointed out that unions and public employers are frequently able to avoid litigation by negotiating agreements for shorter retention of specific disciplinary records, especially records involving less significant employee misconduct. Several members expressed discomfort with allowing collective bargaining agreements to limit the availability of and access to public records.

Members requested the perspective of Assistant Attorney General, Jonathan Bolton, regarding the implications of prohibiting collective bargaining agreements from overriding record retention schedules. Mr. Bolton explained that if legislation affects existing contracts it raises issues under the contracts clauses of the Maine and U.S. Constitution. He noted that this is a policy question for the Legislature; however, any legislation affecting current contracts would need to be carefully considered.

Advisory Committee members generally agreed that additional input should be obtained from multiple stakeholders before a final decision is made regarding the adjustment of records retention schedules for public employee disciplinary decisions. Members questioned whether to craft recommendations to the State Archivist and have her work with the Archives Advisory Board to solicit broader stakeholder input; to propose legislation for the Judiciary Committee, which will then be able to gather additional perspectives through the public hearing process; or instead to itself continue studying and soliciting public comment on this issue over the next year.

The Advisory Committee agreed that this issue is important and complex, as there are many different types of public employees and legal and logistical considerations to keep in mind. Several members commented on the limited time available to the Advisory Committee and that this issue goes beyond the charge of the RTKAC, as it implicates important employment and labor issues. The Advisory Committee recommends that the Judiciary Committee report out a bill creating an interim legislative study group to develop recommendations for the next Legislature addressing the public records issues around public employee disciplinary records. The study could also address issues of progressive discipline, promotions and merit pay increases across different types of public employees and consider the relationship between access to public

records and collective bargaining agreements.

VII. FUTURE PLANS

In 2024, the Right to Know Advisory Committee will continue to discuss the ongoing issues identified in this report, including issues related to burdensome public records requests and to the development of recommendations to increase collaboration between law enforcement and the media to ensure the public has access to timely, reliable information about significant public safety incidents and criminal investigations. The Advisory Committee will also continue to provide assistance to the Joint Standing Committee on Judiciary relating to proposed legislation affecting public access. The Advisory Committee looks forward to another year of activities working with the Public Access Ombudsman, the Judicial Branch and the Legislature to implement the recommendations included in this report.

APPENDIX A

Authorizing Legislation: 1 MRSA §411

AUTHORIZING LEGISLATION

TITLE 1
GENERAL PROVISIONS

CHAPTER 13
PUBLIC RECORDS AND PROCEEDINGS

SUBCHAPTER 1
FREEDOM OF ACCESS

§411. Right To Know Advisory Committee

1. Advisory committee established. The Right To Know Advisory Committee, referred to in this chapter as "the advisory committee," is established to serve as a resource for ensuring compliance with this chapter and upholding the integrity of the purposes underlying this chapter as it applies to all public entities in the conduct of the public's business.

2. Membership. The advisory committee consists of the following members:

A. One Senator who is a member of the joint standing committee of the Legislature having jurisdiction over judiciary matters, appointed by the President of the Senate;

B. One member of the House of Representatives who is a member of the joint standing committee of the Legislature having jurisdiction over judiciary matters, appointed by the Speaker of the House;

C. One representative of municipal interests, appointed by the Governor;

D. One representative of county or regional interests, appointed by the President of the Senate;

E. One representative of school interests, appointed by the Governor;

F. One representative of law enforcement interests, appointed by the President of the Senate;

G. One representative of the interests of State Government, appointed by the Governor;

H. One representative of a statewide coalition of advocates of freedom of access, appointed by the Speaker of the House;

I. One representative of newspaper and other press interests, appointed by the President of the Senate;

J. One representative of newspaper publishers, appointed by the Speaker of the House;

K. Two representatives of broadcasting interests, one appointed by the President of the Senate and one appointed by the Speaker of the House;

L. Two representatives of the public, one appointed by the President of the Senate and one appointed by the Speaker of the House;

M. The Attorney General or the Attorney General's designee;

N. One member with broad experience in and understanding of issues and costs in multiple areas of information technology, including practical applications concerning creation, storage, retrieval and accessibility of electronic records; use of communication technologies to support meetings, including teleconferencing and Internet-based conferencing; databases for records management and reporting; and information technology system development and support, appointed by the Governor; and

O. One representative having legal or professional expertise in the field of data and personal privacy, appointed by the Governor.

The advisory committee shall invite the Chief Justice of the Supreme Judicial Court to designate a member of the judicial branch to serve as a member of the committee.

3. Terms of appointment. The terms of appointment are as follows.

A. Except as provided in paragraph B, members are appointed for terms of 3 years.

B. Members who are Legislators are appointed for the duration of the legislative terms of office in which they were appointed.

C. Members may serve beyond their designated terms until their successors are appointed.

4. First meeting; chair. The Executive Director of the Legislative Council shall call the first meeting of the advisory committee as soon as funding permits. At the first meeting, the advisory committee shall select a chair from among its members and may select a new chair annually.

5. Meetings. The advisory committee may meet as often as necessary but not fewer than 4 times a year. A meeting may be called by the chair or by any 4 members.

6. Duties and powers. The advisory committee:

A. Shall provide guidance in ensuring access to public records and proceedings and help to establish an effective process to address general compliance issues and respond to requests for interpretation and clarification of the laws;

B. Shall serve as the central source and coordinator of information about the freedom of access laws and the people's right to know. The advisory committee shall provide the basic information about the requirements of the law and the best practices for agencies and public officials. The advisory committee shall also provide general information about the freedom of access laws for a wider and deeper understanding of citizens' rights and their role in open government. The advisory committee shall coordinate the education efforts by providing information about the freedom of access laws and whom to contact for specific inquiries;

C. Shall serve as a resource to support the establishment and maintenance of a central publicly accessible website that provides the text of the freedom of access laws and provides specific guidance on how a member of the public can use the

law to be a better informed and active participant in open government. The website must include the contact information for agencies, as well as whom to contact with complaints and concerns. The website must also include, or contain a link to, a list of statutory exceptions to the public records laws;

D. Shall serve as a resource to support training and education about the freedom of access laws. Although each agency is responsible for training for the specific records and meetings pertaining to that agency's mission, the advisory committee shall provide core resources for the training, share best practices experiences and support the establishment and maintenance of online training as well as written question-and-answer summaries about specific topics. The advisory committee shall recommend a process for collecting the training completion records required under section 412, subsection 3 and for making that information publicly available;

E. Shall serve as a resource for the review committee under subchapter 1-A in examining public records exceptions in both existing laws and in proposed legislation;

F. Shall examine inconsistencies in statutory language and may recommend standardized language in the statutes to clearly delineate what information is not public and the circumstances under which that information may appropriately be released;

G. May make recommendations for changes in the statutes to improve the laws and may make recommendations to the Governor, the Legislature, the Chief Justice of the Supreme Judicial Court and local and regional governmental entities with regard to best practices in providing the public access to records and proceedings and to maintain the integrity of the freedom of access laws and their underlying principles. The joint standing committee of the Legislature having jurisdiction over judiciary matters may report out legislation based on the advisory committee's recommendations;

H. Shall serve as an adviser to the Legislature when legislation affecting public access is considered;

I. May conduct public hearings, conferences, workshops and other meetings to obtain information about, discuss, publicize the needs of and consider solutions to problems concerning access to public proceedings and records;

J. Shall review the collection, maintenance and use of records by agencies and officials to ensure that confidential records and information are protected and public records remain accessible to the public; and

K. May undertake other activities consistent with its listed responsibilities.

7. Outside funding for advisory committee activities. The advisory committee may seek outside funds to fund the cost of public hearings, conferences, workshops, other meetings, other activities of the advisory committee and educational and training materials. Contributions to support the work of the advisory committee may not be accepted from any party having a pecuniary or other vested interest in the outcome of the matters being studied. Any person, other than a state agency, desiring

to make a financial or in-kind contribution shall certify to the Legislative Council that it has no pecuniary or other vested interest in the outcome of the advisory committee's activities. Such a certification must be made in the manner prescribed by the Legislative Council. All contributions are subject to approval by the Legislative Council. All funds accepted must be forwarded to the Executive Director of the Legislative Council along with an accounting record that includes the amount of funds, the date the funds were received, from whom the funds were received and the purpose of and any limitation on the use of those funds. The Executive Director of the Legislative Council shall administer any funds received by the advisory committee.

8. Compensation. Legislative members of the advisory committee are entitled to receive the legislative per diem, as defined in Title 3, section 2, and reimbursement for travel and other necessary expenses for their attendance at authorized meetings of the advisory committee. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the advisory committee.

9. Staffing. The Legislative Council shall provide staff support for the operation of the advisory committee, except that the Legislative Council staff support is not authorized when the Legislature is in regular or special session. In addition, the advisory committee may contract for administrative, professional and clerical services if funding permits.

10. Report. By January 15, 2007 and at least annually thereafter, the advisory committee shall report to the Governor, the Legislative Council, the joint standing committee of the Legislature having jurisdiction over judiciary matters and the Chief Justice of the Supreme Judicial Court about the state of the freedom of access laws and the public's access to public proceedings and records.

APPENDIX B

Membership List: Right to Know Advisory Committee

Right to Know Advisory Committee

1 MRSA §411

Membership List

Name	Representation
Rep. Erin Sheehan	House member of Judiciary Committee, appointed by the Speaker of the House
Sen. Anne Carney	Senate member of Judiciary Committee, appointed by the President of the Senate
Amy Beveridge	Representing broadcasting interests, appointed by the President of the Senate
Jonathan Bolton	Attorney General's designee
Vacant	Representing a statewide coalition of advocates of freedom of access, appointed by the Speaker of the House
Justin Chenette	Representing the public, appointed by the President of the Senate
Lynda Clancy	Representing newspaper and other press interests, appointed by the President of the Senate
Linda Cohen	Representing municipal interests, appointed by the Governor
Julie Finn	Representing the Judicial Branch, designated by the Chief Justice of the Supreme Judicial Court
Betsy Fitzgerald	Representing county or regional interests, appointed by the President of the Senate
Chief Michael Gahagan	Representing law enforcement interests, appointed by the President of the Senate
Kevin Martin	Representing state government interests, appointed by the Governor
Judy Meyer	Representing newspaper publishers, appointed by the Speaker of the House
Tim Moore	Representing broadcasting interests, appointed by the Speaker of the House
Kim Monaghan	Representing the public, appointed by the Speaker of the House
Eric Stout	A member with broad experience in and understanding of issues and costs in multiple areas of information technology, appointed by the Governor
Cheryl Saniuk-Heinig	A member with legal or professional expertise in the field of data and personal privacy, appointed by the Governor
Victoria Wallack	Representing school interests, appointed by the Governor

APPENDIX C

Correspondence from the Judiciary Committee to the Right to Know Advisory Committee dated June 29, 2023

STATE OF MAINE
ONE HUNDRED AND THIRTY-FIRST LEGISLATURE
COMMITTEE ON JUDICIARY

June 29, 2023

Dear Right to Know Advisory Committee,

As you may know, the Judiciary Committee considered several bills this year related to the processes by which members of the public may access public records under the state Freedom of Access Act (FOAA) and the state Intelligence and Investigative Record Information Act (IIRIA), including: LD 1203, *An Act to Clarify Deadlines in the Freedom of Access Act and Disclosure Provisions in the Intelligence and Investigative Record Information Act*; LD 1649, *An Act to Support Local Governments in Responding to Freedom of Access Act Requests*; LD 1699, *An Act to Amend the Freedom of Access Act and Related Provisions;* and LD 1764, *An Act Regarding the Charge for Research Time by State Agencies for Freedom of Access Act Requests*.

These bills proposed several reforms to FOAA and IIRIA that readjust the balance these laws strike between ensuring transparency and accountability of governmental business through robust procedures for accessing public records and the sometimes overwhelming burdens that the increasing number of public records requests has placed on many governmental entities and public employees. A majority of the committee voted "ought not to pass" on these legislative documents and respectfully requests that the Right to Know Advisory Committee draw on the expertise of its members and, as necessary, gather additional input from relevant stakeholders to examine the following issues.

1. Whether to expand FOAA's definition of "public records" to include the records of tax-exempt, nonprofit organizations that receive a certain threshold of their annual revenue from federal, state or municipal sources. *See* LD 1699, §1 (proposing to include the records of such organizations that receive at least 50% of their annual revenue from federal, state or municipal sources).

2. Whether the Public Access Ombudsman should be directed to design a form for public records requests under FOAA. And if so, whether all public agencies or officials, or a specific subset of public agencies or officials, may require that members of the public use the form when submitting public records requests. *See* LD 1649, §2 and §6 (proposing to authorize the Public Access Ombudsman to design a "simple, short" form "designed to provide only the basic information required to fulfill the request" and to authorize school districts, in their discretion, to require use of the form).

3. Whether and how to define the "reasonable time" after receipt of a public records request under FOAA within which an agency or official having custody of the record must provide a good faith, nonbinding estimate of the time frame within which it will comply with the request. Alternatively, or additionally, whether to establish a deadline for full compliance with a public records request and, if so: whether agencies or officials should have the ability to request an extension of the deadline; who should decide whether to grant an extension; and what criteria must be met for an extension to be granted. *Compare* LD 1203, §1 (proposing to amend 1 M.R.S. §408-A(3) to require that an estimate of the time to respond to a public records request be provided "no later than 30 days following receipt of the request") *with* LD 1699, §5 (requiring an agency or official to "fully respond to a request" within 60 days of "the date a sufficient description of the public record is received . . . at the office responsible for maintaining the public record" and authorizing the Public Access Ombudsman to extend the deadline for "good cause").

4. Whether and to what extent, under FOAA, an agency or official should be either authorized or directed to prioritize a public records request received from a Maine resident, a journalist or other specific preferred party over a request received from an out-of-state resident, a request for bulk data received from a for-profit, data-mining company, or other specific type of request or requester. If prioritization is appropriate, is it possible to craft the law in a way that will prevent someone with a low priority from soliciting the assistance of a proxy with a higher priority to submit a request on their behalf? *See* LD 1203, §2 (proposing a statutory priority for Maine residents and journalists).

5. Given the testimony we received regarding the burden on staff time and resources caused by public records requests, should the maximum hourly rate a public agency or official may charge for each hour of staff time beyond the first 2 hours spent "searching for, retrieving and compiling the requested public record" be increased? Similarly, should a public agency or official be authorized to charge for the first 2 hours of staff time if the requester previously made a public records request of the same public agency or official during the same calendar year? *Compare* LD 1649, §1 (proposing to increase the maximum hourly fee from $25 to $40 and to authorize charging for the first 2 hours of staff time in the circumstances described above) *with* LD 1764 (proposing to replace the maximum hourly fee in current law with a set hourly fee of $25 for all staff time, including the first 2 hours, spent on a public records request). Alternatively, given the testimony we received regarding the sometimes exorbitant fees charged for public records requests that do not, on their face, appear to be overly burdensome, should the Legislature establish a maximum fee that may be charged either in response to a single public records request or for all requests submitted to a single public entity by the same person in a single calendar year? *See* LD 1699, §7 (proposing to establish a maximum single-request fee of $500, except that there would be a maximum calendar-year-fee of $100 for all public records requests submitted by the same person to a school administrative unit).

6. Whether, given the testimony we received regarding the recent increase in public records requests under FOAA that appear designed to harass specific public employees, especially school personnel, the following procedures, or different procedures, should be established:

    a. If a public agency or official receives a series or a pattern of public records requests that it believes are frivolous or designed to intimidate or harass and not intended for the dissemination of information about government activity to the public, should the public agency or official have an opportunity to request that the Public Access Ombudsman relieve it from the requirement to comply with the request? *See* LD 1649, §2 (proposing to establish such a process for school districts). Would this new process provide meaningful assistance beyond that currently afforded

in 1 M.R.S. §408-A(4-A), which authorizes a body, agency or official to seek an order of protection in Superior Court from a request "that is unduly burdensome or oppressive"?

b. Should a public employee who is the "subject" of a public records request be provided an opportunity to inspect the records before they are disclosed to the requester? Should this opportunity be provided only when a public employee is specifically named in the request or should it also be available whenever a public record that will be disclosed names a specific public employee? *See* LD 1649, §2 (proposing to provide such an opportunity to school employees).

7. Whether to amend IIRIA's current requirement that a Maine criminal justice agency treat as confidential and not disseminate a record that contains intelligence and investigative record information—including, for example, a dashboard or body camera recording of a law enforcement encounter—if there is a reasonable possibility that public release or inspection of the record would constitute an unwarranted invasion of personal privacy. For example, should the individual whose personal privacy might be invaded have the authority to consent to the release of the record; if so, should that individual's status as a potential victim or potential perpetrator affect their authority to consent to the record's release; must each individual whose personal privacy might be invaded by the release of a record consent to its release; and who, if anyone, should have the authority to consent to release of a record if the individual whose privacy might be invaded by its release has died? *See* LD 1203, §3 (proposing amendments to 16 M.R.S. §804(3)).

Thank you in advance for your time and attention to these matters. We look forward to reviewing your recommendations on these important topics. Please do not hesitate to reach out to us if you have any questions.

Sincerely,

Anne M. Carney

Sen. Anne M. Carney
Senate Chair

Matt W. Moonen

Rep. Matthew W. Moonen
House Chair

cc: *(via email)*
Judiciary Committee Members (including Representative Andrews, Sponsor of LD 1699)
Representative David Boyer, Sponsor of LD 1203
Representative Maureen Terry, Sponsor of LD 1649
Senator Mark Lawrence, Sponsor of LD 1764

APPENDIX D

Correspondence from the Right to Know Advisory Committee

- Draft Letter in re PRP Topic 1
- Draft Letter in re LER Topic 2
- RTKAC Letter to EMS Commission
- Draft Letter in re PRP Topic 2
- Draft Letter in re PRE Topic 5-7

STATE OF MAINE

RIGHT TO KNOW ADVISORY COMMITTEE

December XX, 2023

Re: Requirements for executive sessions pursuant to 1 M.R.S. §405(4)

[name of entity, if applicable]

Dear [name of entity/State Freedom of Access Contact/Right to Know Advisory Committee interested party]:

I am writing on behalf of the Right to Know Advisory Committee regarding a matter that was discussed by the Advisory Committee this year after a member of the public shared concerns about the circumstances in which a public body may go into executive session. During discussions of this issue, several Advisory Committee members noted that, in their experience, motions to go into executive sessions are sometimes incomplete. Pursuant to 1 M.R.S. §405(4), fully quoted below, a motion to go into executive session must include both the precise nature of the business of the executive session and a citation of one or more sources of statutory or other authority that permits an executive session for that business.

> **4. Motion contents.** A motion to go into executive session must indicate the precise nature of the business of the executive session and include a citation of one or more sources of statutory or other authority that permits an executive session for that business. Failure to state all authorities justifying the executive session does not constitute a violation of this subchapter if one or more of the authorities are accurately cited in the motion. An inaccurate citation of authority for an executive session does not violate this subchapter if valid authority that permits the executive session exists and the failure to cite the valid authority was inadvertent.

The Advisory Committee is sending this letter as a reminder to public bodies and agencies that utilize executive sessions of the importance of including both statutory elements in a motion to go into executive session. [We ask that you share this letter with your members, as well.] If you have questions regarding the statutory requirements applicable to executive sessions or other aspects of the Freedom of Access Act, you may wish to visit the Maine Freedom of Access Act website, www.maine.gov/foaa, or contact the Public Access Ombudsman.

Thank you for your consideration of these comments.

Sincerely,

Representative Erin Sheehan, Chair
Right to Know Advisory Committee

STATE OF MAINE

RIGHT TO KNOW ADVISORY COMMITTEE

December XX, 2023

Maine Chiefs of Police Association
Chief Edward J. Tolan (ret.), Executive Director
Via Email: mcopa@maine.rr.com

Re: Meeting between representatives of the press and representatives of law enforcement to share concerns regarding the prompt release of information during critical public safety incidents

Dear Chief Tolan:

I am writing on behalf of the Right to Know Advisory Committee regarding a matter we discussed this year. Representatives of the media asked the Advisory Committee to develop recommendations for facilitating the prompt release by law enforcement of information about critical public safety incidents or criminal investigations, especially those that occur on the weekend, without the delays incident to submission of formal public records requests under the Freedom of Access Act (FOAA).

The Advisory Committee formed a subcommittee to discuss this and other proposals related to the public release of information involving law enforcement investigations. After soliciting input from representatives of both law enforcement and the media and after reviewing media relations policies adopted by the Auburn and Presque Isle Police departments, members of the subcommittee agreed that more information should be gathered before deciding whether to recommend legislative action on this issue. While subcommittee members agreed on the importance of public access to critical information during and immediately after critical public safety incidents, it is not clear whether the release of certain information should be required and, if a requirement is imposed, how to define the types of information that law enforcement must release. Nor is it clear what the appropriate timeframe should be for the release of this critical information and how staffing and other resource challenges faced by many law enforcement agencies across the State should be considered in making these decisions.

The Advisory Committee unanimously adopted the subcommittee's recommendation to accept the offer made by your organization to work to increase understanding between members of the law enforcement and media communities regarding each other's concerns in an effort to enhance collaboration during and immediately after critical public safety incidents. Accordingly, we respectfully request that the Maine Chiefs of Police Association coordinate with the Maine Sheriffs Association, Maine State Police, Maine Office of the Attorney General, Maine Press Association and Maine Association of Broadcasters to convene a meeting in the greater Augusta area or another convenient, central location between representatives of both large and small law enforcement agencies as well as members of both print and broadcast media from different areas of the State. We hope that, with the assistance of an experienced facilitator, meeting participants will:

- Share information about the pressures and constraints experienced by members of the media when gathering and timely reporting information regarding public safety incidents and ongoing criminal investigations on the one hand and the deadlines, staffing issues, complex legal issues and other challenges facing law enforcement during these incidents on the other hand; and
- Develop recommendations for increasing collaboration between law enforcement agencies and representatives of the media in a way that will ensure the public has access to timely, reliable information about significant public safety incidents and criminal investigations.

If possible, we would appreciate receiving a report on the meeting and any recommendations that are developed by meeting participants when the Advisory Committee reconvenes next year, which we anticipate will occur in late June or early July.

Thank you for your offer of assistance and for your consideration of this request.

Sincerely,

Representative Erin Sheehan, Chair
Right to Know Advisory Committee

STATE OF MAINE

RIGHT TO KNOW ADVISORY COMMITTEE

December 11, 2023

Sen. Chip Curry, Senate Chair
Speaker Rachel Talbot Ross, House Chair
Blue Ribbon Commission to Study Emergency Medical Services in the State

Re: Review of request for a new public records exception for certain information included in grant applications under the Emergency Medical Services Stabilization and Sustainability Program

Dear Sen. Curry and Speaker Talbot Ross:

On behalf of the Right to Know Advisory Committee, I want to share our comments related to a request that the Advisory Committee consider whether to recommend the enactment of a public records exception to protect from public disclosure certain information included in grant applications under the Emergency Medical Services Stabilization and Sustainability Program, enacted as part of the biennial budget law, Public Law 2023, chapter 412, Part GGGGG. As you know, the Emergency Medical Services Stabilization and Sustainability Program was enacted by the Legislature to provide financial assistance to emergency medical services entities based in the State that are facing immediate risk of failing and leaving their communities without access to adequate emergency medical services.

The Advisory Committee was asked to consider recommending in its report to the Legislature that a public records exception be added to protect as confidential financial statements required to be included in grant applications for funding under the program. The request was made by one of our Advisory Committee members, Sen. Anne Carney, after a discussion with staff in the Speaker's Office. Under the law enacted by the Legislature, emergency medical services entities applying for financial assistance must submit a financial statement for the most recent year. The Advisory Committee referred the issue to its Public Records Exceptions Subcommittee for initial discussion and then considered the issue at its final meeting on December 4th.

While members of the Advisory Committee appreciate that certain emergency medical services entities may have concerns about releasing this information to the public because it may create a competitive disadvantage to those entities, the Advisory Committee concluded that there is no need for a public records exception at this time given that this financial information would already be public for many emergency medical services entities. The Advisory Committee

reasoned that there should be a level-playing field between municipal emergency medical services programs which are funded by taxpayers and whose records are public and other non-profit or for-profit entities who are competing for these grants. These organizations regularly share information about their financial position with the public and disclosure of that information is not protected under the Freedom of Access Act. Further, financial information related to nonprofit entities is also available to the public. The Advisory Committee also noted that there is an existing public records exception that protects trade secrets as confidential; emergency medical services entities applying for grants that are concerned about the public disclosure of their financial statements may invoke that exception when submitting records with any grant application. Because financial assistance will be provided by Maine taxpayers, the members believe that the public interest in the information provided to support an application for assistance outweighs any proprietary business interest in maintaining the confidentiality of that information.

Thank you for your consideration of these comments.

Sincerely,

Representative Erin Sheehan, Chair
Right to Know Advisory Committee

cc: Members, Blue Ribbon Commission to Study Emergency Medical Services in the State
Members, Right to Know Advisory Committee

STATE OF MAINE

RIGHT TO KNOW ADVISORY COMMITTEE

December XX, 2023

Maine School Management Association
Steven Bailey, Executive Director
Via Email: sbailey@msmaweb.com

Re: Public Records Requests Under the Freedom of Access Act

Dear Steven Bailey:

I am writing on behalf of the Right to Know Advisory Committee regarding a matter that was discussed by the Advisory Committee this year. The Joint Standing Committee on Judiciary asked the Advisory Committee to review a proposal contained in LD 1649, considered by the Judiciary Committee in the First Special Session of the 131st Legislature, related to the development and use of a form for the submission of public records requests.

A subcommittee of the full Advisory Committee considered this issue and, while the members understand that schools having been receiving very broad public records requests and are seeking ways to narrow their scope, the subcommittee did not recommend the creation of a form to be used by individuals requesting public records due to concerns about creating barriers to accessing public records. The subcommittee noted, however, that public bodies and agencies are able to create forms for their internal use that may be useful in narrowing down the scope of public records requests and facilitating efficient responses. As a result of the subcommittee's discussions, the Advisory Committee voted to provide your organization with this correspondence and to advise that the Public Access Ombudsman, Brenda Kielty, is available as a resource for best practices and assistance in developing a form.

Thank you for your consideration of these comments.

Sincerely,

Representative Erin Sheehan, Chair
Right to Know Advisory Committee

STATE OF MAINE

RIGHT TO KNOW ADVISORY COMMITTEE

TO: XX

FROM: Representative Erin Sheehan, Chair, Right to Know Advisory Committee

DATE: December X, 2023

RE: Survey: Requests for public records that are burdensome or an abuse of the Freedom of Access Act process

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This year, the Right to Know Advisory Committee considered several topics related to challenges faced by entities responding to public records requests under the Freedom of Access Act (FOAA). The Advisory Committee formed a subcommittee which was charged with discussing, among other things, defining what is a "burdensome" FOAA request as used in 1 M.R.S. §408-A(4), issues related to individuals making repeated FOAA requests and whether the Public Access Ombudsman should be given the authority to relieve an agency or official of its obligation to provide records pursuant to FOAA.

The Subcommittee considered various ways in which a "burdensome" request could be defined and agreed that what is considered a burdensome request would vary by situation. They also discussed situations in which a responding entity might consider a request or series of requests as an abuse of the FOAA process.

The Subcommittee members agreed that additional time and information would be necessary to fully consider this topic. As such, Advisory Committee voted to consider these topics when the committee reconvenes next year and to contact entities that are subject to FOAA for additional information that will assist the Advisory Committee in its work. The Advisory Committee requests the following information from your organization by July 1, 2024. The Advisory Committee is looking for general descriptions of examples to assist with developing recommendations related to these topics – please do not identify specific requestors or share copies of FOAA requests. **Please note that information provided to the Right to Know Advisory Committee in response to this survey will be distributed to Advisory Committee members and will be public.**

1. Please provide examples of the types of public records requests that your organization considers to be "burdensome" requests for public records.

2. Please provide examples of the types of public records requests or situations that your organization believes represent an abuse of the FOAA process.

3. Do you have any recommendations for statutory changes to FOAA to address the examples described in questions 1 or 2? If so, please describe your recommendations.

Thank you for your attention to this matter. You may provide your responses by email to Lindsay.Laxon@legislature.maine.gov or via mail to:

Right to Know Advisory Committee
c/o Office of Policy and Legal Analysis
13 State House Station
Cross Office Building, Room 215
Augusta, Maine 04333-0013

If you have any questions or concerns about our request, please do not hesitate to reach out to Advisory Committee staff, Lindsay Laxon or Colleen McCarthy Reid at (207) 287-1670.

APPENDIX E

Recommended Legislation to amend previously enacted public records exceptions

RECOMMENDED LEGISLATION TO AMEND EXISTING PUBLIC RECORDS EXCEPTIONS REVIEWED IN TITLE 22

Sec. 1. 22 MRSA §3022, sub-§8 is amended to read:

8. Certain information confidential. The following records ~~in the possession or custody of a medical examiner or the Office of Chief Medical Examiner are not public records within the meaning of Title 1, section 402, subsection 3 and~~ are confidential:

A. Medical records relating to a medical examiner case;

B. Law enforcement agency reports or records relating to a medical examiner case;

C. Communications with the Department of the Attorney General relating to a medical examiner case;

D. Communications with the office of a district attorney relating to a medical examiner case;

E. Death certificates and amendments made to the certificates, except for the information for which the medical examiner is responsible, as listed in section 2842, subsection 3, and not ordered withheld by the Attorney General relating to a medical examiner case or missing person;

F. Photographs and transparencies, histological slides, videotapes and other like items relating to a medical examiner case;

G. Written or otherwise recorded communications that express or are evidence of suicidal intent obtained under section 3028, subsections 4 and 5.

Sec. 2. 22 MRSA §3294 is amended to read:

§3294. Confidential information provided to professional and occupational licensing boards

If confidential information regarding a person subject to or seeking licensure, certification or registration by a licensing board indicates that the person may have engaged in unlawful activity, professional misconduct or conduct which may be in violation of the laws or rules relating to the licensing board, the director may release this information to the appropriate licensing board. Confidential information ~~shall~~ must be disclosed and used in accordance with section 3292 and may also be disclosed to members, employees and agents of a licensing board who are directly related to the matter at issue.

1. Notice to the licensee or applicant. Notice of the release of confidential information ~~shall~~ must be provided by the board to the licensee or applicant in accordance with the law and rules relating to the licensing board. If the law or rules relating to a licensing board do not provide for notice to licensees or applicants subject to or seeking licensure, certification or registration, the licensing board shall provide notice to the licensee or applicant upon determination of the board to take further action following its investigation.

2. Licensing board requests for confidential information. Any licensing board pursuing action within the scope of the board's authority or conducting an investigation of any person subject to or seeking licensure, certification or registration by the board for engaging in unlawful activity, professional misconduct or conduct which may be in violation of the laws or rules relating to the board may request confidential information from the bureau. Any information provided to the board for an investigation ~~shall be~~ is governed by section 3292 and this section.

3. Use of confidential information in investigations and proceedings. The use of confidential information in proceedings, informal conferences and adjudicatory hearings ~~shall be~~ is governed by Title 5, section 9057, subsection 6. The use of confidential information in investigations is governed by Title 10, section 8003-B, subsection 2, paragraph G as long as any confidential information disclosed under that subsection is not further disclosed by any person for purposes other than an investigation by a licensing board.

Sec. 3. 22 MRSA §5409 is amended to read:

§5409. Records

Except as provided in this section or by other provision of law, information obtained by the marketplace under this chapter is a public record within the meaning of Title 1, chapter 13, subchapter 1.

1. Financial information. Any personally identifiable financial information, supporting data or tax return of any person obtained by the marketplace under this chapter is confidential ~~and not open to public inspection~~ pursuant to 26 United States Code, Section 6103 and Title 36, section 191.

2. Health information. Health information obtained by the marketplace under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, or information covered by Title 22, section 1711-C is confidential ~~and not open to public inspection~~.

3. Personally identifiable information. Personally identifiable information not otherwise described in subsection 1 or 2 that is obtained by the marketplace under this chapter is confidential. As used in this subsection, "personally identifiable information" means information that permits the identity of an individual to whom the information applies to be able to be reasonably inferred or known by either direct or indirect means.

Summary

This draft implements statutory changes recommended by the Right To Know Advisory Committee after reviewing certain existing public records exceptions in Title 22.

Section 1 amends the public records exception to clarify that records relating to a medical examiner case are confidential and that the location or custodian of the record does not affect its

confidentiality. It also makes other technical and grammatical changes to conform with drafting standards recommended by the Right to Know Advisory Committee.

Section 2 amends the public records exception to clarify that a licensing board that receives confidential information from the department may release that information during the pendency of an investigation as long as that confidential information is not further disclosed for any other purpose. It also makes other technical and grammatical changes.

Section 3 amends the public records exception to clarify that any personally identifiable information obtained by the marketplace confidential. It also makes other technical and grammatical changes.

APPENDIX F

Existing public records exceptions in Title 22 recommended to continue without change

PUBLIC RECORDS EXCEPTIONS REVIEWED IN 2023:
TITLE 22 EXCEPTIONS RECOMMENDED TO BE CONTINUED WITHOUT CHANGE

The following public records exceptions reviewed in Title 22 should remain in law as written:

- Title 22, section 17, subsection 7, relating to records of child support obligors
- Title 22, section 42, subsection 5, relating to DHHS records containing personally identifying medical information
- Title 22, section 261, subsection 7, relating to records created or maintained by the Maternal and Infant Death Review Panel
- Title 22, section 264, subsection 8, relating to records held by the coordinator of the Aging and Disability Mortality Review Panel
- Title 22, section 664, subsection 1, relating to State Nuclear Safety Program facility licensee books and records
- Title 22, section 666, subsection 3, relating to the State Nuclear Safety Program concerning the identity of a person providing information about unsafe activities, conduct or operation or license violation
- Title 22, section 811, subsection 6, relating to hearings regarding testing or admission concerning communicable diseases
- Title 22, section 815, subsection 1, relating to communicable disease information
- Title 22, section 824, relating to persons having or suspected of having communicable diseases
- Title 22, section 832, subsection 3, relating to hearings for consent to test for the source of exposure for a blood-borne pathogen
- Title 22, section 1064, relating to immunization information system
- Title 22, section 1233, relating to syphilis reports based on blood tests of pregnant women
- Title 22, section 1317-C, subsection 3, relating to information regarding the screening of children for lead poisoning or the source of lead exposure
- Title 22, section 1413, relating to information that directly or indirectly identifies individuals included in amyotrophic lateral sclerosis (ALS) registry
- Title 22, section 1494, relating to occupational disease reporting
- Title 22, section 1596, relating to abortion and miscarriage reporting
- Title 22, section 1597-A, subsection 6, relating to a petition for a court order consenting to an abortion for a minor
- Title 22, section 1711-C, subsection 2, relating to hospital records concerning health care information pertaining to an individual
- Title 22, section 1714-E, subsection 5, relating to department records regarding determination of credible allegation of MaineCare fraud
- Title 22, section 1717, subsection 15, relating to personally identifying information or health information created or obtained in connection with DHHS licensing or quality assurance activities

- Title 22, section 1816, subsection 2, paragraph B, relating to survey findings of health care accrediting organization, including deficiencies and work plans, of hospitals reported to DHHS
- Title 22, section 1828, relating to Medicaid and licensing of hospitals, nursing homes and other medical facilities and entities
- Title 22, section 2140, subsection 17, relating to information collected by DHHS regarding compliance with Maine Death with Dignity Act
- Title 22, section 2153-A, subsection 1, relating to information provided to the Department of Agriculture by the US Department of Agriculture, Food Safety and Inspection Service
- Title 22, section 2153-A, subsection 2, relating to information provided to the Department of Agriculture by the US Food and Drug Administration
- Title 22, section 2425-A, subsection 12, relating to applications and supporting information submitted by patients, caregivers and providers under the Maine Medical Use of Marijuana Act
- Title 22, section 2706, subsection 4, relating to prohibition on release of vital records in violation of section; recipient must have "direct and legitimate interest" or meet other criteria
- Title 22, section 2706-A, subsection 6, relating to adoption contact files
- Title 22, section 2769, subsection 4, relating to adoption contact preference form and medical history form
- Title 22, section 3022, subsections 8, 12,13 and 14, relating to medical examiner information
- Title 22, section 3034, subsection 2, relating to the Chief Medical Examiner missing persons files
- Title 22, section 3109, subsection 2-A, relating to personal information of TANF participants surveyed by DHHS
- Title 22, section 3174-X, subsection 6, relating to records of the Medicaid ombudsman program
- Title 22, section 3188, subsection 4, relating to the Maine Managed Care Insurance Plan Demonstration for uninsured individuals
- Title 22, section 3192, subsection 13, relating to Community Health Access Program medical data
- Title 22, section 3292, relating to use of confidential information for personnel and licensure actions
- Title 22, section 3293, relating to confidential information provided to state employees and Bureau of Human Resources
- Title 22, section 3295, relating to confidential information provided in unemployment compensation proceedings related to state employment
- Title 22, section 3474, subsection 1, relating to adult protective records
- Title 22, section 3762, subsection 3, relating to TANF recipients
- Title 22, section 4007, subsection 1-A, relating to a protected person's current or intended address or location in the context of child protection proceeding
- Title 22, section 4008, subsection 1, relating to child protective records

- Title 22, section 4008, subsection 3-A, relating to records of child death and serious injury review panel
- Title 22, section 4018, subsection 4, relating to information about a person delivering a child to a safe haven
- Title 22, section 4019, subsection 9, relating to files, reports, records, communications and working papers used or developed by child advocacy centers
- Title 22, section 4021, subsection 3, relating to information about interviewing a child without prior notification in a child protection case
- Title 22, section 4036, subsection 1-A, relating to child protective case documents in a proceeding awarding parental rights and responsibility
- Title 22, section 4087-A, subsection 6, relating to information held by or records or case-specific reports maintained by the Child Welfare Ombudsman
- Title 22, section 4306, relating to general assistance
- Title 22, section 5307, subsection 2, relating to fingerprint-based criminal background check for "high-risk" MaineCare providers
- Title 22, section 5328, subsection 1, relating to community action agencies records about applicants and providers of services
- Title 22, section 5409, subsections 1 and 2, relating to records held by the Maine Health Insurance Marketplace
- Title 22, section 7250, subsection 1, relating to the Controlled Substances Prescription Monitoring Program
- Title 22, section 7703, subsection 2, relating to facilities for children and adults
- Title 22, section 8110, subsection 5, relating to criminal history record information for employees of a children's residential care facility, an emergency children's shelter, a shelter for homeless children or any group home that provides care for children
- Title 22, section 8302-C, subsection 1, relating to criminal history record information for child care providers and child care staff members
- Title 22, section 8707, relating to records of the Maine Health Data Organization
- Title 22, section 8714, subsection 1, relating to protected health information in data collected by MHDO
- Title 22, section 8715-A, subsection 2, relating to cancer-incidence registry data and vital statistics data reported to MHDO
- Title 22, section 8733, relating to information provided to MHDO by a prescription drug manufacturer, wholesale drug distributor or pharmacy benefits manager
- Title 22, section 8754, relating to medical sentinel events and reporting
- Title 22, section 8824, subsection 2, relating to the newborn hearing program
- Title 22, section 8943, relating to the registry for birth defects
- Title 22, section 9061, relating to criminal background check record or other personally identifiable information for direct access worker

State of Maine
131st Legislature, First Regular and First Special Sessions

Task Force to Study the Creation of a Comprehensive Career and Technical Education System

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSIONS

Task Force to Study the
Creation of a Comprehensive Career
and Technical Education System

Members:
Sen. Joe Rafferty, Chair
Rep. Kelly Noonan Murphy, Chair
Rep. David Woodsome
Sen. James Libby
Rob Callahan
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Table of Contents

Executive Summary

The 131st Maine Legislature established the Task Force to Study the Creation of a Comprehensive Career and Technical Education System (referred to in this report as the "task force") with the passage of Resolve 2023, chapter 92 (Appendix A). Pursuant to the resolve, 20 members were appointed to the task force:

- Two members of the Senate appointed by the President of the Senate, including one member from each of the two parties holding the largest number of seats in the Legislature and one of whom is a member of the Joint Standing Committee on Education and Cultural Affairs;
- One member who is a current career and technical education high school administrator, appointed by the President of the Senate;
- One member who represents a statewide association of career and technical education administrators, appointed by the President of the Senate;
- One member who is a member of a skilled trades union or representative of a skilled trades business or industry, appointed by the President of the Senate;
- One member who is a principal of a secondary school, appointed by the President of the Senate;
- Two members of the House of Representatives, including one member from each of the two parties holding the largest number of seats in the Legislature, one of whom is a member of the Joint Standing Committee on Education and Cultural Affairs, appointed by the Speaker of the House;
- One member who is a current career and technical education high school administrator, appointed by the Speaker of the House;
- One member who is on the State Board of Education, appointed by the Speaker of the House;
- One member who is a member of a skilled trades union or representative of a skilled trades business or industry, appointed by the Speaker of the House;
- One member who is a superintendent of a school administrative unit, appointed by the Speaker of the House;
- One member who is a Maine Community College System administrator, appointed by the Governor;
- One member who is on a local board of education in a Maine community, appointed by the Governor;
- One member who is an officer of the Maine Education Association, appointed by the Governor;
- Three members who are members of a skilled trades union or representatives of a skilled trades business or industry, appointed by the Governor;
- One member who is an administrator at the University of Maine System, appointed by the Governor; and
- The Commissioner of Education or the commissioner's designee.

A list of task force members can be found in Appendix B.

The duties of the task force, which are set forth in Resolve 2023, chapter 93, are as follows:

1. Examine the feasibility of establishing a comprehensive four-year high school career and technical education program to provide a technical high school setting for middle school students to attend at the completion of the eighth grade, including but not limited to the advantages and disadvantages of a comprehensive four-year high school career and technical education model, obstacles to implementation of a comprehensive four-year high school career and technical education model and other models for comprehensive four-year high school career and technical education that exist around the State and on a national level; and

2. Examine increasing crosswalks and intersections between technical and occupational knowledge and curricula and academic standards in order to promote multiple pathways for awarding content area credit to students enrolled in career and technical education programs, including but not limited to building on prior and current work among the Department of Education, superintendents of school administrative units and career and technical education administrators.

Over the course of four meetings, the task force developed the following recommendations:

Recommendation #1. Support the ongoing work of CTE centers and regions and their respective governing or affiliated SAUs in developing equivalency agreements for credit gained through a CTE program to be accepted as core credit toward a high school diploma as required by Public Law 2023, chapter 247 (LD 436). Support should include periodic updates on the progress to the Joint Standing Committee on Education and Cultural Affairs to determine when and where additional resources, financial or otherwise, may be needed.

Recommendation #2. Support the State's existing 27 CTE centers and regions to increase capacity, grow programs, increase exposure to CTE programs (especially for 9th and 10th grade students), and require the data collection necessary to capture the true scope of needed resources to address barriers.

Recommendation #3. Explore ways to increase capacity at CTE centers and regions specifically for oversubscribed programs.

I. Introduction

The 131st Maine Legislature established the Task Force to Study the Creation of a Comprehensive Career and Technical Education System (referred to in this report as the "task force") with the passage of Resolve 2023, chapter 92 (Appendix A). Pursuant to the resolve, 20 members were appointed to the task force:

- Two members of the Senate appointed by the President of the Senate, including one member from each of the two parties holding the largest number of seats in the Legislature and one of whom is a member of the Joint Standing Committee on Education and Cultural Affairs;
- One member who is a current career and technical education high school administrator, appointed by the President of the Senate;
- One member who represents a statewide association of career and technical education administrators, appointed by the President of the Senate;
- One member who is a member of a skilled trades union or representative of a skilled trades business or industry, appointed by the President of the Senate;
- One member who is a principal of a secondary school, appointed by the President of the Senate;
- Two members of the House of Representatives, including one member from each of the two parties holding the largest number of seats in the Legislature, one of whom is a member of the Joint Standing Committee on Education and Cultural Affairs, appointed by the Speaker of the House;
- One member who is a current career and technical education high school administrator, appointed by the Speaker of the House;
- One member who is on the State Board of Education, appointed by the Speaker of the House;
- One member who is a member of a skilled trades union or representative of a skilled trades business or industry, appointed by the Speaker of the House;
- One member who is a superintendent of a school administrative unit, appointed by the Speaker of the House;
- One member who is a Maine Community College System administrator, appointed by the Governor;
- One member who is on a local board of education in a Maine community, appointed by the Governor;
- One member who is an officer of the Maine Education Association, appointed by the Governor;
- Three members who are members of a skilled trades union or representatives of a skilled trades business or industry, appointed by the Governor;
- One member who is an administrator at the University of Maine System, appointed by the Governor; and
- The Commissioner of Education or the commissioner's designee.

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The duties of the task force, which are set forth in Resolve 2023, chapter 93, are as follows:

1. Examine the feasibility of establishing a comprehensive four-year high school career and technical education program to provide a technical high school setting for middle school students to attend at the completion of the eighth grade, including but not limited to the advantages and disadvantages of a comprehensive four-year high school career and technical education model, obstacles to implementation of a comprehensive four-year high school career and technical education model and other models for comprehensive four-year high school career and technical education that exist around the State and on a national level; and

2. Examine increasing crosswalks and intersections between technical and occupational knowledge and curricula and academic standards in order to promote multiple pathways for awarding content area credit to students enrolled in career and technical education programs, including but not limited to building on prior and current work among the Department of Education, superintendents of school administrative units and career and technical education administrators.

The task force is also directed to submit a report with recommendations for presentation to the Second Regular Session of the 131st Legislature. The report due date is January 15, 2024.

II. Background

Career and technical education (also referred to as CTE) in Maine is built on a model of providing secondary students opportunities for relevant and challenging applied learning to enhance their occupational, personal and academic success, while at the same time preparing them for their next steps after graduation, whether that be continued education or entering the workforce. Throughout Maine there are 27 CTE centers and regions. CTE Centers are governed, operated and administered by a single school administrative unit (SAU) and make its programs available to serve secondary students from the SAU with which it is affiliated. A CTE region is a quasi-municipal corporation established by the Legislature to provide CTE to secondary students that is comprised of all of the SAUs within the geographical boundaries of the region and is governed by a cooperative board.

Across the State, almost 9,800 students are enrolled in a CTE program. While programing has traditionally been geared towards juniors and seniors, there has been an increase in enrollment in CTE Exploratory programs, which primarily serve freshmen and sophomores and are designed to introduce students to multiple CTE programs on a small scale with the goal that the student will gain interest and become more focused during the student's junior and senior years. Middle school pilot programs introduced in recent years have also seen growth, with enrollment during the 2021-2022 school year reaching 4,431 students at 21 CTE schools.

However, even with this growth, there are many barriers to students accessing CTE programs. As noted in the authorizing legislation, this task force was charged with examining two specific

issues related to CTE in Maine: the feasibility of a comprehensive four-year high school CTE program to provide a technical high school setting for high school students and increasing crosswalks and intersections between technical and occupational knowledge and curricula and academic standards in order to promote multiple pathways for awarding content area credit to students enrolled in CTE programs.

In Maine, the instructional requirements leading to a high school diploma must be part of a program of at least four years that meets the requirements of Title 20-A, section 4722 and any other instructional requirements established by the Commissioner of Education and the local school board. Minimum requirements established by state statute include four years of English, two years of social studies and history, two years of mathematics, two years of science and one year of fine arts. However, most, if not all, local school boards include additional requirements. A secondary school student may earn a diploma if the student has satisfactorily completed all diploma requirements in accordance with the academic standards of the SAU and the statutory requirements. CTE students may satisfy the diploma requirements through separate or integrated study within the career and technical school curriculum, including through courses provided through CTE centers and regions, on the approval of the commissioner and the local school board.

In recent years bills have been presented to the Legislature aimed at increasing the ability of CTE students to gain core academic credit for the work and courses they complete through the CTE centers and regions. When the initial bill to establish a task force to study the creation of a comprehensive CTE system and establishing a comprehensive four-year high school CTE program was introduced during the 129th Legislature, the sponsor of the legislation testified that he was seeking clarity on what such a program would look like.[1] The committee at that time also heard about a potential project coming out of the Region 10 Technical High Cooperative Board, which was exploring a proposed 4-year technical high school model similar to those found in Massachusetts and Connecticut.[2]

Although that task force from the 129th Legislature was never convened, subsequent legislation did focus on increasing access to CTE. For example, the 130th Legislature also passed LD 313, which directed the Department of Education to convene a stakeholder group to explore innovative approaches to advancing CTE opportunities, including by identifying existing systemic barriers to expanding access to CTE programs.[3] That bill resulted in two reports

[1] See Public Hearing Testimony of Representative Norm Higgins on LD 1036, "Resolve, Establishing a Task Force to Study the Creation of a Comprehensive Career and Technical Education System to Support Workforce Development" 129th Legislature.
[2] See Public Hearing Testimony of Nancy Weed, Superintendent/Director of Region 10 Technical High School in Brunswick, on LD 1036, "Resolve, Establishing a Task Force to Study the Creation of a Comprehensive Career and Technical Education System to Support Workforce Development" 129th Legislature.
[3] Finally passed as Resolve, 2021, chapter 36, Resolve, to Advance Career and Technical Education Opportunities in Maine.

submitted to the Legislature.[4] Simultaneously, the State Board of Education was also including in its five-year strategic plan for CTE, the goal of promoting CTE program alignment including ensuring congruence between CTE coursework and district-wide graduation requirements and standards.

Subsequently, the Joint Standing Committee on Education and Cultural Affairs, through its contract with the Maine Education Research Policy Institute ("MEPRI)," directed MEPRI to examine challenges faced by Maine CTE students in earning core academic graduation credits and some of the strategies currently in use for overcoming those challenges. That report[5] which was presented to the Joint Standing Committee on Education and Cultural Affairs in September 2023 and to the task force at its first meeting in October, included that the two biggest barriers to CTE are limited seats in preferred programs and CTE schedule conflicts with preferred academic courses. The MEPRI survey found that 5% to 33% of CTE students are challenged to earn the academic credits they need to graduate, in part due to scheduling misalignment, relevance and rigor of high school English and math courses and lack of math credit recovery options.

Of those who responded to the survey, 60% said their sending high schools award academic credit to at least some students for work done in CTE programs through integrated, embedded and newly-created options and that 20% of CTEs offer discrete core academic classes on site at the CTE center or region. However, academic credit is often awarded for coursework in CTE programs "as needed" or on a case-by-case basis rather than in a uniform, systematic way. Recommendations from sending school staff and administrators include to "[r]equire or at a minimum incentivize, districts to provide pathways for students to earn core academic credit through CTE programs, and support schools with knowledge and financial resources to make it possible." Ultimately, even where the work is being done, successful crosswalks need agreement between sending schools and CTEs, dedicated, well-qualified staff with time to build and continuously update the program, strong support from school leadership, buy-in from high school teachers, and student awareness of the options available to them. The survey also noted alternative strategies, such as offering core academics at more CTE centers and regions, leveraging early college courses beyond elective credits at more CTE centers and regions, and exploring adopting a technical high school model.

Simultaneous to the formation of this task force and the MEPRI study, another piece of legislation was winding its way through the process: LD 436, "An Act to Provide Career and Technical Education Students with Credit Toward High School Graduation for Work Completed in Career and Technical Education Centers and Regions" (sponsored by Rep. David Woodsome). LD 436 was ultimately enacted as Public Law 2023, chapter 247, and it requires that, before the school year beginning after June 30, 2025, cooperative agreements between school

[4] Interim Report (December 15, 2021) available here: https://legislature.maine.gov/doc/7793; Final Report (March 16, 2022) available here: https://legislature.maine.gov/doc/8627.

[5] Available here: https://bpb-us-w2.wpmucdn.com/wpsites.maine.edu/dist/e/97/files/2023/06/Models_for_Earning_Academic_Requirements_for_High_School_Graduation_Through_Career_and_Technical_Education_Programs.pdf

administrative units and career and technical education centers and regions must include an equivalency agreement for credit gained through a career and technical education program to be accepted as core credit toward a high school diploma and provides that career and technical education students may satisfy local diploma requirements in accordance with the equivalency agreements included in the cooperative agreements.

As the members heard during the first meeting of the task force, by the time this task force convened in the Fall of 2023, the Department of Education, Maine Administrators of Career and Technical Education (MACTE), the Maine Curriculum Leaders Association (MCLA), and superintendents across the State had made great strides in improving these academic crosswalks and intersections.

III. Task Force process

The task force held four meetings on the following dates: October 18, November 8, November 30 and December 14.

A. First Meeting: October 18, 2023

The first meeting of the task force was held on October 18, 2023. The meeting began with task force member introductions. Legislative staff provided an overview of the enabling legislation (Resolve 2023, chapter 92 in Appendix A) covering the duties, process, and timeline for the task force's work.

The focus of the first meeting was on the background related to the second duty of the task force – to "[E]xamine increasing crosswalks and intersections between technical and occupational knowledge and curricula and academic standards in order to promote multiple pathways for awarding content area credit to students enrolled in career and technical education programs."

Accordingly, the task force heard a presentation by Amy Johnson and Jennifer Chace from the Maine Education Policy Research Institute (MEPRI) drawn from their report on this issue, *Models for Earning Academic Requirements for High School Graduation Through Career and Technical (CTE) Programs* (May 2023). More information and details of what was included in this report and its presentation are included in Section II. Amy and Jennifer were joined by Dwight Littlefield, Career and Technical Education Team Coordinator at the Maine Department of Education (DOE) to provide further background.

The task force ended the meeting with a robust discussion of what each member hoped to get out of the task force. Overall, members expressed that they hope to expand capacity of CTE programs to increase access for students, explore statewide approaches that will benefit all students across the State, ensure equitable access for students and preparing students for the next steps in their lives, whatever it may be, increasing awareness of CTE programs, and minimizing barriers.

B. Second Meeting: November 8, 2023

The second meeting of the task force was held on November 8, 2023. The focus of the second meeting was on the task force's first duty to "[e]xamine the feasibility of establishing a comprehensive four-year high school career and technical education program to provide a technical high school setting for middle school students to attend at the completion of the eighth grade, including but not limited to the advantages and disadvantages of a comprehensive four-year high school career and technical education model, obstacles to implementation of a comprehensive four-year high school career and technical education model and other models for comprehensive four-year high school career and technical education that exist around the State and on a national level."

Accordingly, the task force heard from two other states on the models that their respective states use for providing comprehensive CTE high schools, as well as a presentation on a feasibility study conducted for a comprehensive CTE high school in Region 10 Technical High School, located in Brunswick, Maine.

Massachusetts

Erin Orcutt, Business Administrator at Cape Cod Regional Technical High School located in Harwich, Massachusetts, presented details on how Cape Code Regional Technical High School operates, as well as a brief overview of career and technical education in Massachusetts generally. Orcutt noted that the Commonwealth of Massachusetts has 28 regional technical/vocational high schools, as well as 47 state-approved "Chapter 74 programs," which are programs that meet the definition of vocational technical education pursuant to Massachusetts law. Districts apply for program approval to the Massachusetts Department of Elementary and Secondary Educations Office for College, Career, and Technical Education (OCCTE) pursuant to Chapter 74 and the Vocational Technical Education Regulations.[6]

Orcutt explained that in Cape Cod Regional Technical High School there are currently 666 students. Of that total, 43.5% of the district comprise of low-income students, while 22.2% of the district comprise of students with disabilities.

The school offers traditional academics, such as social studies, as well as CTE courses. Also included are Advanced Placement ("AP") courses, as well as supports for students with individualized education programs (IEPs). Orcutt said that at Cape Cod Regional Technical High School, students complete two-week rotations between academics and "shop," a CTE program, such as health sciences or automotive technology. At her high school, students take English language and mathematics courses for the full school year (180 days) in 9th and 10th grades, while students take science for the full school year (180 days) in 9th grade. In addition to

[6] https://www.doe.mass.edu/ccte/cvte/programs/

Commonwealth of Massachusetts requirements for graduation, Cape Cod Regional Technical High School requires a senior project that students must complete.

The school is organized into "academies" based on CTE fields.

Orcutt told task force members that there are challenges that the school faces while conducting its CTE to students. She specifically mentioned scheduling is challenging, particularly for students on a pathway toward college who often take AP courses. Because of the two-week rotations, students are only in traditional academic courses 90 days per year. In order to make up for time spent in CTE, students often commit one Saturday per month during the academic year to stay prepared for AP exams.

Also challenging is the commitment to collaboration and professional development, which Orcutt told the task force is essential. She said that for one hour per week, 17-25 teachers get together and work on possible projects that align with student work and the cross-curricular learning.

Other challenges include community buy-in and the financial cost of CTE. Orcutt explained that the school needed new facilities, which ultimately cost approximately $120 million for a 220,000 sq. ft. education center. Voters in Harwich, Massachusetts and the surrounding communities voted overwhelmingly to approve the construction of the new facilities.

New York

Dr. James Neidermeier, Associate Superintendent of Curriculum, Instruction, and Accountability at Questar III Boards of Cooperative Educational Services (BOCES), presented a model of CTE in New York. BOCES was founded by the New York State Legislature in 1948 to provide shared educational programs and services to school districts within the state.[7]

As a BOCES, Questar III serves about 700 students in CTE, with the option for students to choose from 24 programs. Dr. Neidermeier told the Task Force that 30-40% of CTE students have an IEP and that 98.2% of students graduate with a Regents Diploma.[8] A Regents Diploma is one of three diplomas available to New York State high school graduates. For a student to receive a Regents Diploma, a student must achieve specific scores on exams in math, social studies, English language arts and science. Additionally, students must earn 44 credits in high school in core classes such as math, world languages, English, social studies, arts education, science, physical education and electives.[9] Dr. Neidermeier told the Task Force that 60% of graduates attend postsecondary education.[10]

[7] https://www.boces.org/about-boces/
[8] https://legislature.maine.gov/doc/10412
[9] https://www.schools.nyc.gov/learning/student-journey/graduation-requirements.
[10] https://legislature.maine.gov/doc/10412

Dr. Neidermeier highlighted two specific New York State High Schools that Questar III BOCES works with: Tech Valley High School and STEM High School.

Dr. Neidermeier explained that Tech Valley High School opened in 2008 and is project-based learning focused. About 30% of students have an IEP or a 504 plan. In order to be admitted to Tech Valley High School, students are chosen by a lottery. There are about 150 students from 30 school districts enrolled at Tech Valley High School. Each student participates in a two-week annual career exploration program, where the student explores each CTE program that the high school offers. In addition to traditional academic courses, students must also perform 100 hours of community service to graduate and take 4 years of math and science. Additionally, two years of Mandarin Chinese must be taken. Dr. Neidermeier said that the average number of college credits earned by graduating seniors is 19, but that a 60-credit associate degree option is also available.

STEM High School opened in 2021 and is designed to give students historically underrepresented at the postsecondary level a jumpstart on their college education and careers. There are several career pathways available to students, including computer information systems and civil engineering. There are currently 100 students enrolled in grades 9-11. Dr. Neidermeier noted that because the school only opened in 2021, data is preliminary. However, he noted that in the last academic year, 169 college credits were earned by students attending STEM High School.

Region 10 Technical High School Brunswick, Maine

The Task Force also heard from John Stivers, Assistant Director, and Shawn Chabot, Superintendent, both from Region 10 Technical High School. Stivers and Chabot presented findings from a feasibility study on a four-year technical high school in Region 10 in Brunswick, Maine. Hart Consulting, Inc. conducted the study, which was sponsored by the Harold Alfond Foundation.

Stivers and Chabot noted that part-time CTE models lead to scheduling challenges for the State's high schools, as well as in Region 10. There are limited seats for programs, with some high-demand programs seeing waitlists. In order to attend the program, students have to be in good academic standing and a student's sending school determines whether a student can earn specific academic credit for CTE. They said that CTE programs can only offer academic courses in cases where scheduling conflicts would prohibit a student from attending the program.

In conducting the feasibility study, assumptions were made about a proposed comprehensive high school, including:

- The school will be a public day school;
- It will be a full-time comprehensive technical high school with traditional part-time CTE program access;
- It will award high school credits and diplomas;
- It will be located at Brunswick Landing;
- It will attract at least 300-350 full-time students;

- It will provide all required services and extra-curricular activities (either on-site, or as a cooperative agreement with other schools); and
- It will have inclusive admissions, including those with special education needs and those whose second language is English.

Stivers and Chabot noted that in 9th grade, students will take foundational coursework; in 10th grade, intermediate coursework; and in 11th and 12th grades, students will take advanced coursework, have dual enrollment in CTE programs and perform work-based learning at job sites.

In describing the location at Brunswick Landing, Stivers and Chabot noted that there are 18,000 high school students in towns within 30 miles of Brunswick and that 3,200 students attend high schools in districts that have large populations commuting to the Bath/Brunswick area of the State. They also noted that 80% of Brunswick's workforce comes from neighboring communities and there is opportunity to be on or close to Brunswick Landing, with 150 companies in the surrounding area in diverse industries such as energy, aviation and manufacturing. There are also regional campuses of the University of Maine at Augusta, Southern Maine Community College and four aviation schools.

Stivers and Chabot also showed data from a survey sent to students of schools who currently send students to complete CTE programs at Region 10. The survey was designed to gauge their interests in a comprehensive high school and asked what features a comprehensive high school should include. Fifty-one percent of respondents showed medium to high interest in attending the four-year, full-time comprehensive high school. This includes 41% of eighth-graders indicating they were interested or very interested. When asked about the most important features of the new school, 68% of respondents said hands-on learning was the most important, followed by 56% indicating a clear pathway to a career or postsecondary education.[11]

A survey was also distributed to caregivers of students of the sending schools. When asked how interested the caregivers would be in sending their student to a new comprehensive high school, 47% indicated they were "extremely interested," with 22% indicating "very interested" and 21% indicating "somewhat interested."

Stivers and Chabot explained that as of October 2022, Region 10 receives $2,893,205 for its CTE program from the State's Essential Programs and Services formula. The two estimate that additional funding of about $3.6 million will be needed if the comprehensive high school at Brunswick Landing is to go forward. Additionally, Stivers and Chabot explained that the feasibility study estimates a construction cost of at least $60M, assuming a footprint of 130,500 sq. ft. This $60M+ figure comes from Sanford High School and Regional Technical Center, which is 330,000 square feet but cost about $100M, plus an estimated 40% increase in costs due to inflation.

[11] https://legislature.maine.gov/doc/10412

Stivers and Chabot admitted there are many unknowns and uncertainties about opening and operating a comprehensive high school, including but not limited to any necessary statutory changes and identifying a funding model that does not take funding away from CTE centers and regions currently operating.

C. Third Meeting: November 30, 2023

The third meeting of the task force was held on November 30, 2023. After taking the first two meetings to examine the duties laid out in the authorizing legislation, the task force then turned its focus to discussion of what findings and recommendations the task force wanted to include in its report. Preliminarily, the task force received an overview of the state of CTE in Maine from Amanda Peterson, Director, Maine Administrators of Career and Technical Education (MACTE), who is also the Director at United Technologies Center in Bangor. Petersen was joined by Bobby Deetjen, Director of the Mid-Coast School of Technology in Rockland.

Peterson spoke about the challenges to CTE in Maine, barriers in CTE and how to serve more students in CTE.

She said that next year she will have 7 open teaching positions due to the expansion of programming offered. Attracting industry professionals to teach CTE programs is challenging because of certification requirements and because industry professionals are often unsure they want to work with teenagers. Those that do leave their fields and come to CTE programs to teach are often looking for a better lifestyle balance than their industry currently provides. Peterson said that is one way they recruit educators, by selling the stability of the profession and the predictability of an academic schedule to professionals. The other piece that makes it difficult to retain CTE program educators is that they are often taking a pay cut. By teaching their craft to the next generation, they often give up making more money than they would if they had stayed in their industry.

Peterson also said that funding is a huge challenge, particularly with special education, transportation, infrastructure and supplies required to teach the CTE programs. She said that in the first 30 days of the last academic school year she lost 55 students with individualized education programs because the CTE center did not have support for the students.

Speaking to barriers, Peterson said that resources vary heavily among the State's 27 CTE centers and regions. Each CTE center and region has its own culture, buildings and communities, which can make it challenging when trying to garner resources. She also said a lack of data is also a hindrance, acknowledging that superintendents, guidance counselors, the Maine Department of Education and CTE centers and regions could do a much better job in uniformly tracking this information so it is available when requested and necessary.

Peterson recommended building capacity statewide so students will be able to attend a desired CTE program without being turned away due to spacing or staffing issues. Also important to building capacity is to take a statewide approach when examining increasing capacity. She also recommended tying CTE in with the State's economic growth strategy, which seeks to attract 75,000 people to the State's talent pool.[12]

Following Peterson's presentation, the task force discussed at length some of the potential recommendations, specifically regarding supporting the ongoing work of increasing crosswalks and intersections between technical and occupational knowledge and curricula and academic standards to meet the timeline required in LD 436, and increasing support and resources, as needed to the current 27 CTE Centers and Regions, and to the extent that the level of support required is unknown, recommending the data collection needed to understand the extent of resources needed. The task force also discussed recommending a potential pilot project for a comprehensive four-year technical high school.

D. Fourth Meeting: December 14, 2023

The task force held its fourth meeting on December 14, 2023. The task force reviewed a draft report as well as comments, questions and feedback on the draft report that had been submitted by members prior to the meeting. The information regarding the substantive discussions, votes and recommendations are included in the recommendations section of this report.

IV. Recommendations

Votes on recommendations were taken during the third and fourth meetings of the task force. As previously summarized, the task force met four times in the development of its findings and recommendations and examination of the issues as required by the authorizing legislation. Over the course of those meetings, the task force heard from many of the stakeholders on the work that is currently being done to overcome many of the barriers to access to CTE. The task force is cognizant of the importance of supplementing – rather than supplanting - that ongoing work. The task force also recognizes that there are numerous other areas that may require further study and/or support but that went beyond the scope of the duties of this task force. Those additional issues and recommendations are included below and discussed in "Other Considerations."

Recommendation #1. Support the ongoing work of CTE centers and regions and their respective governing or affiliated SAUs in developing equivalency agreements for credit gained through a CTE program to be accepted as core credit toward a high school diploma as required by Public Law 2023, chapter 247 (LD 436). Support should include periodic updates on the progress to the Joint Standing Committee on Education and Cultural

[12] https://www.maine.gov/decd/sites/maine.gov.decd/files/inline-files/DECD_120919_sm.pdf

Affairs to determine when and where additional resources, financial or otherwise, may be needed. (Unanimous).

As noted above, Public Law 2023, chapter 247 requires that in the school year beginning after June 30, 2025, a cooperative agreement between a CTE center equivalency agreement for credit gained through a CTE program to be accepted as a core credit toward a high school diploma for each of the school administrative units governing or affiliated with the center. This could mean, for example, that a student is able to receive credit for a geometry course at their sending high school that counts towards a high school diploma for successful completion of a construction math course at a CTE center.

This will avoid situations in which a student is precluded from participating in CTE simply because the student is missing required core academic credit that is perhaps only offered at a particular time during the school day, because the student needs to make-up a credit, or any other reason. Although many SAUs and CTE centers and regions engage in this kind of credit-work on a case-by-case or as-needed basis, a more systematic process will ensure that credits are awarded equitably and that students are able to plan ahead to achieve their academic and applied learning goals. As the task force heard, because curriculum and graduation requirements – beyond those minimally required by the State – are local decisions, each SAU may have different requirements. This makes uniformity across the State especially difficult. To lessen this burden, and in order to implement the new requirement, the task force learned that MACTE, MCLA, DOE, and other stakeholders have formed a working group, identified a working plan to audit CTE curriculum program and are working on guidelines that can be distributed to sending SAUs. The working group is expected to have a draft document complete in February 2024. Task force member Rob Callahan noted that the intent behind the document is to put that guidance in the hands of all CTE center directors and the sending school administrators to facilitate conversations between sending high school and the CTE centers about crosswalks between academic core credit and CTE program credit. Thus, even though local graduation requirements differ across the State, sending schools CTE will be able to utilize this document as a basis for determining necessary crosswalks and intersections between the sending school requirements and the programs and coursework at the affiliated CTE.

Because of Public Law 2023, chapter 247, the task force discussed and ultimately recommends ensuring that the progress toward implementation is continuous and that the timeline is on track. In discussing how to do this, members recommended that the Legislature's Education and Cultural Affairs Committee request updates from MACTE and its working group on the progress. In demonstrating its commitment to the law's implementation, the task force also recommends that the Education and Cultural Affairs Committee provide MACTE, CTE centers and sending schools with resources, including financial resources, if necessary, as the law nears implementation and as the work is being complete by MACTE and all of the other stakeholders.

One potential recommendation that was discussed but rejected was to add CTE curriculum into the Maine Learning Results. However, the task force ultimately decided this could further prohibit the offering of CTE education to students because of varying graduation requirements

among school districts. While the State sets minimum graduation requirements, some school districts go further and require additional coursework or activities to graduate, such as with volunteer hours. If CTE were included among these requirements, the task force felt it would have an adverse effect on CTE participation and decided not to recommend that.

Ultimately, the task force emphasizes that this work will require ongoing effort and initiative. Over time, local graduation requirements change, new CTE programs are added and current program curricula is amended, and national industry standards are updated. The equivalency agreements will need to be continuously updated and amended to ensure that they reflect the current needs of the SAUs, CTE centers and regions, and most importantly the students. The task force encourages the Legislature, through the Joint Standing Committee on Education and Cultural Affairs, to remain committed to the ongoing work and the time, commitment, and resources necessary to make this work successful today and into the future.

Recommendation #2. Support the State's existing 27 CTE centers and regions to increase capacity, grow programs, increase exposure to CTE programs (especially for 9th and 10th grade students), and require the data collection necessary to capture the true scope of needed resources to address barriers. (19 In favor; 1 opposed)[13].
Task Force members repeatedly heard throughout their meetings and from each other that demand for specific CTE programs surpasses supply. This results in CTE centers and regions turning away students who may have otherwise been successful in the programs simply because the center does not have enough capacity to accept the student. This capacity limitation is due to a number of factors, including physical space and staff recruitment and retention.

One issue that was continuously raised is that while there is ample anecdotal evidence of waitlists for programs, staffing shortages and physical capacity limitations there is no systematic data collection to truly understand the scope of the needed resources. The task force heard from presenters and its own task force membership that most, if not all, CTE centers and regions have programs with these waitlists and that the CTE centers and regions cannot accept eligible students for no other reasons other than physical space limitations and lack of educators for that program. However, no data collection is required or in a centralized location, legislators are not in a position to know about the needs of each CTE center and region and cannot make decisions that reflect the on-the-ground needs of the CTE programs. The State does not have adequate data identifying how many students would like to attend a CTE program but can't because of space, how many teachers are needed to fill vacant and new positions, and what is the cost to fill those gaps. The task force recognizes that this puts policymakers and legislators at a disadvantage in trying to determine how many resources are needed, and where to direct those resources to make the most impact. Without having this data accessible, any numeric funding recommendations would be estimates. Accordingly, task force members also recommend that data collection be required so that legislators can make better decisions about what CTE centers and regions need generally.

[13] Opposed: James Ford.

However, while task force members recommend increased investment, including financially, some members also expressed concern that an increase in CTE funding could have an adverse effect on other school funding by drawing funds from the other necessary costs of public education in the State. To avoid this, Rep. Woodsome expressed the idea that the State should provide all funding for CTE centers and that local communities should be spared from having to increase local taxes for such a statewide need.

Another area of concern and identified need for resources is that there should be more support for CTE specifically in the area of special education. Currently, when a student who needs one-on-one support via an education technician due to an individual education plan, the financial calculation of that need is distributed to the student's high school. If the student decides to attend a CTE program at a CTE center or region, that one-to-one support does not automatically translate to that student being able to take that educational technician with them to the CTE center or region. Members expressed that they are currently educating students unsupported, as the CTE center or region does not get funding to employ an education technician for that student. This is likely to become an increasing problem as more students are anticipated to be attending CTE centers and regions once the equivalency agreements for core academic credit are implemented in accordance with LD 436.

Members also recommend that funding be expanded to include more CTE program exposure to 9th and 10th grade students. Members agreed that the earlier a student's interest in the CTE fields can be captured, the more likely the student is to be successful and to know that CTE can lead to a pathway that works for the student and is desired by the student. Task Force member Dr. Terri Cooper expressed that if the students are not taken care of during their education years, then they will need to be taken care of as adults. Early exploration, even at the elementary and middle school levels, will help students understand the different pathways available to them and help ensure their successful futures.

Recommendation #3. Explore ways to increase capacity at CTE centers and regions specifically for oversubscribed programs. (Unanimous).

As noted in the previous recommendation, increasing capacity at CTE centers and regions is crucial to expanding access for students. The task force at its fourth and final meeting talked at length about the fact that there are specific programs, in particular, that are over capacity and regularly have waiting lists and sought to explore solutions that could alleviate the capacity issues in these oversubscribed programs.

Accordingly, the task force specifically recommends further exploring ways to increase capacity at CTE centers and regions specifically for these oversubscribed programs. A number of potential avenues for increasing programmatic capacity were put forth by the task force that should be considered by the Legislature, Department of Education and local communities. In exploring these options, the task force emphasizes that there is no one-size-fits-all approach that will work for each CTE center, region, SAU or local community. Rather, each local community

will best be able to identify the local, existing resources that could be tapped to increase programmatic capacity.

One area that deserves further exploration would be adding a so-called "3rd option," where another cohort of students could be accommodated to increase the number of times a particular CTE program is offered. This 3rd option could be offered after school or during the evening hours while still utilizing existing teaching staff and facilities, and would allow an additional cohort of students to be enrolled. Providing programming outside of the traditional school day alleviates some of the issues surrounding gaining necessary graduation credits and having to choose between CTE programs and courses at the local sending school, as discussed previously in this report. This 3rd option would give students more flexibility and choice in pursuing CTE education.

Program-specific expansion could also be accomplished through the use of off-site locations and collaboration with partners supplementing, not supplanting, the existing staff and facilities. Task force members discussed the use of collaborations and partnerships, including with adult education, the Maine Community College System, the University of Maine System and the use of unions and the trades. Task force members Robert Burr and Anthony Sirois, members representing skilled trades, discussed how their respective trade unions offer apprenticeship training for many fields that are common in CTE centers and regions such as welding and plumbing. Task force member Robert Burr also said that the Maine State Building and Constructions Trades Council, consisting of 20 affiliated unions representing over 6,000 craftspeople across Maine, may be an avenue to explore solutions with. Additionally, there was discussion about possibly utilizing mobile resources, where a trade organization supplies a mobile classroom to help students learn a specific trade. Alternately, CTEs could explore the leasing of space in a former business or other available buildings or structures in the community, if physical space is a barrier.

Again though, the task force acknowledges that each CTE center and region is different and has different limitations within its community; what works for one may not work for another. The task force recommends that each CTE center and region think creatively on how to come up with a way to offer more space and programming options.

Another area of exploration recommended by the task force is an examination of the Department of Education new CTE program application and the timeline that is required for submission by a CTE center or region when a new program is added. Currently, a CTE program must be approved by the Commissioner of Education in order to be offered by a CTE center, region or affiliated unit, receive state subsidy or receive approval for federal funding (although some *federal* funding may be approved for new or emerging industry programs prior to granting approval for the CTE program).[14]

[14] See 20-A MRSA §8306-B.

Task force members noted that this application could be modified, or a new application process could be modeled off of this process, for a CTE program that is interested in expanding or modifying its current operations to serve more students. CTE programs aim to educate students to meet the needs of a diverse – and everchanging – workforce. Accordingly, which programs are gaining interest and seeing waitlists may vary from year to year and the expansion and/or modification of those programs often lags behind the need. Offering a new cohort of students within an existing program incurs additional expenses such as employee pay, transportation expenses or new equipment and supplies.

Accordingly, task force member Dwight Littlefield emphasized that one issue to consider around funding is this a lag time between when funding is applied for and when it is received by the CTE center or region. Task force member Dave Keaton noted that it would be beneficial if there was a fund at the Department of Education that could be designated to pay for materials and supplies to help expand or modify a CTE offering that is seeing high-demand. Having funding available immediately for the pressing need of expanding or modifying current CTE programing would allow the CTE centers and regions react quickly to the needs of the State's workforce, local community, and the interests of the students, and ultimately be better-situated to serve more students.

Regardless of how a CTE center or region ultimately addresses the oversubscription of some of its programs, the task force recommends local solutions that work for that CTE center or region. The task force recognizes that each CTE center and region is different and has varying needs, so members expressed their desire that local CTEs maintain their creativity and flexibility when considering serving the needs of CTE students and getting more students into oversubscribed programs.

V. Additional Considerations

At its final two meetings, task force members discussed and voted[15] on creating a pilot project for a four-year comprehensive high school, where students attend one school after eighth grade that includes both core academic offerings and CTE programs in one location.

Members supporting this recommendation noted that an innovative pilot project could serve as a model for future CTE education throughout the State. The pilot project would help identify those aspects that could be replicated elsewhere, as well as those that would need to be different depending on location and interest. The pilot could be implemented as a complement to the existing CTE structure and would not preclude improvement, support and innovation of the existing 27 centers and regions. Given the current capacity issues and waitlists for programs, this pilot project would not be in competition with current programming, but would instead provide an opportunity to serve more students. Furthermore, an all-inclusive comprehensive

[15] Favor: Anthony H. Sirois, James Grant, Sen. Rafferty, Sen. James Libby, Ashley B. Richards, Jr., Robert Burr, Dr. Terri Cooper. Opposed: Dave Keaton, Dwight Littlefield, Grace Leavitt, Rosa Redonnett, Krista Okerholm, Rep. Woodsome, Tom Danylik, Becky Smith, Julie Kenny and Rep. Murphy; Abstain: James Ford; Absent: Rob Callahan and Garrett Stewart.

CTE school would be beneficial and students would have a sense of pride in participating in extracurricular activities at the same place that they participate in CTE and regular education programming.

Except as noted below, task force members in support of this recommendation did not make a specific recommendation or endorsement of the Region 10 proposal as part of the pilot project nor recommend any specificity in terms of the location of the pilot project. The details of the location and scope of the pilot project would need to be determined as part of the planning process prior to moving forward with the pilot project.

Task force member Ashley B. Richards, although voting in favor of the recommendation, noted that the four-year comprehensive high school model is successful in other states and that recommending merely a pilot project is inadequate. He noted that the recommendation should go further and that the State should move forward with Region 10 proposal as presented during the second meeting.

Task force members in opposition to this recommendation expressed concern with recommending such a full-scale proposal when there are immediate needs that have not yet been solved within the existing CTE centers and regions. Task Force member Rob Callahan, in expressing his opposition, noted that Maine has the lowest participation rates among the U.S. in CTE programs. After the completion of a pilot project of a comprehensive CTE high school, he further questioned whether that school would then be in the same predicament as the 27 CTE centers and regions are in now, with waiting lists for high-demand programs. Concern was also raised that a pilot project would be competing with other local schools for students, staff and funding. Thus, while generally not opposed to the idea of a pilot project, he could not support this recommendation.

Task force members in opposition to the recommendation also noted the potential cost of the pilot project, and felt that funding and resources are better directed at supporting the three previous recommendations and ensuring that the existing CTE structure has what it needs to be successful. Additionally, there were concerns that, by its very nature, the pilot project would be inequitable as it would only serve students in a specific region in the State and not provide statewide benefits. The pilot project would also likely affect local budgets in the region in which it is located.

Those in opposition noted that at this time they could not support a proposed pilot project for a four-year comprehensive high school.

Ultimately, the proposed recommendation was not adopted because it did not receive majority support of the task force.

VI. Conclusion

The task force's work and the publication of its report comes at a time of great interest and support for improving and expanding CTE in this State. All task force members reiterated throughout the task force's meetings the need to reduce barriers for students, respond better to industry and workforce needs, and expand capacity of CTE programming throughout the State. While task force members recognize that investment in CTE can require a lot of resources, the benefits of doing so are innumerable and critically necessary to support the State's future.

And, this work does not end with the task force's report; the task force hopes that the recommendations contained in this report encourage further discussion and action by the Legislature, Department of Education, and local communities in reducing barriers to CTE access and improving and expanding CTE programs.

Finally, the task force would like to thank all of its members and presenters for generously offering their time, expertise and advice on the complicated issues involved in supporting CTE in this State. The knowledge, perspectives, and previous research provided through the task force's work were invaluable in developing the findings and recommendations of the task force. Ultimately, CTE in this State would not be what it is without the dedicated and devoted teachers, administrators, schools, local communities, tradespeople, and – most importantly – students that work and learn every day to improve CTE, and the task force would like to thank them all for continuing their important and critical work.

APPENDIX A

Authorizing Legislation: Resolve 2023, c. 92

APPROVED
JULY 7, 2023
BY GOVERNOR

CHAPTER
92
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

S.P. 520 - L.D. 1283

Resolve, to Reestablish the Task Force to Study the Creation of a Comprehensive Career and Technical Education System

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

Whereas, the Task Force to Study the Creation of a Comprehensive Career and Technical Education System is reestablished pursuant to this legislation to study the feasibility of establishing a comprehensive 4-year high school career and technical education program to provide a technical high school setting for students; and

Whereas, the study must be initiated before the 90-day period expires in order that the study may be completed and a report submitted in time for submission to the next legislative session; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Task force established. Resolved: That the Task Force to Study the Creation of a Comprehensive Career and Technical Education System, referred to in this resolve as "the task force," is established.

Sec. 2. Task force membership. Resolved: That, notwithstanding Joint Rule 353, the task force consists of 20 members as follows:

1. Six members appointed by the President of the Senate as follows:

A. Two members of the Senate, including one member from each of the 2 parties holding the largest number of seats in the Legislature, one of whom is a member of the Joint Standing Committee on Education and Cultural Affairs;

B. One member who is a current career and technical education high school administrator;

C. One member who represents a statewide association of career and technical education administrators;

D. One member who is a member of a skilled trades union or representative of a skilled trades business or industry; and

E. One member who is a principal of a secondary school;

2. Six members appointed by the Speaker of the House as follows:

A. Two members of the House of Representatives, including one member from each of the 2 parties holding the largest number of seats in the Legislature, one of whom is a member of the Joint Standing Committee on Education and Cultural Affairs;

B. One member who is a current career and technical education high school administrator;

C. One member who is on the State Board of Education;

D. One member who is a member of a skilled trades union or representative of a skilled trades business or industry; and

E. One member who is a superintendent of a school administrative unit;

3. Seven members appointed by the Governor as follows:

A. One member who is a Maine Community College System administrator;

B. One member who is on a local board of education in a Maine community;

C. One member who is an officer of the Maine Education Association;

D. Three members who are members of a skilled trades union or representatives of a skilled trades business or industry; and

E. One member who is an administrator at the University of Maine System; and

4. The Commissioner of Education or the commissioner's designee.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the task force.

Sec. 4. Appointments; convening of task force. Resolved: That, notwithstanding Joint Rule 353, the appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the task force.

Sec. 5. Duties. Resolved: That the task force shall:

1. Examine the feasibility of establishing a comprehensive 4-year high school career and technical education program to provide a technical high school setting for middle school students to attend at the completion of the 8th grade, including but not limited to the advantages and disadvantages of a comprehensive 4-year high school career and technical education model, obstacles to implementation of a comprehensive 4-year high school career and technical education model and other models for comprehensive 4-year high school career and technical education that exist around the State and on a national level; and

2. Examine increasing crosswalks and intersections between technical and occupational knowledge and curricula and academic standards in order to promote multiple pathways for awarding content area credit to students enrolled in career and technical education programs, including but not limited to building on prior and current work among

the Department of Education, superintendents of school administrative units and career and technical education administrators.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the task force, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, notwithstanding Joint Rule 353, no later than January 15, 2024, the task force shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Second Regular Session of the 131st Legislature.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership list: Task Force to Study the Creation of a Comprehensive Career and Technical Education System

Task Force to Study the Creation of a Comprehensive Career and Technical Education System

Resolve 2023, Ch. 92

Membership List

Name	Representation
Senator Joe Rafferty - Chair	Member of the Senate
Representative Kelly Murphy – Chair	Member of the House
Rep. David Woodsome	Member of the House
Senator James Libby	Member of the Senate
Rob Callahan	Member who is a current career and technical education high school administrator
David Keaton	Member who represents a statewide association of career and technical education administrators
Anthony H. Sirois	Member who is a member of a skilled trades union or representative of a skilled trades business or industry
Tom Danylik	Member who is principal of a secondary school
Julie Kenny	Member who is a current career and technical education high school administrator
James Ford	Member who is on the State Board of Education
Garrett Stewart	Member who is a member of a skilled trades union or representative of a skilled trades business or industry
Dr. Terri Cooper	Member who is a superintendent of a school administrative unit
Rebecca Birrell Smith	One member who is a Maine Community College System administrator
James S. Grant	One member who is on a local board of education in a Maine community
Grace Leavitt	One member who is an officer of the Maine Education Association
Robert A. Burr	Member who is a member of a skilled trades union or representative of a skilled trades business or industry
Krista Okerholm	Member who is a member of a skilled trades union or representative of a skilled trades business or industry
Ashley B. Richards, Jr.	Member who is a member of a skilled trades union or representative of a skilled trades business or industry
Rosa A. Redonnett	Member who is an administrator of the University of Maine System
Dwight Littlefield	Commissioner of Education or the commissioner's designee

State of Maine
131st Legislature, First Regular and First Special Session

Commission Regarding Foreign-trained Physicians Living in Maine

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSON

Commission Regarding Foreign-trained Physicians Living in Maine

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Members:
Sen. Donna Bailey, Chair
Rep. Kristi Mathieson, Chair
Senate President Troy Jackson
Rep. Samuel Zager
David Ngandu
Sally Sutton
Tim Terranova
Sally Weiss
Mufalo Chitam
Imad Durra
Bruno Salazar-Perea
James W. Jarvis
Anne L. Head

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Executive Summary

The Commission Regarding Foreign-trained Physicians Living in Maine, referred to in this report as the "commission," was established by Resolve 2023, chapter 93 to study integrating foreign-trained physicians, including physicians who identify as surgeons, living in the State into the health care workforce to best reflect their level of skills and training, with a focus on those who are here as refugees and asylum seekers, and reducing barriers to licensing for foreign-trained physicians and physicians from other states. The resolve directs the commission to submit a report that includes its findings and recommendations to the Maine Legislature no later than January 15, 2024. A copy of the commission's authorizing legislation (Resolve 2023, chapter 93) is included in Appendix A.

Pursuant to the resolve, the commission has 13 members: four legislative members and nine non-legislative members representing interests specifically identified in the resolve. Of the non-legislative members, four members were appointed by the President of the Senate, four members were appointed by the Speaker of the House of Representatives and one member was appointed by the Governor. Members were appointed who have expertise in issues affecting foreign-trained physicians living in Maine; immigrant rights; workforce shortages in the medical field; and medical licensure. Three members were appointed to represent the interests of physicians who are refugees or immigrants, at least one of whom is licensed to practice in the State of Maine. Senator Donna Bailey was named Senate chair and Representative Kristi Matheson was named House chair. The complete membership list of the commission is included in Appendix B.

The commission's specific duties as set forth in the resolve include:

- study integrating foreign-trained physicians, including physicians who identify as surgeons, living in the State into the health care workforce to best reflect their level of skills and training, with a focus on those who are here as refugees and asylum seekers, and reducing barriers to licensing for foreign-trained physicians and physicians from other states;

- explore a wide range of options for how to help enable foreign-trained physicians who wish to live and practice in the State to best use their skills and talents, increase health care workforce cultural competency and address potential workforce shortages;

- review and identify best practices learned from similar efforts in other states; and

- make recommendations on:

    - strategies to integrate foreign-trained physicians into the health care workforce;
    - other ways, outside of being licensed as a physician, that foreign-trained physicians can be supported to best use their skills and training;
    - changes for regulations that may pose unnecessary barriers to practice for foreign-trained physicians and physicians from other states;

- necessary supports for foreign-trained physicians moving through the different steps in the licensing process prior to involvement with the Maine Board of Licensure in Medicine (BOLIM);
- opportunities to advocate for corresponding changes to national licensing requirements; and
- any other matters pertaining to foreign-trained physicians and physicians from other states considered necessary by the commission.

Over the course of four meetings, the commission developed the following recommendations:

Recommendation #1. Create a pathway to full licensure for international medical graduates (IMGs).

Recommendation #2. Limit sponsors for the sponsorship program to the four existing sponsoring institutions in Maine.

Recommendation #3. Require IMGs to have minimum number of years of prior licensed practice (or its equivalent) to qualify for the sponsorship program.

Recommendation #4. Ensure that the age of the IMG's prior license (or equivalent) is not a barrier in order to qualify for the sponsorship program.

Recommendation #5. Limit the number of years of a temporary educational certificate within the sponsorship program to two years, with no more than two renewals for each two-year educational certificate.

Recommendation #6. Implement service obligations for an IMG who has completed training in a sponsorship program and has obtained a license to practice medicine.

Recommendation #7. Require IMGs to obtain Educational Commission for Foreign Medical Graduates (ECFMG) certification in order to be eligible for the sponsorship program.

Recommendation #8. Require IMGs to reside in the State of Maine for at least 12 months to be eligible for the sponsorship program.

Recommendation #9. Limit the number of slots for IMGs (also known as pathway physicians) funded by the State in the sponsorship program to 10 at any given time.

Recommendation #10. Utilize the existing infrastructure of the Maine Rural Graduate Medical Education (MERGE) Collaborative to screen candidates for the sponsorship program.

Recommendation #11. Create a fund for clinical readiness programs and career/educational instruction for IMGs to prepare IMGs for eligibility for a sponsorship program.

Recommendation #12. Create an IMG assistance program.

Recommendation #13.

A. Develop and administer a pilot project for a loan guarantee program for IMGs who are returning to school to pursue any health care professional degree (not necessarily M.D.) and who do not have access to traditional student loans; and
B. Develop an alternative Free Application for Federal Student Aid (FAFSA) form to be used by Maine's public and private educational institutions and in other situations where FAFSA is required for students.

Recommendation #14. Direct the Office of New Americans (ONA), once it is established, to work with appropriate educational programs to develop programs for IMGs entry into and completion of educational programs in alternative health professions.

I. INTRODUCTION

The Commission Regarding Foreign-trained Physicians Living in Maine, referred to in this report as the "commission," was established by Resolve 2023, chapter 93 to study integrating foreign-trained physicians, including physicians who identify as surgeons, living in the State into the health care workforce to best reflect their level of skills and training, with a focus on those who are here as refugees and asylum seekers, and reducing barriers to licensing for foreign-trained physicians and physicians from other states. The resolve directs the commission to submit a report that includes its findings and recommendations to the Maine Legislature no later than January 15, 2024. A copy of the commission's authorizing legislation (Resolve 2023, chapter 93) is included in Appendix A.

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- explore a wide range of options for how to help enable foreign-trained physicians who wish to live and practice in the State to best use their skills and talents, increase health care workforce cultural competency and address potential workforce shortages;

- review and identify best practices learned from similar efforts in other states; and

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- necessary supports for foreign-trained physicians moving through the different steps in the licensing process prior to involvement with the Maine Board of Licensure in Medicine (BOLIM);
- opportunities to advocate for corresponding changes to national licensing requirements; and
- any other matters pertaining to foreign-trained physicians and physicians from other states considered necessary by the commission.

Resolve 2023, chapter 93 became effective on July 7, 2023. The commission met four times: October 18, November 1, November 14 and December 5. Meetings were conducted in a hybrid format, with participation from commission members and presenters taking place in-person and through Zoom. The meetings are accessible to the public through live streams on the Legislature's webpage. More information about the commission, including meeting agenda, meeting materials and presentations are posted on the commission's webpage at: https://legislature.maine.gov/commission-regarding-foreign-trained-physicians-living-in-maine.

Over the course of four meetings, the commission solicited, received and discussed a great deal of information relevant to its charge set forth in its authorizing legislation.[1] The commission received presentations at the first meeting from the following commission members: Sally Weiss of the Maine Hospital Association (MHA) and Dr. James Jarvis of the Maine Medical Association (MMA) who presented on health care workforce issues in Maine; Sally Sutton of the New Mainers Resource Center and Mufalo Chitam of the Maine Immigrants' Rights Coalition who discussed challenges for foreign-trained health professionals; and Tim Terranova of BOLIM who presented on the pathway to licensure in medicine in Maine. In addition, commission staff presented a comprehensive view of other states' approaches to licensure for foreign-trained physicians.

At the second meeting the commission received presentations from the following: Mike Zimmer of World Education Services, about other states' pathways to practice for foreign-trained physicians; Dr. Jane Carreiro of the University of New England (UNE) College of Osteopathic Medicine, who discussed how UNE supports foreign-trained health care professionals; Amy Grunder of the Massachusetts Immigrant and Refugee Advocacy Coalition and Dr. Robert Marlin of the Lowell Community Health Center, who discussed a similar study commission in Massachusetts; commission member David Ngandu, who gave the perspective of a foreign-trained physician living in Maine; and Kim Moore of the Maine Department of Labor, who explained the current practices for integrating immigrants into Maine's medical workforce.

Drawing on the information included in these presentations and resources and following substantive discussion and deliberation by commission members, the commission proposes 14 recommendations (which can be found in section IV of this report) for consideration by the 131st Maine Legislature.

[1] See section II of this report for a summary of the commission process.

II. COMMISSION PROCESS

The commission held four public meetings at the Cross State Office Building on October 18, November 1, November 14 and December 5 in 2023. These meetings were conducted using a hybrid format through which commission members could choose to attend each meeting either in person or remotely through the Zoom meeting platform. Members of the public were afforded an opportunity to attend each meeting in person or to view a live video stream. Materials distributed and reviewed at these meetings as well as additional background and other study-related materials are posted online and accessible at the following website: https://legislature.maine.gov/commission-regarding-foreign-trained-physicians-living-in-maine.

A. First Meeting – October 18, 2023

The commission held its first meeting on October 18, 2023. The meeting began with opening remarks by the chairs and introductions by commission members. Staff then provided an overview of the commission's authorizing legislation, including duties, the study process and the projected timeline for completion of the commission's work. Materials distributed at all commission meetings as well as an archived video recording of those meetings are available at https://legislature.maine.gov/commission-regarding-foreign-trained-physicians-living-in-maine.

The commission next received a number of presentations on topics relevant to the duties of the commission as set forth in its authorizing legislation. First, the commission received an overview of issues facing the Maine health care workforce from commission members Sally Weiss and James Jarvis. This presentation highlighted the physician workforce shortage facing Maine, barriers to hiring new physicians as well as giving an in-depth explanation on the physician training process in Maine. The commission next heard from commission members Sally Sutton and Mufalo Chitam regarding challenges facing foreign-trained health care professionals. This presentation gave examples of the largest barriers for a foreign-trained physician who is now living in Maine, including a lack of access to financial resources and additional barriers as a result of immigration status on both the State and federal level. Third, was a presentation from commission member Tim Terranova on the pathway to licensure for foreign-trained physicians in Maine including an overview of the costs and requirements for a foreign-trained physician to be eligible to take the United States Medical Licensing Examination (USMLE). Lastly, the commission received a presentation from staff on legislation in other states regarding pathways to practice for foreign-trained physicians – both enacted and pending legislation.

Throughout these presentations, commission members asked clarifying questions and the meeting closed with a discussion of the information the commission should seek to acquire or have presented at future meetings. The commission requested presentations from the UNE College of Osteopathic Medicine, which is a Maine-based medical school program, and from members of Massachusetts' Special Commission on Foreign-trained Medical Professionals (referred to in this study as the "special commission") among others.

B. Second Meeting – November 1, 2023

The second commission meeting was held on November 1, 2023. The first presentation highlighted other states' pathways to practice for foreign-trained physicians by Mike Zimmer, senior policy advisor for World Education Services. Mr. Zimmer took a state-by-state approach, describing the trends and differences between other states' approaches beginning with the impact of enacted legislation, then moved on to pending legislation. Mr. Zimmer ended by outlining the major decision points of each of the pieces of legislation, namely what the pathway will be, who will be eligible and what the entry point into the pathway will be.

The commission next heard from Dr. Jane Carreiro, Dean of the UNE College of Osteopathic Medicine. Dr. Carreiro spoke from her experience working as an expert with the World Health Organization (WHO) on the training of medical practitioners. Dr. Carreiro emphasized that the language used around the qualifications of a medical professional vary greatly worldwide. As a result, the WHO does not refer to the education of a physician, but instead focuses on training as an all-encompassing category. Dr. Carreiro advised it is important that the language used in the commission's recommendations be clear so as to not inadvertently include or leave out individuals.

The commission next received a presentation from Amy Grunder, director of State Government Affairs at the Massachusetts Immigrant and Refugee Advocacy Coalition and Dr. Robert Marlin, Associate Chief Medical Officer at the Lowell Community Health Center, both members of the special commission in Massachusetts. The Maine commission became interested in the Massachusetts special commission process at the first meeting and requested a more in depth look at the Massachusetts process. The presentation by Ms. Grunder and Dr. Marlin reviewed the history and scope of the special commission, the process and presentations received by the special commission and the creation of the pathway framework and recommendations of the special commission as well as explaining the differences between the special commission's recommendations and the pending legislation in Massachusetts.

The commission heard from commission member David Ngandu on his experiences as a foreign-trained physician and his first-hand account of going through the Educational Commission for Foreign Medical Graduates (ECFMG) exam and USMLE process. Mr. Ngandu addressed challenges related to foreign-trained medical professionals having the experience, but running into barriers such as the costs associated with becoming licensed in the United States (U.S.) and English proficiency requirements.

Finally, the commission heard from Kim Moore, director of the Bureau of Employment at the Maine Department of Labor who presented on the integration of immigrants into Maine's workforce. Ms. Moore explained the current pathways for entrance into the health care workforce, highlighting outreach campaigns, training programs and retention strategies currently in place. Included in the programs explained by Ms. Moore was a tuition remission program geared toward other health care workforce areas, though not a pathway to becoming a licensed physician. Other apprenticeships and scholarships were included in the presentation as well, with the same caveat.

The second meeting ended with a discussion between commission members and staff regarding next steps. It was determined that in preparation for the third meeting, commission members would send their proposed recommendations to staff to be compiled. Commission members were directed to review the compilation of recommendations prior to the third meeting.

C. Third Meeting – November 14, 2023

The third commission meeting was held on November 14, 2023. Commission members were instructed to review the compiled recommendations and come prepared to discuss and ultimately vote on which recommendations should be included in the final study report. During the meeting, commission members were invited to bring forward recommendations that they wished the commission to discuss and ultimately vote on. The commission engaged in a lengthy and deliberate discussion of each of the presented recommendations, including asking clarifying questions to staff and chairs and ultimately weighed the merits of each recommendation before taking a vote. As described in section IV of this report, a majority of the commission ultimately voted in favor of 14 recommendations to be included in the final study report. The meeting concluded with additional commission discussion regarding the distribution of a draft report and the review of that report at the fourth and final commission meeting.

D. Fourth Meeting – December 5, 2023

The fourth and final commission meeting was held on December 5, 2023. Based on the input provided at the third meeting, commission staff prepared and distributed to commission members a draft report for review and discussion at the final meeting. Commission members posed clarifying questions regarding the report and made additional suggestions for changes to the report and its recommendations, which were discussed and agreed to be included in the final report. After a discussion regarding the process for finalizing and distributing the report, the commission adjourned its fourth and final meeting.

III. BACKGROUND

It is well documented that Maine and states across the nation are experiencing significant health care workforce shortages. The reasons for this shortage are complex, but a significant factor is demographics. People are living longer and requiring more medical attention as they age. At the same time, the health care workforce itself is aging and retiring at a pace faster than workers are replaced.[2] The pandemic exacerbated the problem in two ways. First, people delayed care during the early years of the pandemic, and as restrictions relaxed, patients flooded the health care system seeking service. Secondly, the health care workforce shrank during the pandemic, leaving fewer health care professionals to see an increasing number of patients.[3]

According to the MHA, Maine continues to deal with a significant health care workforce shortage in all areas of the State. With an estimated 74,860 health care workers in Maine, 20,961 are 55 years of age or older; thus, 30 percent of Maine's health care workforce will retire in 10 years, if not sooner, based on current trends. Maine ranks first in the nation for number of

[2] https://www.oracle.com/human-capital-management/healthcare-workforce-shortage/#
[3] https://www.pressherald.com/2023/10/22/maine-has-a-health-care-access-crisis-and-its-making-us-sicker/

physicians aged 60 years or older (at 39.3 percent or 1,746). While Maine has a higher than average ratio of physicians to population, those data do not reflect the maldistribution across the State.[4]

At the same time, almost one quarter of physicians and physicians-in-training in the U.S. are international medical graduates (IMGs). IMGs are defined as those who have graduated from a medical school not accredited in the U.S.; some are U.S. citizens and others are foreign nationals. However, as commission members Sally Sutton, Mufalo Chitam and David Ngandu noted in presentations and discussions, IMGs face many challenges on their pathway to obtaining full licensure as a medical doctor. Challenges can vary based on individual circumstances, but some common issues include educational and training differences; licensing examinations; clinical experience and exposure; residency matching; issues related to immigration status; cultural and communication challenges; and lack of financial resources.

David Ngandu, who came to Maine in 2016 from the Democratic Republic of Congo, is one of the foreign-trained physicians living in Maine that serves on the study commission. Commission member Ngandu, who is not currently licensed, is working at MaineHealth as a medical laboratory assistant and interpreter. Ngandu noted that practicing medicine is not just a vocation, but for him, it is his passion. It is his hope that Maine can find a pathway for foreign-trained physicians like him because practicing medicine is what he feels he should be doing and what he wants to be doing.

Integrating highly skilled IMGs into Maine's health care workforce has the potential to lessen the impact of workforce shortages. Medical licensing assures the quality of care provided by health care providers and protects the public. However, at the state level, variation in standards, particularly those that may be more challenging to meet for IMGs than those for U.S. medical school graduates, may hamper IMGs' opportunity to contribute to the health care workforce.[5] One way to facilitate this integration is by streamlining the process for IMGs to obtain licenses and credentials needed to practice medicine.[6]

In addition, increasing the diversity of Maine's health care workforce will lead to better outcomes particularly for historically underrepresented and underserved communities. Diversity of the population in Maine and the U.S. is increasing; racial and ethnic concordance between a physician and a patient has been linked to improved health incomes.[7] Commission members David Ngandu and Mufalo Chitam emphasized the importance of cultural competence and ethnic diversity in health care particularly among the immigrant community. Strategies to increase cultural competence include: providing interpreter services; recruiting and retaining minority staff; incorporating culture-specific attitudes and values into health promotion tools; and including family and community members in health care decision making.

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[4] See pages 8-28 of meeting materials for October 18 meeting for Maine Hospital Association and Maine Medical Association PowerPoint presentation at the following link: https://legislature.maine.gov/doc/10403.
[5] Andrews, Ryan, Elliott, Brotherton, *Easing the Entry of Qualified International Medical Graduates to U.S. Medical Practice* published in Academic Medicine – the Journal of the Association of American Medical Colleges
[6] Ibid.
[7] Ibid.

Commission member Sally Sutton, who represents the New Mainers Resource Center - an organization that serves skilled foreign-trained professionals, noted in her presentation on October 18 that most new residents of Maine who are foreign-trained professionals came to the U.S. as refugees or asylum seekers. In fact, the authorizing legislation for this study directs the commission to focus on those who are here as refugees and asylum seekers. Sutton pointed out that refugees or asylum seekers did not plan to come to the U.S., but were forced to flee their home country for their safety due to threats of violence or imprisonment. Refugee and asylum seekers are often fleeing political unrest, trauma, war and other dangerous conditions. IMGs who come to the U.S. as a result of forced migration have not been planning for careers in the U.S. and, therefore, face a different set of challenges with licensing.[8]

One of the primary barriers for IMGs is lack of access to financial resources for expenses related to schooling or licensing itself. Costs related to obtaining school transcripts and diplomas, test application fees, and test preparation materials and courses can range from $10,000 to $15,000.[9] In most cases, IMGs who come to the U.S. need to work to meet basic needs (food, clothing, shelter, child care and health care) for themselves and their families. Working to meet these basic needs means that the IMG has less time and financial resources to study English, prepare for tests and obtain clinical experience. Asylum seekers are eligible for food stamps, Medicare and cash assistance. Asylum seekers are also eligible for work permits once they have completed the waiting period after filing asylum applications. However, asylum seekers are not eligible for most medical residency programs until they obtain lawful permanent status. Because of backlogs in the U.S. immigration system, the waiting period to receive permanent status can be five to ten years. In addition to supporting a family in the U.S., refugees and asylum seekers may also provide support to families back in their home country.

Another significant barrier for IMGs (and for increasing the health care workforce generally) is the limited number and therefore highly competitive nature of residency slots. Maine, as well as the rest of the nation, has a limited number of residency slots. Medicare is the largest source of federal graduate medical education (GME) funding. There are two types of payments: direct (DGME) and indirect (IME). The Centers for Medicare and Medicaid Services (CMS) establishes the rules for GME payments. The number of residents that a hospital may receive payment for is "capped" due to a provision in the Balanced Budget Act of 1997, which limits the number of positions or slots that Medicare can fund.[10] Medicaid, a joint federal-state program, is the second largest source of support for GME. Through this program, states may elect to recognize GME training costs as a component of overall hospital costs. The federal government shares payment for these expenses through federal matching funds. According to commission member James Jarvis of MMA, about two-thirds of hospitals in Maine are currently training more residents than those for which they receive Medicare GME funding. Currently, there are 11 residents not supported by Medicare DGME in Maine.[11] More information about the cost per residency slot can be found in recommendation #9.

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[8] See pages 38-49 of meeting materials for October 18 meeting for the New Mainers Resource Center presentation materials at the following link: https://legislature.maine.gov/doc/10403.
[9] Ibid.
[10] See pages 8-28 of meeting materials for October 18 meeting for Maine Hospital Association and Maine Medical Association PowerPoint presentation at the following link: https://legislature.maine.gov/doc/10403.
[11] Ibid.

A number of states in the nation have considered establishing a sponsorship program for IMGs to support and facilitate the entry of foreign-trained physicians into the U.S. health care system. A sponsor may be an institution that is accredited to provide graduate medical education, also known as a teaching hospital. Key features of a sponsorship program may include: eligibility criteria, credential evaluation, examinations, supervised clinical practice, language proficiency, support services, and a service obligation. The overarching goal of a sponsorship program is to enhance the health care workforce, especially in regions facing shortages, by integrating qualified foreign-trained physicians into the local health care system.

IV. RECOMMENDATIONS

Recommendation #1. Create a pathway to full licensure for IMGs (12 in favor, 1 absent).[12]

The commission unanimously recommends that the State of Maine create a pathway to full licensure for IMGs.

The commission recommends establishing a sponsorship program for IMGs as an alternative pathway to full licensure. First, the commission recommends a sponsorship for a limited amount of time where a qualified IMG receives a temporary educational certificate from BOLIM to act as a hospital resident. Secondly, the commission recommends implementing service obligations for an IMG who has completed educational training in the sponsorship program and has obtained a medical license**.** Further detail about recommendations relating to the sponsorship program and service obligations can be found in recommendations #2 through #10 below.

The commission discussed at length the pathway to full licensure proposed by the Massachusetts special commission and used the Massachusetts sponsorship model as the basis for recommendations. However, the only similarity between the Massachusetts special commission proposal and this commission's recommendations is creation of a sponsorship program as an alternative pathway for an IMG.

The Massachusetts special commission recommended creating a limited license for IMGs with a two-step process: first, a sponsorship for a limited amount of time and, second, a limited-period restricted license. An IMG is eligible for full licensure after a number of years of practicing under a restricted license. The limited license is described in the special commission's long-term recommendation #1 on Pages 21 – 22 of their report (which can be found in the meeting materials for the Maine commission's November 1 meeting). The Massachusetts legislation (H2224) to implement this recommendation, among others, was introduced in February 2023 and, as of the writing of this report, is pending in the Massachusetts Legislature.

The scope of the special commission was broader than this study commission. The special commission studied the licensing of not only internationally trained physicians, but also other health professionals, including nurses, dentists and physician assistants with the goal of expanding and improving medical services in rural and underserved areas. The special

[12] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, David Ngandu, James Jarvis, Tim Terranova, Bruno Salazar-Perea, Mufalo Chitam, Imad Durra, Sally Weiss; Absent: Senate President Troy Jackson.

commission was staffed by the Massachusetts Bureau of Health Professions Licensure and met seven times between September 2021 and May 2022.

In addition to the Massachusetts legislation, which proposes a sponsorship program, Senior Policy Advisor for World Education Services Mike Zimmer, who presented at the November 1 meeting, noted multiple states have proposed legislation to establish a similar "sponsorship model" as an alternative pathway to full licensure for IMGs. West Virginia and Washington have created a category of "restricted" or "limited" physician licensure that allows IMGs with exceptional professional credentials to practice under limitations or conditions defined by the state's board of medicine.[13] According to Zimmer, as of November 2023, 50 IMGs in Washington State have secured a license under this law. Other states such as Tennessee, Idaho and Illinois have adopted some variation of a sponsorship model in 2023.

The next nine recommendations (#2 through #10) relate to the sponsorship model components.

Recommendation #2. Limit sponsors for the sponsorship program to the four existing sponsoring institutions in Maine (11 in favor, 1 opposed, 1 absent).[14]

A majority of commission members recommends that sponsors for the "sponsorship program" described in recommendation #1 be limited to the four existing "sponsoring institutions" accredited by the Accreditation Council for Graduate Medical Education (ACGME) in the State of Maine – namely Central Maine Medical Center (CMMC); Eastern Maine Medical Center (EMMC); MaineGeneral – Maine Dartmouth Family Medicine Residency; and Maine Medical Center (MMC). These sponsoring institutions are the only four teaching hospitals in Maine.

ACGME is an independent, nonprofit organization that establishes and monitors voluntary professional education standards for preparing physicians to deliver safe, high-quality medical care. "Graduate medical education" (GME) refers to the period of education in a particular specialty (residency) or subspecialty (fellowship) following medical school. ACGME oversees the accreditation of residency and fellowship programs in the U.S.[15]

Maine does not have a State-sponsored medical school, but it has two Maine-based medical school programs, including Tufts University School of Medicine – Maine Medical Center (Maine Track) and the UNE College of Osteopathic Medicine. In addition, medical schools outside of Maine, including Boston University, University of Vermont and Tufts University, place medical students in Maine for clinical education.[16]

According to MHA, there are currently 396 resident or fellow physicians training in Maine; this includes residents or fellows supported by Medicare GME funding (see background section of

[13] https://documents.ncsl.org/wwwncsl/Labor/Opening-Pathways-to-Practice-for-Internationally-Trained-Physicians.pdf

[14] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, David Ngandu, James Jarvis, Tim Terranova, Mufalo Chitam, Imad Durra, Sally Weiss; Opposed: Bruno Salazar-Perea; Absent: Senate President Troy Jackson.

[15] https://www.acgme.org/about/overview/

[16] See pages 8-28 of meeting materials for October 18 meeting for Maine Hospital Association and Maine Medical Association PowerPoint presentation at the following link: https://legislature.maine.gov/doc/10403

this report for explanation of "the cap") and residents or fellows funded by the sponsoring institution itself (or above "the cap"). GME programs, also referred to as training programs, are three to five years in duration. Specialists, such as critical care physicians who work in intensive care units, must complete additional training after residency; these slots are referred to as "fellowship" slots.[17]

Maine does well with retaining medical graduates who choose to come to Maine to train. Maine ranks 13th in the nation (at 49.8 percent) for the number of active physicians who completed in-state and are actively practicing medicine in Maine. However, Maine ranks 45th in the nation when it comes to the total number of residents and fellows in the ACGME program per 100,000 population.[18]

Recommendation #3. Require IMGs to have minimum number of years of prior licensed practice (or its equivalent) to qualify for the sponsorship program (11 in favor, 2 opposed).[19]

A majority of the commission recommends requiring IMGs to have minimum number of years of prior licensed practice (or its equivalent)[20] to qualify for the sponsorship program. The commission did not decide on a definitive minimum number of years of licensed (or equivalent) practice, but a majority of commission members recommended between one and five years for the minimum.

Recommendation #4. Ensure that the age of the IMG's prior license (or equivalent) is not a barrier in order to qualify for the sponsorship program (12 in favor, 1 absent).[21]

The commission unanimously recommends ensuring that the sponsorship program does not disqualify IMGs due to the age of the IMGs prior license (or equivalent).

Recommendation #5. Limit the number of years of a temporary educational certificate within the sponsorship program to two years, with no more than two renewals for each two-year educational certificate (12 in favor, 1 absent).[22]

The commission unanimously recommends limiting the number of years of a temporary educational certificate, which is issued by BOLIM, to two years, with no more than two renewals for each two-year educational certificate. Educational certificates are used by medical graduates

[17] Ibid
[18] Ibid
[19] In favor: Senator Donna Bailey, Senate President Troy Jackson, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, James Jarvis, Mufalo Chitam, Imad Durra, Sally Weiss, Bruno Salazar-Perea; Opposed: David Ngandu, Tim Terranova.
[20] "Equivalent" means recognized ability to practice medicine by a sovereign state outside of the U.S.
[21] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, James Jarvis, Mufalo Chitam, Imad Durra, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Absent: Senate President Troy Jackson.
[22] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, James Jarvis, Mufalo Chitam, Imad Durra, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Absent: Senate President Troy Jackson.

to apply to practice in a residency program and are site specific. The renewable temporary educational certificate (analogous to the "limited license" or "supervised license" period in the sponsorship model in Massachusetts) allows the pathway physician to practice in a participating sponsoring institution in order to gain familiarity with non-clinical skills and standards appropriate for a Maine medical practice environment and leads to issuance of a full, unrestricted license.

Recommendation #6. **Implement service obligations for an IMG who has completed training in a sponsorship program and has obtained a license to practice medicine (11 in favor, 1 abstention, 1 absent).**[23]

The commission unanimously recommends implementing service obligations for an IMG who has completed training in a sponsorship program, also referred to as "pathway physician," and has obtained a license to practice medicine. More specifically, the commission recommends requiring a pathway physician who has obtained a license to practice medicine in an underserved area in the State of Maine for the same number of years the pathway physician participated in the sponsorship program.

Recommendation #7. **Require IMGs to obtain ECFMG certification in order to be eligible for the sponsorship program (12 in favor, 1 absent).**[24]

The commission unanimously recommends requiring IMGs to obtain ECFMG certification in order to be eligible for the sponsorship program. The commission also unanimously recommends authorizing BOLIM to adopt rules to grant waivers for this requirement for exceptional circumstances.

Although the commission unanimously supports this recommendation, a few commission members expressed concern about creating another barrier for IMGs when, in fact, the purpose of the study commission is to find ways integrate foreign-trained physicians into the health care workforce and to reduce barriers for IMGs trying to obtain a medical license in Maine. The commission views this recommendation as a starting point as it is difficult to know what the impacts of requiring ECFMG certification will be on IMGs who want to participate in the sponsorship program. It is the commission's hope that this will not have an adverse impact on an IMG's path to full licensure.

ECFMG is the standard for evaluating the qualifications of IMGs before they enter U.S. post graduate training (PGT) where IMGs provide supervised patient care. ECFMG is used by every state in the nation; however, California provides an exception for foreign medical schools approved by the Medical Board of California.

[23] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Anne Head, Sally Sutton, James Jarvis, Mufalo Chitam, Imad Durra, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Abstain: Representative Samuel Zager; Absent: Senate President Troy Jackson.
[24] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, James Jarvis, Mufalo Chitam, Imad Durra, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Absent: Senate President Troy Jackson.

To obtain a medical license in Maine, BOLIM requires U.S. and Canadian medical graduates to: a) graduate from a medical school accredited by Liaison Committee on Medical Education (LCME); b) pass all three steps of the USMLE process – step 3 is normally taken during residency; and c) complete 36 months of PGT accredited by the Accreditation Council on Graduate Medical Education (ACGME). According to BOLIM, ACGME is currently the only accrediting body for U.S. graduate medical education residency programs.

LCME is jointly sponsored by the American Association of Medical Colleges (AAMC) and the American Medical Association (AMA) and is recognized by the U.S. Department of Education and the World Federation for Medical Education (WFME) as the notable authority for the accreditation of medical education programs leading to a medical degree (doctor of medicine or M.D.). It is worth noting that LCME will end its accreditation of Canadian medical Schools on June 30, 2025. As of that date, Canadian medical graduates will be considered IMGs.

BOLIM requires IMGs (excluding Canadian medical graduates until June 30, 2025) who graduate from a non-LCME-accredited school to: a) obtain ECFMG certification or pass some comprehensive exam equivalent as determined by BOLIM;[25] pass all three steps of USMLE (step 3 is usually taken during residency); and complete 36 months of PGT accredited by ACGME. In addition, IMGs must demonstrate English proficiency.

Recommendation #8. Require IMGs to reside in the State of Maine for at least 12 months to be eligible for the sponsorship program (10 in favor, 2 abstentions, 1 absent).[26]

The commission unanimously recommends requiring IMGs to reside in the State of Maine for at least 12 months to be eligible for the sponsorship program.

Recommendation #9. Limit the number of slots for IMGs funded by the State in the sponsorship program to 10 at any given time (11 in favor, 1 abstention, 1 absent).[27]

The commission unanimously recommends limiting the number of slots for IMGs funded by the State in the sponsorship program to 10 at any given time. Commission member Dr. James Jarvis estimated that the cost of PGT residents at EMMC is approximately $270,000 per resident per year. Dr. Jarvis noted that nationally the average cost of a medical resident per year is $250,000. With this in mind, the commission supports limiting the number of slots to 10 for a total cost of approximately $2.5 million. Funding for residency slots typically goes directly to the hospital as the sponsoring institution. The cost covers the resident who is considered an employee of the

[25] According to BOLIM, the following exam sets are equivalent: Licentiate of the Medical Council of Canada (LMCC); USMLE; Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS); Federation of Licensing Examination (FLEX) which is a predecessor to USMLE; and the United Kingdom's Applied Knowledge Test (AKT) in conjunction with the Recorded Consultation Assessment (RCA).
[26] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Anne Head, Sally Sutton, James Jarvis, Imad Durra, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Abstain: Representative Samuel Zager, Mufalo Chitam; Absent: Senate President Troy Jackson.
[27] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, James Jarvis, Imad Durra, Sally Weiss, Bruno Salazar-Perea, Mufalo Chitam, Tim Terranova; Abstain: David Ngandu; Absent: Senate President Troy Jackson.

sponsoring institution and also covers the cost to the institution for having a learning physician on staff.

As of the writing of this report, the status of LD 1797, An Act to Expand Maine's Health Care Workforce by Expanding Educational Opportunities (amended title) is pending. LD 1797 was introduced in the First Regular/Special Session of the 131st Maine Legislature, placed on the Special Appropriations Table in the Senate, and ultimately carried over to the Second Regular Session. The bill includes a General Fund appropriation to the Department of Health and Human Services of $2.5 million per year in State fiscal years ending 2024 and 2025 for the Maine Medical Education Training and Residency Fund, which may potentially provide a portion of the funding needed for this recommendation.

However, it is not the commission's intent to take funds away from any of the proposed initiatives in LD 1797, which provides funding for previously established initiatives and programs, such as, the nursing education loan repayment program, the Maine Health Care Provider Loan Repayment Program Fund, the Maine Rural Graduate Medical Education (MERGE) Collaborative and the Doctors for Maine's Future Scholarship Fund. One of the goals of LD 1797 is sustain these currently existing programs and funds.

Recommendation #10. **Utilize the existing infrastructure of the MERGE Collaborative to screen candidates for the sponsorship program (9 in favor, 3 abstentions, 1 absent).**[28]

The commission unanimously recommends utilizing the existing infrastructure of the MERGE Collaborative to screen candidates for the sponsorship program. In 2021, using federal American Rescue Plan Act (ARPA) funds, the Maine Legislature provided funding to the four ACGME sponsoring institutions in Maine for the purpose of creating a collaboration to develop high-quality residency rotations at hospitals and community-based health centers across Maine. The goal of the MERGE Collaborative is to give medical students experience in providing health care for Maine's diverse socioeconomic, racial and regional populations.[29]

Commission member Sally Weiss of MHA noted the importance of implementing a process for IMGs to apply for the sponsorship program, including evaluation of IMGs eligibility for the program and determination of placement for IMGs at a sponsoring institution. Weiss recommended that placement be based on where the candidate resides, the candidate's specialty, and the availability of a residency or fellowship slot in that location. Because there is representation of all four sponsoring institutions in the MERGE Collaborative, the collaborative could serve as the receiving entity of applicants. Weiss suggested that funds flow through the MERGE Collaborative to the sponsoring institutions with the intent that funds follow the IMG.

As noted above, in 2021, the Maine Legislature passed legislation that used federal ARPA funds to implement Governor Mills' Maine Jobs and Recovery Plan. Public Law 2021, chapter 483 appropriated $500,000 in fiscal year ending 2022 and $1.1 million in fiscal year ending 2023 to

[28] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Anne Head, Sally Sutton, James Jarvis, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Abstain: Representative Samuel Zager, Imad Durra, Mufalo Chitam; Absent: Senate President Troy Jackson.
[29] https://mergecollaborative.org/about/

provide incentives to providers to serve as preceptors and clinical sites for health care students who require clinical hours and related oversight; and $900,000 in fiscal year ending 2022 and $1.8 million in fiscal year ending 2023 to provide funding to develop and refine health care career pathways and implement health care apprenticeships. The funding is set to expire in December 2024.

The next three recommendations (#11 through #13) relate to funding IMG support.

Recommendation #11. Create a fund for clinical readiness programs and career/educational instruction for IMGs to prepare IMGs for eligibility for a sponsorship program (11 in favor, 1 abstention, 1 absent).[30]

The commission unanimously recommends creating a fund for clinical readiness programs and career/educational instruction for IMGs on Maine's medical landscape to prepare IMGs for eligibility for a sponsorship program. The target population is an IMG with licensure (or its equivalent) in a country outside of the U.S.

As mentioned in the background section of this report, IMGs face several challenges when seeking to practice medicine in the U.S. A clinical readiness program can help IMGs overcome some of these challenges. Variations in medical education and training standards across countries may result in differences in clinical knowledge and skills. IMGs often need to bridge these gaps to meet U.S. standards. Gaining clinical experience is essential for an IMG to adapt to local practices and to understand the U.S. health care delivery system.

Pursuing clinical readiness programs and preparing for licensing exams can be financially burdensome. IMGs may not be able to cover the costs associated with exam fees, travel and living expenses during the preparation period. In addition, preparing and passing medical licensing exams in the U.S. can be daunting, particularly for IMGs who have been out of medical school for an extended period of time. Some IMGs may not have access to the same resources and support systems as U.S. medical graduates; this includes mentorship, networking opportunities and guidance on the application process. An adequately funded clinical readiness program is essential to helping IMGs assimilate into the Maine's medical landscape.

Recommendation #12. Create an IMG assistance program (10 in favor, 2 abstentions, 1 absent).[31]

The commission unanimously recommends creating a program to assist IMGs who wish to re-establish their medical careers in the State of Maine. The program must be similar to the State of Colorado's and adequately funded to achieve the same goals as the Colorado program as outlined below.

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[30] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, James Jarvis, Imad Durra, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Abstain: Mufalo Chitam; Absent: Senate President Troy Jackson.

[31] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, Mufalo Chitam, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Abstain: James Jarvis, Imad Durra; Absent: Senate President Troy Jackson.

Colorado recently enacted legislation to establish an IMG assistance program within Colorado's Department of Labor and Employment (CDLE). The department is required to provide direct services to IMGs through a contract with a third party to administer the program and the executive director of CDLE determines the eligibility criteria for participation in the IMG assistantship program.

The Colorado IMG assistance program does the following:

- reviews the background, education training and experience of program participants in order to recommend appropriate steps to enable participants to integrate into the state's health care workforce as physicians or to pursue an alternative health care career;

- provides technical support and guidance to program participants through the credential evaluation process, including preparing for the USMLE and other applicable tests or evaluations;

- provides scholarships or access to scholarships or funds for certain program participants to help cover or offset the cost of the medical licensure process, including the costs of the credential evaluation process, preparing for the USMLE and other applicable tests or evaluations, the residence application process and other costs associated with returning to a career in health care;

- develops, in partnership with community organizations that work with IMGs, voluntary rosters of IMGs interested in entering into the state's health care workforce as physicians and IMGs seeking alternative health care careers; and

- provides guidance to IMGs to apply for medical residency programs or other pathways to licensure.

Recommendation #13.

A. Develop and administer a pilot project for a loan guarantee program for IMGs who are returning to school to pursue any health care professional degree (not necessarily M.D.) and who do not have access to traditional student loans; and

B. Develop a state-based alternative Free Application for Federal Student Aid (FAFSA) form to be used by Maine's public and private educational institutions and in other situations where FAFSA is required for students (9 in favor, 3 abstentions, 1 absent).[32]

The commission unanimously recommends developing and administering a pilot project for a loan guarantee program for IMGs who are returning to school to pursue any health care professional degree (not necessarily M.D.) and who do not have access to traditional student

[32] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Sally Sutton, Mufalo Chitam, Sally Weiss, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Abstain: James Jarvis, Imad Durra, Anne Head; Absent: Senate President Troy Jackson.

loans. The Finance Authority of Maine (FAME) or similar entity may administer this pilot project.

The commission also unanimously recommends that FAME or other appropriate entity develop a state-based alternative FAFSA form to be used by Maine's public and private educational institutions and in other situations where FAFSA is required for students. The target audience is students who are not eligible to complete the FAFSA form, such as asylum seekers.

In summary, the commission supports the use of any and all resources available to meet the goals set forth in recommendations #11 through #13. In addition, the commission recommends that the Maine Legislature and the State provide the additional appropriations needed to fund these programs and initiatives.

Recommendation #14. **Direct the Office of New Americans (ONA), once it is established, to work with appropriate educational programs to develop programs for IMGs entry into and completion of educational programs in alternative health professions (11 in favor, 1 abstention, 1 absent).**[33]

The commission unanimously recommends directing the Office of New Americans (ONA) to work with appropriate educational programs to develop programs for IMGs entry into and completion of educational programs in alternative health professions, such as physician assistant, nurse or nurse practitioner.

On August 3, 2023, Governor Janet Mills signed an executive order directing the Governor's Office of Policy Innovation and the Future (GOPIF) to work with stakeholders to create a plan for the establishment of ONA by January 19, 2024. The primary goal of ONA is to ensure that the State is effectively incorporating immigrants into Maine's workforce and communities to strengthen the State's economy.

In addition, the Governor's executive order directs GOPIF to participate in the national Office of New Americans State Network, which is a consortium of U.S. states with dedicated offices or staff positions established to facilitate immigrant integration. The national network is supported by World Education Services and the American Immigrant Council. Maine will be the 19th state in the U.S. to join this network with the creation of Maine's ONA.

V. CONCLUSION

IMGs can play a crucial role in addressing health care workforce shortages in Maine and, in particular, can help address shortages of physicians in underserved areas or specialties. To maximize the impact of IMGs in addressing health care workforce shortages, it is essential for the State to have an improved regulatory framework, support systems and programs to ensure that these professionals can be integrated into Maine's health care workforce while maintaining

[33] In favor: Senator Donna Bailey, Representative Kristi Mathieson, Representative Samuel Zager, Anne Head, Sally Sutton, Mufalo Chitam, Sally Weiss, James Jarvis, Bruno Salazar-Perea, David Ngandu, Tim Terranova; Abstain: Imad Durra; Absent: Senate President Troy Jackson.

high standards of care. The commission believes strongly that more coordination and collaboration among State agencies and interested parties is needed to achieve this goal.

The commission recognizes that medical licensing serves to protect the public, maintain standards of care and ensure the competence and ethical conduct of health care professionals. As mentioned earlier in the report, variations in medical education and training standards across countries may result in differences in clinical knowledge and skills. IMGs need to bridge these gaps to meet U.S. standards. Commission member Mufalo Chitam stressed the importance of building bridges for IMGs and creating pathways so that these highly skilled professionals can transition smoothly into the U.S. and Maine health care system. IMGs often do not have access to the same support systems as U.S. medical graduates. The State must provide more resources and guidance for IMGs on their pathway to medical licensure.

While there are clear benefits to integrating foreign-trained physicians into Maine's health care workforce, it is essential to ensure that the integration of IMGs is done thoughtfully, considering factors like language proficiency, cultural competency, and the need for additional training to meet U.S. standards. It is also important to address challenges such as credentialing and licensing processes to ensure patient safety and maintain high standards of care.

APPENDIX A

Authorizing Legislation: Resolve 2023, c. 93

APPROVED
JULY 7, 2023
BY GOVERNOR

CHAPTER
93
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

H.P. 584 - L.D. 937

Resolve, to Establish the Commission Regarding Foreign-trained Physicians Living in Maine

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

Whereas, this legislation establishes the Commission Regarding Foreign-trained Physicians Living in Maine to study integrating foreign-trained physicians into the health care workforce; and

Whereas, this legislation must take effect before the expiration of the 90-day period so that the commission may timely meet and make its report to the Legislature; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Commission Regarding Foreign-trained Physicians Living in Maine, referred to in this resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 13 members appointed as follows:

1. Two members of the Senate, appointed by the President of the Senate, at least one of whom must be a member of the Joint Standing Committee on Health Coverage, Insurance and Financial Services;

2. Two members of the House of Representatives, appointed by the Speaker of the House of Representatives, at least one of whom must be a member of the Joint Standing Committee on Health and Human Services;

3. One member who is a member or staff member of the Board of Licensure in Medicine, appointed by the President of the Senate;

4. One member who is a representative of the Maine Hospital Association, appointed by the President of the Senate;

5. One member who is a representative of the New Mainers Resource Center, appointed by the President of the Senate;

6. Three members who are physicians who are refugees or immigrants, 2 of whom are appointed by the Speaker of the House of Representatives, at least one of whom must be licensed to practice in the State, and one of whom is appointed by the President of the Senate;

7. One member who is a representative of the Maine Medical Association, appointed by the Speaker of the House of Representatives;

8. One member who is a representative of the Maine Immigrants' Rights Coalition, appointed by the Speaker of the House of Representatives; and

9. One member from the staff of the Office of the Governor, appointed by the Governor.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

Sec. 5. Duties. Resolved: That the commission shall study integrating foreign-trained physicians, including surgeons, living in the State into the health care workforce to best reflect their level of skills and training, with a focus on those who are here as refugees and asylum seekers, and reducing barriers to licensing for foreign-trained physicians and physicians from other states. The commission shall explore a wide range of options for how to help enable foreign-trained physicians who wish to live and practice in the State to best use their skills and talents, increase health care workforce cultural competency and address potential workforce shortages. The commission shall make recommendations on:

1. Strategies to integrate foreign-trained physicians into the health care workforce;

2. Other ways, outside of being licensed as a physician, that foreign-trained physicians can be supported to best use their skills and training;

3. Changes for regulations that may pose unnecessary barriers to practice for foreign-trained physicians and physicians from other states;

4. Necessary supports for foreign-trained physicians moving through the different steps in the licensing process prior to involvement with the Board of Licensure in Medicine;

5. Opportunities to advocate for corresponding changes to national licensing requirements; and

6. Any other matters pertaining to foreign-trained physicians and physicians from other states considered necessary by the commission.

The commission shall review and identify best practices learned from similar efforts in other states. The commission may hold hearings and invite testimony from experts and the public to gather information. The commission may develop guidelines for full licensure and conditional licensure of foreign-trained physicians and physicians from other states and recommendations for the types of strategies, programs and support that would benefit foreign-trained physicians and physicians from other states to use the fullest extent of their training and experience.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Stakeholder participation. Resolved: That the commission may invite the participation of stakeholders to participate in meetings or subcommittee meetings of the commission to ensure the commission has the information and expertise necessary to fulfill its duties, including, but not limited to, representatives of health insurance carriers, the University of New England College of Osteopathic Medicine, medical graduate residency programs in the State, the Maine Public Health Association, the Maine Osteopathic Association and the Maine Association of Physician Assistants.

Sec. 8. Report. Resolved: That, notwithstanding Joint Rule 353, no later than January 15, 2024, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health Coverage, Insurance and Financial Services. The joint standing committee may report out legislation to the Second Regular Session of the 131st Legislature based on the report.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership List: Commission Regarding Foreign-trained Physicians Living in Maine

Commission Regarding Foreign-trained Physicians Living in Maine

Resolve 2023, c. 93

Membership List

Name	Representation
Senator Donna Bailey, Chair	Member of the Senate, appointed by the President of the Senate, at least one of whom must be a member of HCIFS
Representative Kristi Mathieson, Chair	Member of the House of Representatives, appointed by the Speaker of the House of Representatives, at least one of whom must be a member of HHS
Senator Troy Jackson	Member of the Senate, appointed by the President of the Senate, at least one of whom must be a member of HCIFS
Representative Samuel Zager	Member of the House of Representatives, appointed by the Speaker of the House of Representatives, at least one of whom must be a member of HHS
David Ngandu	Member who is a physician who is a refugee or immigrant, appointed by the President of the Senate
Sally Sutton	Member who is a representative of the New Mainers Resource Center, appointed by the President of the Senate
Tim Terranova	Member who is a member or staff member of the Board of Licensure in Medicine, appointed by the President of the Senate
Sally Weiss	Member who is a representative of the Maine Hospital Association, appointed by the President of the Senate
Mufalo Chitam	Member who is a representative of the Maine Immigrants' Rights Coalition, appointed by the Speaker of the House of Representatives
Imad Durra	Members who are physicians who are refugees or immigrants, at least one of whom must be licensed to practice in the state, appointed by the Speaker of the House of Representatives
Bruno Salazar-Perea	Members who are physicians who are refugees or immigrants, at least one of whom must be licensed to practice in the state, appointed by the Speaker of the House of Representatives
James W. Jarvis	Member who is a Representative of the Maine Medical Association
Anne L. Head	Member from the staff of the Office of the Governor

State of Maine
131st Legislature, First Regular and First Special Sessions

Blue Ribbon Commission to Study Emergency Medical Services in the State

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSIONS

Blue Ribbon Commission to Study Emergency Medical Services in the State

Members:
Sen. Chip Curry, Chair
Speaker Rachel Talbot Ross, Chair
Sen. Brad Farrin
Rep. Mark Blier
Rep. Scott Cyrway
Rep. Suzanne Salisbury
Robert Chase
Beth-Anne Damon
Scott Dow
Mike Hildreth
Kevin Howell
Joe Kellner
Carrie Kipfer
Bill Montejo
Rick Petrie
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Executive Summary

The Blue Ribbon Commission to Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Resolve 2023, chapter 99 (Appendix A). Pursuant to that resolve, the commission consisted of the following 17 members: two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature; two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents; one member who represents a statewide association of emergency medical services providers; one member who represents a private, for-profit ambulance service; one member who represents a statewide association of municipalities; four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature; one member who represents a tribal emergency medical service; one member who represents a volunteer emergency medical service; one member who represents a county government; one member who represents a statewide association of hospitals; the Commissioner of Health and Human Services or the commissioner's designee; and the Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

A list of commission members may be found in Appendix B.

The duties of the commission are set forth in Resolve 2023, chapter 99 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate with Maine Emergency Medical Services so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to costs and funding, workforce development and sustainability, Maine EMS structure, as well as regionalization.

Over the course of five meetings, the commission developed the following recommendations:

Costs and Funding

Recommendation A-1: The Legislature should enact emergency legislation in 2024 eliminating from the Emergency Medical Services Stabilization and Sustainability Program the requirement that the EMS Board adopt rules establishing sustainability grant program requirements and should instead directly stipulate those requirements in law.

Recommendation A-2: The Legislature and Maine EMS should take all actions necessary to ensure the timely and efficient implementation of the Emergency Medical Services Stabilization and Sustainability Program and the distribution of the funding and grants associated with that program.

Recommendation A-3: The Legislature should enact legislation providing ongoing funding to the Maine Emergency Medical Services Community Grant Program and the Legislature and Maine EMS should take all actions necessary to ensure the timely and efficient implementation of that program and the distribution of associated grants.

Recommendation A-4: The Legislature should enact legislation, as proposed in LD 1751, increasing reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine.

Recommendation A-5: The Legislature should enact legislation, as proposed in LD 1751, implementing an ambulance assessment program, which would establish an ambulance service assessment fee on non-municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program.

Recommendation A-6: The Legislature should enact legislation, whether as an amendment to LD 1751 or otherwise, to implement an intergovernmental transfer program, which would authorize municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program through provider payment of the non-federal cost share.

Recommendation A-7: The Legislature should enact legislation, whether as an amendment to LD 1832 or otherwise, requiring health insurance carriers to provide coverage and reimbursement for community paramedicine services in state-regulated health plans.

Recommendation A-8: Maine EMS should conduct a funding needs analysis of communities seeking to engage in regional collaborative efforts or in the adoption of a regional model for the delivery of EMS.

Recommendation A-9: The Legislature should enact legislation, as proposed in LD 1409, to address situations where an EMS entity can be reimbursed its costs for training and credentialing an EMS provider if the provider is hired by another EMS entity within a specified period of time after the first entity's initial incurrence of those costs.

Regulation and Oversight

Recommendation B-1: The Legislature should provide Maine EMS with the funding, staffing and associated resources necessary to properly support its core functions and responsibilities: licensing and regulation of EMS entities; provision of resources and other support to licensed EMS entities; and systemic planning, oversight and stewardship of the statewide EMS system.

Recommendation B-2: The Legislature should enact legislation to facilitate the timely appointment of members to fill vacant seats and reappointment of members in expired seats on the EMS Board, including by shifting the appointing authority for some board members to the President of the Senate and the Speaker of the House of Representatives.

Recommendation B-3: The Legislature should support the proposed reorganization of the EMS Board, which would establish a 9-member EMS Board charged with the strategic direction and oversight of the EMS system as well as a 9-member EMS Licensing Board, charged with the regulation of EMS licensing.

Recommendation B-4: The Legislature should charge the reorganized EMS Board with taking all actions necessary to ensure that individuals in all areas of the State have access to transporting ambulance services, with particular focus given to those areas identified as unserved or underserved by EMS.

Recommendation B-5: The Legislature should enact legislation requiring Maine EMS to report when the EMS Board has failed to commence an initial rulemaking required by law within 90 days of the relevant effective date and to stipulate, for new programs or initiatives, that any required rulemaking be commenced within 90 days of the relevant effective date.

System Resilience and Sustainability

Recommendation C-1: The Legislature should enact legislation requiring each municipality in the State to adopt a plan for the delivery of transporting EMS within the municipality.

Recommendation C-2: The Legislature should enact legislation establishing a permanent EMS commission, to be charged with monitoring and evaluating the statewide EMS system on a continuing basis and providing recommendations to Maine EMS and the Legislature regarding necessary changes to that system.

Recommendation C-3: The Legislature should enact legislation directing Maine EMS to develop and implement a public informational campaign designed to increase public awareness of and appreciation for the essential services provided by EMS providers in Maine.

Recommendation C-4: Maine EMS should collaborate with Volunteer Maine to evaluate opportunities for funding or otherwise facilitating volunteer management and leadership training for volunteer EMS providers and to support recruitment of volunteer EMS providers in Maine.

Recommendation C-5: The Legislature should support community collaboration in the development and implementation of tiered-response systems utilizing paramedic intercept programs.

Recommendation C-6: The Legislature should enact legislation amending the Maine Emergency Medical Services Act to authorize an EMS provider to render EMS within a hospital or health care facility where the EMS provider is a contractor of the hospital or facility but not an employee.

Recommendation C-7: Using LD 1515 or other available legislative instruments, the Legislature should enact legislation necessary to better support and fund the EMS system and to better facilitate the efficient and sustainable delivery of EMS services in Maine.

I. INTRODUCTION

The Blue Ribbon Commission to Study Emergency Medical Services in the State, referred to in this report as "the commission," was established by Resolve 2023, chapter 99.[1] Pursuant to the resolve, the commission consisted of 17 members:

- Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;
- Two members who are employed or volunteer in the field of emergency medical services (EMS), including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;
- One member who represents a statewide association of EMS providers;
- One member who represents a private, for-profit ambulance service;
- One member who represents a statewide association of municipalities;
- Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;
- One member who represents a tribal EMS;
- One member who represents a volunteer EMS;
- One member who represents a county government;
- One member who represents a statewide association of hospitals;
- The Commissioner of Health and Human Services or the commissioner's designee; and
- The Director of Maine Emergency Medical Services (Maine EMS) within the Department of Public Safety or the director's designee.[2]

A list of commission members may be found in Appendix B.

[1] A copy of Resolve 2023, c. 99 is included in Appendix A.

[2] As noted in the commission member list included in Appendix B, Maine EMS Director Sam Hurley served as a commission member for the purposes of the October 23rd commission meeting. After that meeting and before the November 6th meeting, Director Hurley designated Maine EMS Deputy Director Anthony Roberts as his designee to the commission and Deputy Director Roberts served as a commission member for the remainder of the commission's meetings.

The duties of the commission are set forth in Resolve 2023, chapter 99 and charged the commission to examine and make recommendations on the structure, support and delivery of EMS in the State and to maintain communication and coordinate with Maine EMS so that Maine EMS is informed of the work of the commission and the commission is informed of the strategic planning work of Maine EMS. The commission was authorized to look at all aspects of EMS, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

The commission was directed to submit a report, with findings and recommendations, including suggested legislation, to the Joint Standing Committee on Criminal Justice and Public Safety.

II. BACKGROUND INFORMATION

General background information regarding the EMS system in Maine can be found in the 2022 commission's final report, which is included in this report as Appendix C.[3]

A. 2022 Commission Process

The establishment of this commission was one of a number of legislatively-implemented recommendations of the 2022 Blue Ribbon Commission to Study Emergency Medical Services in the State. Although the 2022 commission made a number of substantive recommendations in its final report, most of which were considered by the Legislature in 2023 and many enacted into law, the members of that commission believed there were still outstanding issues to be addressed to ensure the short-term and long-term sustainability of EMS in Maine. To that end, a majority of the members of the 2022 commission recommended reestablishing the commission in 2023 to continue the important work it had begun.

Additional information regarding the process and recommendations of the 2022 commission can be found in the 2022 commission's final report, which is included as Appendix C.

B. 2023 Legislative Actions

The 2022 commission in its final report made a number of specific recommendations, all of which resulted in legislation introduced during the 2023 sessions of the 131st Legislature. In addition, many other proposals concerning or relating to the EMS system and EMS entities were considered by the Legislature in 2023. A chart outlining each of these proposals and their respective dispositions, prepared by commission staff and reviewed by commission members at the October 23, 2023 commission meeting, is included as Appendix D.

[3] Note that the 2022 report included in Appendix C does not include that report's published appendices. The full 2022 report, which includes those appendices, is available at https://legislature.maine.gov/doc/9404.

III. COMMISSION PROCESS

In conducting its work, the commission held five meetings on the following dates: October 23rd, November 6th, November 13th, November 27th and December 11th. Meeting materials, including meeting agendas and other materials, can be found at: https://legislature.maine.gov/blue-ribbon-commission-to-study-emergency-medical-services-in-the-state.

A. First Meeting - October 23, 2023

The first meeting of the commission took place on October 23rd.[4] Members began by introducing themselves, their involvement or experience with EMS in Maine, the organization or interests they are representing on the commission and their goals for the commission's work this year. Following introductions, commission staff reviewed the commission's authorizing legislation and duties and the study commission process generally. Staff also reviewed the final report and recommendations of the 2022 Blue Ribbon Commission to Study Emergency Medical Services in the State and highlighted legislation proposed in 2023 that was related to that report or to EMS generally.

Commission member and Maine EMS Director Sam Hurley next provided an update on the process for disbursement of funding under the newly established Emergency Medical Services Stabilization and Sustainability Program, reviewed the strategic plan published by Maine EMS and adopted by the EMS Board earlier that year and highlighted the Maine EMS Connectivity and Roadway Safety Project. The commission next received a presentation from Bill Montejo, the commission member representing the Department of Health and Human Services, regarding that department's role generally in supporting the EMS system in Maine and in the administration of the new Emergency Medical Services Stabilization and Sustainability Program. The meeting concluded with commission member discussion regarding desired outcomes for the commission's work this year and identification of additional information the commission should receive or review at future meetings.

B. Second Meeting - November 6, 2023

The second meeting of the commission took place on November 6th.[5] The meeting began with commission staff providing an analysis and discussion of how different states address what it means for EMS to be an "essential service" and how those other states structure and fund their EMS systems.[6] The commission next received a presentation from commission member and Maine EMS Deputy Director Anthony Roberts regarding the structure of the EMS system in

[4] Materials distributed at the October 23, 2023 commission meeting are available at https://legislature.maine.gov/doc/10402 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#127?event=89632&startDate=2023-10-23T13:00:00-04:00.

[5] Materials distributed at the November 6, 2023 commission meeting are available at https://legislature.maine.gov/doc/10413 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#127?event=89633&startDate=2023-11-06T09:00:00-05:00.

[6] A copy of a chart outlining the differing approaches taken to funding EMS by states that designate EMS as an essential service, prepared by commission staff and reviewed by commission members at the November 6th meeting, is included in Appendix E.

Maine and details regarding implementation of the Maine EMS strategic plan. Deputy Director Roberts also provided various data and information regarding EMS response, patient care and other information requested by commission members at the prior meeting. Commission member Joe Kellner next provided a presentation discussing the costs associated with providing EMS services, updating a similar presentation given to the 2022 commission.[7]

The commission also received a presentation on November 6th from Michael Colleran, Chief Operating Officer and General Counsel of the Maine Public Employees Retirement System (MainePERS), regarding the legal issues with allowing EMS providers to participate in government employee retirement plans, as has been proposed in LD 882, "An Act to Allow Nonmunicipal Emergency Medical Services Providers to Be Considered State Employees for Purposes of Certain Benefits," introduced in and voted "ought not to pass" by the 131st Legislature in 2023.[8] Finally, the commission on November 6th received two presentations on different regional EMS models, one from commission member Kevin Howell regarding a public-private partnership model and the other from commission member Mike Senecal regarding a hospital-operated ambulance service model.[9]

As described by commission member Kevin Howell, the Town of Carmel in 2018 entered into an agreement with Northern Light Health to address identified region-wide EMS issues, including insufficient call volumes, staff recruitment and retention, funding shortfalls, long response times and contractual limitations on response areas. Under that agreement, Northern Light provides some EMT staffing to the Carmel during normal business hours and EMS training to Carmel's EMS staff. Carmel provides all other needs for the operation of its ambulance service and provides an additional EMS response in the Towns of Dixmont and Newburgh, with secondary support provided by Northern Light. Carmel receives all revenues from its Carmel area responses and a split percentage of revenues for all other responses.

This agreement, which included the implementation of a common dispatch protocol, has facilitated improved response times in the covered multi-municipal region by dispatching the closest available resource and has resulted in better resourcing and a manageable financial balance for Carmel. Commission member Howell closed by reiterating that, while identification and empowering of rural hubs for EMS, as in his region, can dramatically improve the efficiency and sustainability of the local EMS system, it is important that each community contribute a fair share of the costs of EMS delivery and that each community control its own destiny when it comes to decisions about the local provision of EMS.

Commission member Mike Senecal next described the regional ambulance service model implemented in greater Franklin County as NorthStar EMS. Starting in 1995, Franklin Memorial Hospital began acquiring and operating a number of small local ambulance services, which were merged in 2003 and ultimately became NorthStar EMS, managed as a single department of the hospital, which is itself part of the MaineHealth system. EMS responses by NorthStar are

[7] A copy of commission member Joe Kellner's presentation is included in Appendix F.

[8] More information on LD 882 can be found at https://legislature.maine.gov/billtracker/#Paper/882?legislature=131.

[9] Copies of commission member Kevin Howell's and commission member Mike Senecal's presentations are included in Appendix F.

dispatched from the Franklin County Regional Communication Center, with a goal of providing a paramedic level of staffing on all ambulances by strategically positioning and coordinating ambulance placement. NorthStar has also implemented a community paramedicine program in its service area and has a backcountry medical response team that responds to calls in off-road or hard-to-access areas. In fiscal year 2023, NorthStar ambulances made more than 7,400 runs. It is currently contracted with 29 towns to provide emergency coverage, each of which contribute a municipal subsidy based on demographic data to help offset the service's operating costs. For fiscal year 2023, that combined municipal subsidy totaled $690,000 and the service operated with a net loss of $703,356.

In response to these presentations, commission member Robert Chase noted that Med-Care Ambulance, which provides ambulance services to 11 communities in northern Oxford County, is operating using a similar model to that of NorthStar, albeit pursuant to an interlocal agreement. Commission members concluded the November 6th meeting with additional discussion regarding the benefits and barriers to implementation of regional models, the importance of community self-determination in consideration of regionalization efforts and the needs of those communities for State-level support and resources as they engage in such efforts.

C. Third Meeting - November 13, 2023

The third meeting of the commission took place on November 13th.[10] It began with an opportunity for public comment, during which the commission heard from Donald Sheets of Southern Maine Community College's EMS department, Ben Harris of Goodwin's Mills Fire-Rescue, Jay Bradshaw of Sidney and Jesse Thompson of Union Fire Rescue. Those testifying each highlighted the obstacles they believe are impeding Maine's EMS growth and sustainability, including a lack of educators to teach EMT courses, low student demands for such courses and concerns about the efficacy and structure of the EMS Board.

Following public comment, the commission received a presentation on tribal EMS systems in Maine from commission member Mike Hildreth. The remainder of the third meeting was spent with commission members narrowing the focus of discussion to identify potential recommendations for inclusion in the final report. Three broad categories of identified recommendations were: (1) EMS funding; (2) responsibility for the delivery of EMS and regionalization; and (3) the structure of Maine EMS and the EMS Board. Having established these broader categories, commission members engaged in an in-depth discussion to develop recommendations designed to address responsibility for the delivery of EMS and regionalization. Before adjourning, commission chairs requested that commission members submit potential recommendations to staff prior to the next meeting for compilation, distribution and consideration at the fourth commission meeting.

[10] Materials distributed at the November 13, 2023 commission meeting are available at https://legislature.maine.gov/doc/10420 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#228?event=89737&startDate=2023-11-13T13:00:00-05:00.

D. Fourth Meeting - November 27, 2023

The fourth meeting of the commission was held on November 27th.[11] Although the meeting focused primarily on discussion and development of recommendations for inclusion in the final report, the commission did receive a brief presentation from Alexa Altman of the consulting firm Sellers Dorsey, on behalf of the Maine Ambulance Association, regarding the potential implementation of an intergovernmental transfer program and an ambulance assessment program. The remainder of the meeting was spent with commission members reviewing, discussing and initially voting on the potential recommendations members had identified and submitted to commission staff following the third meeting. At the conclusion of the fourth meeting, commission staff were directed to prepare a draft report that included the recommendations receiving a majority of initial votes from commission members during the meeting, to be reviewed and receive final votes from members during the fifth and final meeting.

E. Fifth Meeting - December 11, 2023

The fifth and final meeting of the commission was held on December 11th.[12] The meeting began with a briefing by Department of Public Safety Commissioner Michael Sauschuck regarding the implementation of the recently established Emergency Medical Services Stabilization and Sustainability Program.[13] As commission members learned, the EMS Board had very recently approved the emergency adoption of a rule implementing the stabilization funding component and that it was anticipated applications for that funding would be available imminently. The Commissioner also advised members that the development of rules to implement the sustainability grant funding component were on track to be adopted and in place by the summer of 2024. Some commission members expressed frustration with the complexity of the stabilization rule, skepticism regarding the ability of Maine EMS to adequately assist EMS entities with completing the application process and concern over the anticipated delay in the availability of sustainability grants.

The remainder of the fifth meeting was spent by commission members in reviewing the draft report prepared by commission staff and conducting substantive voting on the recommendations to be included in the commission's final published report. Commission staff reviewed with members the process for finalizing the report and commission members discussed the various legislative instruments and processes that might be utilized during the 2024 session of the Legislature to consider and implement the commission's recommendations.

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[11] Materials distributed at the November 27, 2023 commission meeting are available at https://legislature.maine.gov/doc/10492 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#228?event=89778&startDate=2023-11-27T09:00:00-05:00.

[12] Materials distributed at the December 11, 2023 commission meeting are available at https://legislature.maine.gov/doc/10495 and the archived video of the meeting is available at https://legislature.maine.gov/audio/#228?event=89843&startDate=2023-12-11T13:00:00-05:00.

[13] More information regarding the Emergency Medical Services Stabilization and Sustainability Program is included as part of Recommendation A-1.

IV. RECOMMENDATIONS

A. Costs and Funding

In its final report, the 2022 commission recognized that "[t]he primary issue facing EMS is a lack of funding." That commission subsequently endorsed the following finding: "Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to supporting transporting EMS services in the State."[14] As described later in this report, although the Legislature in 2023 took a number of critical steps towards closing that identified funding gap, a continued lack of adequate funding for EMS entities remains a primary and significant issue for the EMS system in Maine.

Indeed, many of this commission's discussions involved consideration of measures designed to better fund and support the operations of EMS entities and to encourage greater efficiency and sustainability within the EMS system now and into the future. The commission also spent time reviewing existing funding mechanisms and programs and identifying barriers to EMS entities maximizing the use of those resources. Recognizing the Legislature's recent provision of additional and significant funding mechanisms to support the EMS system, commission members suggest that, in evaluating recommendations in this report, the Legislature identify and consider a range of funding options as necessary, including the use of existing funding and resources, available federal funding and other available public and private resources. With these considerations in mind, commission members make the following recommendations relating to the funding of the EMS system in Maine.

Recommendation A-1: The Legislature should enact emergency legislation in 2024 eliminating from the Emergency Medical Services Stabilization and Sustainability Program the requirement that the EMS Board adopt rules establishing sustainability grant program requirements and should instead directly stipulate those requirements in law.[15]

The Legislature in 2023 enacted Public Law 2023, chapter 412 (the "biennial budget"), which in Part GGGGG established the Emergency Medical Services Stabilization and Sustainability Program.[16] That program has two primary components. First, the program provides stabilization funding – financial assistance to EMS entities at immediate risk of failing and leaving their

[14] *See* 2022 report, Part IV(A), included in Appendix C.

[15] Fourteen commission members voted in support of Recommendation A-1 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[16] More information on the biennial budget bill, LD 258, can be found at https://legislature.maine.gov/billtracker/#Paper/258?legislature=131. The biennial budget was enacted as general legislation with an effective date of October 25, 2023. See also, LD 526, which provided a minor amendment to this program as enacted in the biennial budget, https://legislature.maine.gov/billtracker/#Paper/526?legislature=131.

communities without access to adequate EMS.[17] Second, the program provides sustainability grants – grants to EMS entities to increase support and develop plans for sustainability, collaboration and enhancement of efficiency in the delivery of EMS in the State.[18]

The Legislature, also as part of the biennial budget (Part A, section A-29), capitalized this program using a one-time General Fund transfer of $31 million, broken down between the two above-described program components as follows:

- *Stabilization funding* (financial assistance available under 32 MRSA §98(3))
    - For ambulance services - $10,000,000 in FY 23-24
    - For nontransporting EMS - $2,000,000 in FY 23-24
- *Sustainability grants* (grant funding available under 32 MRSA §98(4))
    - For ambulance services - $14,140,161 in FY 23-24
    - For nontransporting EMS - $3,000,000 in FY 23-24
    - For EMS training centers - $1,000,000 in FY 23-24

The remaining $859,839 of the $31 million transfer was dedicated to establish 4 limited-period positions in FY 23-24 and FY 24-25 at Maine EMS, funded through June 7, 2025, to administer the Emergency Medical Services Stabilization and Sustainability Program.

Under the Emergency Medical Services Stabilization and Sustainability Program, the disbursement of the $12 million of stabilization funding does not explicitly require the adoption of implementing rules. The commission understands, however, that Maine EMS, after consultation with the Office of the Attorney General, has opted for the EMS Board to adopt rules, on an emergency basis, for implementation of this program component.

The law does explicitly require the EMS Board to adopt rules to establish the requirements for the issuance of sustainability grants under the program. Commission members were advised by representatives of Maine EMS that the rulemaking necessary to implement the sustainability grant program component could take up to one year to complete or potentially longer. During the December 11th meeting, however, commission members learned from the Commissioner of Public Safety that the EMS Board is hoping to adopt that rule by the summer of 2024.

As discussed by commission members at multiple meetings, the rulemaking requirement for sustainability grants presents a potentially significant barrier to the efficient and timely establishment of this program and the associated distribution of the almost $19 million in available grant funding. Given this concern and, as representatives of Maine EMS suggested to commission members that rulemaking may not actually be necessary for the implementation of this grant program, commission members recommend the Legislature enact emergency legislation in 2024 to remove the rulemaking requirement for the sustainability grant program

[17] *See* 32 MRSA §98(3).

[18] *See* 32 MRSA §98(4).

and to instead, as necessary and appropriate, stipulate directly in statute the requirements for issuance of those grants.

Recommendation A-2: The Legislature and Maine EMS should take all actions necessary to ensure the timely and efficient implementation of the Emergency Medical Services Stabilization and Sustainability Program and the distribution of the funding and grants associated with that program.[19]

As previously described, the Legislature in 2023 established the Emergency Medical Services Stabilization and Sustainability Program and capitalized that program with a one-time General Fund transfer of $31 million. Of that funding, $12 million was dedicated to the provision of stabilization funding, which is financial assistance available to EMS entities at immediate risk of failing and leaving their communities without access to adequate EMS, while almost $19 million was dedicated to the provision of the previously described sustainability grants.

During multiple commission meetings, members requested information from Maine EMS regarding the specific timeline for distribution of this stabilization funding. As previously noted, during the December 11th meeting, the Commissioner of Public Safety advised members that the applications for this funding would become available to EMS entities imminently although it remains unclear to members when that funding might actually be distributed to approved applicants. At multiple meetings, many commission members also expressed frustration that such critical funding has not yet been made available to EMS entities, many of which continue to experience significant financial difficulties. Further, as previously noted, the statutory requirement that the EMS Board adopt rules to implement the sustainability grant component of this program has the potential to significantly delay the availability of the almost $19 million in funding dedicated for that separate purpose.

Although commission members expressed strong support and appreciation for the Legislature's establishment of this program and provision of the associated $31 million in funding, many members remain deeply concerned about the speed and efficiency by which that funding will actually be made available to EMS entities. Accordingly, commission members recommend that the Legislature and Maine EMS take all actions necessary to ensure the timely and efficient implementation of the Emergency Medical Services Stabilization and Sustainability Program and the distribution of the $31 million in funding and grants associated with that program, including, but not limited to, the specific measures identified elsewhere in this report.

The commission understands that, pursuant to Public Law 2023, chapter 412 (the biennial budget), Part GGGGG-3, the EMS Board is required to submit a report regarding the Emergency Medical Services Stabilization and Sustainability Program to the Joint Standing Committee on Criminal Justice and Public Safety no later than January 12, 2024. This report must include information on the actual and planned expenditures and encumbrances

[19] Fifteen commission members voted in support of Recommendation A-2 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

and applications submitted and accepted under the program and will provide the Legislature an opportunity to consider the need for additional actions to ensure the program's timely and efficient implementation.

Recommendation A-3: The Legislature should enact legislation providing ongoing funding to the Maine Emergency Medical Services Community Grant Program and the Legislature and Maine EMS should take all actions necessary to ensure the timely and efficient implementation of that program and the distribution of associated grants.[20]

The Legislature in 2022 enacted Public Law 2021, chapter 700, which established the Maine Emergency Medical Services Community Grant Program and provided a one-time $200,000 General Fund appropriation to capitalize that program.[21] The stated purpose of this program is to provide financial assistance to communities that plan to examine or are examining the provision of EMS through a process of informed community self-determination and are considering a new, financially stable structure for delivering EMS that provides high-quality services effectively and efficiently.[22] To implement the program, the EMS Board is required by law to adopt routine technical rules establishing the grant application process, which commission members understand was attempted in 2023 and failed final adoption. Commission members learned that Maine EMS intends to reinitiate the formal rulemaking process for these rules in early January 2024, however, the time frame for the distribution of this program funding to EMS entities remains unclear.

At multiple meetings, many commission members expressed their frustration that such this critical program and its associated funding have not yet been made available to EMS entities despite its enactment by the Legislature more than a year ago and voiced their concern regarding the capacity of Maine EMS and the EMS Board to timely and efficiently implement this and other important programs and initiatives. Commission members believe this grant program in particular represents a critically-important mechanism towards supporting community-driven measures that will increase the efficiency and sustainability of Maine's EMS system. For that reason, commission members recommend that the Legislature enact legislation to provide ongoing funding to this program at an appropriate level, considering all available funding options. Further, commission members recommend the Legislature and Maine EMS take all necessary steps to ensure the timely and efficient implementation of the program and the distribution of associated grants.

[20] Fourteen commission members voted in support of Recommendation A-3 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[21] *See* 32 MRSA §97; P.L. 2022, ch. 700 (LD 1859) (available at https://legislature.maine.gov/billtracker/#Paper/1859?legislature=130).

[22] 32 MRSA §97(2).

Recommendation A-4: The Legislature should enact legislation, as proposed in LD 1751, increasing reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine.[23]

LD 1751, "An Act to Maximize Federal Funding in Support of Emergency Medical Services," was introduced to the Legislature in 2023 and referred to the Joint Standing Committee on Health and Human Services (HHS).[24] Among other things, the bill as printed proposes increases to reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine. The HHS Committee ultimately decided to carry the bill over to the 2024 legislative session.

Although the commission understands that some of the proposals included in LD 1751 have been or are being considered as part of other legislative proposals, commission members generally express support for enactment of proposals represented in LD 1751 that are designed to maximize federal funding by increasing reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine.

Recommendation A-5: The Legislature should enact legislation, as proposed in LD 1751, implementing an ambulance assessment program, which would establish an ambulance service assessment fee on non-municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program.[25]

LD 1751, as previously described, also proposes implementing an ambulance assessment program, which would establish an ambulance service assessment fee on non-municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program. The commission was briefed at its November 27, 2023 meeting by Alexa Altman, a representative of the consulting firm Sellers Dorsey, on behalf of the Maine Ambulance Association, regarding the potential benefits to be achieved through the implementation of such a program.

The commission understands that this program would benefit non-municipal ambulance services by requiring the State to collect an assessment from those services and using that money as the State's share for federal Medicaid matching funds, thus increasing Medicaid rates by making supplemental payments to those services. Commission members generally express support for the enactment of such a program, which, like the previous recommendation, will also serve to maximize federal funding for many EMS entities in the State.

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[23] Fourteen commission members voted in support of Recommendation A-4 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[24] More information on LD 1751 is available at https://legislature.maine.gov/billtracker/#Paper/1751?legislature=131.

[25] Fourteen commission members voted in support of Recommendation A-5 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

Recommendation A-6: The Legislature should enact legislation, whether as an amendment to LD 1751 or otherwise, to implement an intergovernmental transfer program, which would authorize municipal ambulance service providers to maximize federal funding for reimbursement to those providers under the MaineCare program through provider payment of the non-federal cost share.[26]

As previously noted, the commission was briefed at its November 27, 2023 meeting by Alexa Altman, a representative of the consulting firm Sellers Dorsey, on behalf of the Maine Ambulance Association, who described the scope of and potential benefits to be derived through the implementation of an intergovernmental transfer (IGT) program in Maine. The commission understands that an IGT program would authorize municipal ambulance services to use public funds to pay the non-federal cost share portion for federal Medicaid matching funds, thus increasing Medicaid rates by making supplemental payments to those services, similar to the ambulance assessment program described in the prior recommendation. An IGT program would be set up as a voluntary, opt-in program, allowing but not requiring municipal ambulance services to participate. Commission members understand that the reimbursement amounts paid under such a program to each participating service would be dependent on, among other things, the level of payment the service is able to dedicate as the non-federal cost share portion.

Commission members recommend that LD 1751, as previously described, be amended to include language directing the Department of Health and Human Services to include an IGT program in its Medicaid State plan and to provide support, resources and education to municipal ambulance services so that they may effectively use the program.

Recommendation A-7: The Legislature should enact legislation, whether as an amendment to LD 1832 or otherwise, requiring health insurance carriers to provide coverage and reimbursement for community paramedicine services in state-regulated health plans.[27]

LD 1832, "An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services," was introduced in 2023 and referred to the Joint Standing Committee on Health Coverage, Insurance and Financial Services (HCIFS).[28] The bill as printed requires an ambulance service to be reimbursed for the cost of treating a person, regardless of whether the ambulance service transports the person to a hospital. The HCIFS Committee ultimately decided to carry the bill over to the 2024 session.

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[26] Fourteen commission members voted in support of Recommendation A-6 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[27] Fourteen commission members voted in support of Recommendation A-7 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[28] More information on LD 1832 is available at https://legislature.maine.gov/billtracker/#Paper/1832?legislature=131.

Commission members learned that the HCIFS Committee carried over LD 1832 specifically as a vehicle for consideration of a narrower proposal to require health insurance carriers to provide coverage and reimbursement for community paramedicine services in state-regulated health plans. This proposal would not apply to MaineCare, Medicare or self-insured group health plans. To that end, the HCIFS Committee requested that the Bureau of Insurance prepare a review and evaluation of LD 1832 based on a proposed committee amendment addressing coverage and reimbursement for community paramedicine services. The review and evaluation is due to the HCIFS Committee no later than January 15, 2024.

As a corollary proposal to the MaineCare-specific reimbursement rate proposal presented in LD 1751, commission members express support for requiring health insurance carriers to provide coverage and reimbursement for community paramedicine services in state-regulated health plans as presented in a proposed HCIFS Committee amendment to LD 1832.

Recommendation A-8: Maine EMS should conduct a funding needs analysis of communities seeking to engage in regional collaborative efforts or in the adoption of a regional model for the delivery of EMS.[29]

At multiple commission meetings, members discussed the potential benefits of and barriers to community and regional collaborative efforts for the delivery of EMS. The commission received presentations, as previously described, regarding two different regional models implemented in Maine that have enhanced the efficiency and reduced the costs of providing EMS for the participating communities. One of the primary barriers to regionalization efforts identified by commission members is cost – the initial capital, start-up and operating costs of implementing a regional model are often a significant enough barrier to dissuade communities from exploring collaborative options that might ultimately reduce their EMS costs.

Commission members recognize there have recently been a number of funding sources made available to communities for these purposes, namely the grant funding available under the Maine Emergency Medical Services Community Grant Program and under the Emergency Medical Services Stabilization and Sustainability Program, both of which were described in greater detail earlier in this report. Given the diverse funding and structural needs of municipalities and regions throughout the State and the disparity in EMS available from area to area, it is unclear whether communities seeking to collaborate in the development of a regional model for EMS will have access to the level funding and support necessary for successful implementation of those models.

To that end, commission members recommend that Maine EMS conduct a funding needs analysis of communities seeking to engage in regional collaboration or the adoption of a regional model in the delivery of EMS and report the results of that analysis and any accompanying recommendations to the Legislature. Commission members believe this analysis will be critical in determining the unfilled community resource needs that must be addressed to effectively

[29] Fifteen commission members voted in support of Recommendation A-8 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

support regional collaborative efforts by communities in the delivery of EMS and further recommend the report from Maine EMS should indicate whether such an analysis should be conducted on an ongoing basis. Although the commission believes Maine EMS currently has the expertise and resources to conduct this analysis, commission members suggest that Maine EMS communicate with the Legislature regarding any funding concerns it may have in implementing this recommendation.

Recommendation A-9: The Legislature should enact legislation, as proposed in LD 1409, to address situations where an EMS entity can be reimbursed its costs for training and credentialing an EMS provider if the provider is hired by another EMS entity within a specified period of time after the first entity's initial incurrence of those costs.[30]

LD 1409, "An Act to Require Reimbursement When a Municipality Hires First Responders Whose Training Costs Were Incurred by Another Municipality," was introduced in 2023 and referred to the Joint Standing Committee on State and Local Government (SLG).[31] The bill as printed, establishes a formula to reimburse municipalities for training costs for training full-time first responders if the first responder is hired by another municipality within 5 years of the first municipality's initial incurrence of training costs. The SLG Committee ultimately decided to carry the bill over to the 2024 session.

Commission members recognize that problems with recruiting, training and retaining EMS providers are significantly impacting the delivery of EMS for many EMS entities, causing delayed response times and contributing to provider stress and burnout. Compounding those issues for municipal EMS entities in particular are where an entity incurs costs in training and credentialing new and existing providers only to have those providers leave for other employment. According to the Maine Municipal Association in its public hearing testimony on LD 1409, although it is challenging to estimate these types of costs, the average cost to provide all first responder credentialing and on the job training to the point that the provider can work "moderately unsupervised" could be in the range of $15,000 to $20,000, much of which represents the salary paid to the provider during the period of on the job training.[32]

As printed, LD 1409 proposes to implement a reimbursement mechanism to address that situation in a similar manner to the law enforcement and corrections officer training cost sharing mechanisms currently provided for in law.[33] But as acknowledged by the bill's sponsor in public hearing testimony, while the genesis of the bill was simply "to reimburse a municipality, who has paid for training in expectation that an employee will continue to work for that municipality,

[30] Fourteen commission members voted in support of Recommendation A-9 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member voted in opposition (Dow), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

[31] More information on LD 1409 is available at https://legislature.maine.gov/billtracker/#Paper/1409?legislature=131.

[32] *See* https://legislature.maine.gov/backend/app/services/getDocument.aspx?doctype=test&documentId=173002.

[33] *See* 25 MRSA §§2808, 2808-A.

if that employee moves on," the bill as proposed "isn't a perfect framework for what is a common-sense policy idea."[34]

Recognizing, therefore, that this proposal will likely be subject to further legislative discussion during the 2024 session, commission members express general support for implementation of the policy goals raised by LD 1409. Commission members recommend that the SLG Committee consider broadening the scope of the proposal to include all EMS providers and not just first responders. Further, commission members suggest the SLG Committee consider methods of ensuring equity in the implementation of any such proposal between municipal and non-municipal EMS entities so that all EMS entities are able to take advantage of any reimbursement formula and have a responsibility for reimbursement when their hiring of an EMS provider impacts another EMS entity that has incurred costs in training and credentialing that provider.

B. Regulation and Oversight

The EMS system in Maine is overseen by Maine EMS, a bureau within the Maine Department of Public Safety, in coordination with the EMS Board, an 18-member entity established pursuant to the Maine Emergency Medical Services Act of 1982. The EMS system is divided into 6 EMS regions, each with its own regional council, office and medical director. At present, Maine EMS contracts with each regional office, which are established as independent, not-for-profit 501(c)(3) corporations, to assist in oversight of training, quality assurance, medical directions and systems operation within its respective region. Based on the biennial budget enacted by the Legislature in 2023, Maine EMS is expected to have an operating budget of approximately $2.3 million in fiscal years 2023-24 and 2024-25, with the bulk of those funds originating from the State's General Fund.

Given the ongoing and anticipated changes to Maine EMS and the EMS Board, which are described in further detail below, commission members recognize that both entities may require increased funding, staffing and associated resources in future biennia to ensure the proper oversight and support of the EMS system. While Maine EMS and the EMS Board play a critical role in licensing and regulating EMS entities in the State, they must also be able to provide the resources and other support that those licensed entities need to sustainably operate. Furthermore, these two entities must ensure the systemic planning, oversight and stewardship of the EMS system, now and into the future. To support a robust and sustainable governance structure for EMS in Maine, commission members make the following recommendations relating to the regulation and oversight of EMS.

[34] See https://legislature.maine.gov/backend/app/services/getDocument.aspx?doctype=test&documentId=173001.

Recommendation B-1: The Legislature should provide Maine EMS with the funding, staffing and associated resources necessary to properly support its core functions and responsibilities: licensing and regulation of EMS entities; provision of resources and other support to licensed EMS entities; and systemic planning, oversight and stewardship of the statewide EMS system.[35]

Maine EMS is currently in the process of implementing a long-term strategic plan, which will involve substantial changes to the structure of the agency and the EMS Board, as well as to the general governance structure of the EMS system. The implementation of these changes is expected to require, among other things, the provision of additional funding and resources, including increased staffing support. The commission believes this restructuring provides an important opportunity to examine, reinforce and support the core functions and responsibilities of the agency.

Commission members suggest that these core governance functions and responsibilities of Maine EMS and the EMS Board fall within three primary areas: (1) oversight of the licensing and regulation of EMS entities; (2) the provision of resources and other support to licensed EMS entities; and (3) the systemic planning, oversight and stewardship of the statewide EMS system. Supporting each of these core functions is critical to the future of the EMS system and commission members recognize that Maine EMS must be provided with the funding, staffing and associated resources necessary to successfully implement its strategic plan. The commission accordingly supports the Legislature in its consideration of any future funding and resource requests made by Maine EMS relating to the implementation of its strategic plan and recommends the Legislature consider all available funding options in properly resourcing Maine EMS and the EMS Board.

Recommendation B-2: The Legislature should enact legislation to facilitate the timely appointment of members to fill vacant seats and reappointment of members in expired seats on the EMS Board, including by shifting the appointing authority for some board members to the President of the Senate and the Speaker of the House of Representatives.[36]

The Maine Emergency Medical Services Act of 1982 establishes the composition of the EMS Board.[37] The EMS Board is comprised of 18 members, one for each of the 6 regions represented by regional councils, and the remaining 12 members are as follows: an emergency physician, a representative of emergency medical dispatch providers, a representative of the public, a representative of for-profit ambulance services, an emergency professional nurse, a representative of nontransporting EMS, a representative of hospitals, a fire chief, a representative

[35] Fourteen commission members voted in support of Recommendation B-1 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[36] Fourteen commission members voted in support of Recommendation B-2 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[37] *See* 32 MRSA §88.

of a statewide association of fire chiefs, a municipal EMS provider, a representative of not-for-profit ambulance services and a representative in the field of pediatrics. All 18 members are appointed by the Governor and serve 3-year terms.

As commission members learned, at present 6 of the 18 board seats are currently vacant (the seats representing South Maine Region/Region 1; Northeast Region/Region 4; nontransporting EMS representative; for-profit ambulance services representative; emergency professional nurse member; and pediatrics representative).[38] Moreover, the appointment terms for the 12 non-vacant seats are all expired as of July 2023, with at least one term having expired as early as December 2020. Many commission members expressed frustration with these vacancies and lack of reappointments as necessary to support the activities of an entity that is so critically involved with the regulation and oversight of the EMS system. Commission members recognize that, as part of the implementation of the Maine EMS strategic plan, described later this report, the EMS Board is expected to be reconfigured and its membership reduced to create a separate licensing board. While the time frame for those changes is unclear, commission members are concerned that the present iteration of the EMS Board, with its 6 vacancies and 12 expired appointments, may be frustrating its ability to effectively regulate the EMS system.

To this end, commission members recommend the Legislature enact legislation to facilitate the timely appointment of members to fill vacant seats and reappointment of members in expired seats on the EMS Board. One mechanism for achieving this goal, which the commission supports, is to shift the appointing authority for some board seats from the Governor to the President of the Senate and to the Speaker of the House of Representatives. Commission members believe this to be a reasonable and appropriate mechanism by which the Legislature can facilitate the timely achievement of a fully appointed board. The commission anticipates a robust legislative discussion in 2024 regarding the EMS Board and its current composition as the Legislature considers a new bill, LD 2071, "Resolve, to Fill all Vacant and Expired Seats on the Emergency Medical Services Board."[39]

Recommendation B-3: The Legislature should support the proposed reorganization of the EMS Board, which would establish a 9-member EMS Board charged with the strategic direction and oversight of the EMS system as well as a 9-member EMS Licensing Board, charged with the regulation of EMS licensing.[40]

Commission members understand that, as part of the implementation of the Maine EMS strategic plan, the EMS Board is expected to undergo a significant reorganization, which the current board has endorsed.[41] That proposal would reduce the size of the current EMS Board from 18 to 9

[38] *See* https://www.maine.gov/ems/boards-committees/ems-board.

[39] More information on LD 2071 is available at https://legislature.maine.gov/billtracker/#Paper/2071?legislature=131.

[40] Fourteen commission members voted in support of Recommendation B-3 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[41] A copy of this proposal is included in Appendix G.

members and charge that smaller board with ensuring the strategic direction and oversight of the EMS system. That board's responsibilities would include: (1) continued implementation of the strategic plan; (2) coordinating rulemaking activities not related to personnel licensing; (3) hearing and deciding service-licensing waiver requests and appeals of disciplinary actions; and (4) approving and confirming the Maine EMS director position.

At the same time, the proposal would establish a new 9-member EMS Licensing Board and charge that board with ensuring the regulation of licensed EMS persons. That board's responsibilities would include: (1) coordinating rulemaking activities relating to personnel licensing; (2) considering disciplinary action for licensed personnel, including entering of consent agreements; (3) granting, suspending or revoking a personnel license; (4) investigating complaints or allegations of violations; (5) conducting disciplinary and administrative hearings; and (6) evaluating licensing waiver requests.

Commission members recommend that the Legislature support this proposed reorganization of the EMS Board, understanding that many of the critical details, such as the diversity of representation on these two boards, will undergo further development with public discussion, input and legislative consideration prior to implementation.

Recommendation B-4: The Legislature should charge the reorganized EMS Board with taking all actions necessary to ensure that individuals in all areas of the State have access to transporting ambulance services, with particular focus given to those areas identified as unserved or underserved by EMS.[42]

Commission members repeatedly discussed that in many areas of the State, residents lack access to a timely or sufficient EMS response, which often leads to significant negative health outcomes. EMS entities, particularly in rural areas, are often stretched very thin and have limited resources and staffing; this contributes to increased response times, provider stress and burnout. As discussed later in this report, commission members believe that the minimum standard for EMS delivery to be achieved for all residents of Maine is access to transporting EMS.

Achieving this goal in the areas of the State that are underserved or unserved by EMS – the so-called "ambulance deserts" – may prove challenging. But the recent implementation by the Legislature of a number of different programs and initiatives along with many of the recommendations in this report will undoubtedly help to better identify the "ambulance deserts" in Maine and the needs of underserved and unserved communities as well as to provide much-needed funding to support a more efficient and sustainable EMS system statewide.

Recognizing, therefore, that the previously described reorganization of the EMS Board will provide additional opportunity to consider its core purposes and functions, commission members recommend the Legislature charge the reorganized EMS Board with taking all actions necessary

[42] Fifteen commission members voted in support of Recommendation B-4 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

to ensure that residents in all areas of the State have access to transporting ambulance services, with particular focus given to those areas identified as unserved or underserved by EMS.

Recommendation B-5: The Legislature should enact legislation requiring Maine EMS to report when the EMS Board has failed to commence an initial rulemaking required by law within 90 days of the relevant effective date and to stipulate, for new programs or initiatives, that any required rulemaking be commenced within 90 days of the relevant effective date.[43]

Under the Maine Emergency Medical Services Act of 1982, the EMS Board is charged with the adoption of rules necessary to carry out the purposes, requirements and goals of that law.[44] As members learned during the first commission meeting, a rulemaking by the EMS Board to adopt the framework necessary to implement the Maine Emergency Medical Services Community Grant Program recently failed final adoption due, at least in part, to an apparent failure to meet the applicable rulemaking time frames set forth in the Maine Administrative Procedure Act (MAPA). As a result, the EMS Board will need to formally re-initiate rulemaking to adopt implementing rules for a program the Legislature established and funded in 2022.

Described earlier in this report, the newly enacted Emergency Medical Services Stabilization and Sustainability Program also requires the adoption of implementing rules for sustainability grants under that program – a process Maine EMS estimates could take one year or more. Many commission members expressed frustration with the ability of Maine EMS and the EMS Board to efficiently and timely initiate the rulemakings necessary to implement critical funding programs like these. Commission members learned that, when accounting for the additional time necessary to develop a proposed rule, an EMS Board rulemaking often takes a year or more, much of which does not involve the formal rulemaking process governed by the MAPA.

Given these recent difficulties by Maine EMS and the EMS Board in timely developing and adopting rules for critical programs, as directed by the Legislature, commission members expressed support for enacting legislation requiring Maine EMS to report to the Legislature when the EMS Board has failed to commence an initial rulemaking required by law within 90 days of the effective date of that law. That report should specify the reasons for the delay in commencement of rulemaking and the Board's plans for completion of the rulemaking process. Commission members also recommend that, for any new statutory programs or initiatives to be implemented by Maine EMS and the EMS Board with required rulemaking, the Legislature stipulate that the rulemaking be commenced within 90 days of the effective date of the proposal.

[43] Fourteen commission members voted in support of Recommendation B-5 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[44] See 32 MRSA §84.

C. System Resilience and Sustainability

While many of the measures recommended and discussed by this commission focused on the immediate short-term needs of the EMS system, the commission's members recognized that ensuring the long-term resilience and sustainability of EMS in Maine is just as critical. As previously described, following the adoption this year of a strategic plan, Maine EMS and the EMS Board are now currently engaged in a long-term reorganization of the EMS governance structure. While those organizational changes are designed to support a more resilient and sustainable EMS system, commission members recognized that there are many issues facing the EMS system beyond just its funding and governance structure.

Indeed, the commission devoted a significant amount of time to discussions regarding such issues, including: (1) the essentiality of EMS; (2) the implications posed by unserved and underserved areas, the so-called "ambulance deserts"; (3) the decline in volunteerism, especially within the EMS field; (4) the efficiencies and benefits that can be realized through the adoption of community or regional collaborative efforts in the delivery of EMS; and (5) other barriers to, as well as opportunities for, improving the resilience and sustainability of the EMS system in Maine. While the commission's previously described recommendations are unquestionably critical to ensuring a bright future for EMS in Maine, the following recommendations targeted at improving the resilience and sustainability of the EMS system are no less important.

Recommendation C-1: The Legislature should enact legislation requiring each municipality in the State to adopt a plan for the delivery of transporting EMS within the municipality.[45]

The Legislature in 2022 enacted Public Law 2021, chapter 749.[46] In addition to establishing the 2022 commission, that law also amended the "statement of purpose" of the Maine Emergency Medical Services Act of 1982 to add the following language: "The Legislature finds that emergency medical services provided by an ambulance service are essential services."[47] Commission members discussed at multiple meetings what it means to designate ambulance services or EMS as "essential services" and reviewed the approaches to such essential service designation taken by other states and the funding mechanisms for EMS implemented in those states.[48]

Recognizing that no entity in the State currently has a legal responsibility to provide or ensure the provision of EMS within a particular municipality or community, commission members discussed what the scope of that responsibility might be and who might be the appropriate entity to charge with that responsibility. Ultimately, commission members agreed that EMS is

[45] Fourteen commission members voted in support of Recommendation C-1 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[46] *See* P.L. 2022, ch. 749 (LD 1988) (available at https://legislature.maine.gov/billtracker/#Paper/1988?legislature=130).

[47] 32 MRSA §81-A.

[48] See chart included in Appendix E.

typically addressed and funded first and foremost at the local level and that each community is best positioned to decide how and at what level EMS is provided within that community. Commission members considered the implications of mandating municipalities at a minimum provide or facilitate the provision of transporting EMS within a municipality and the barriers to achieving that goal, particularly in very rural areas of the State and in the unorganized and deorganized areas that lack the governance structure of organized municipalities.

Commission members generally agreed that almost all organized municipalities in the State have in place some type of plan for providing transporting EMS, even if they do not directly provide or fund that service. Accordingly, commission members recommend that the Legislature enact legislation requiring each municipality in the State to adopt a plan for the delivery of transporting EMS within the municipality. In addition to reinforcing the essentiality of EMS within each community, commission members believe such a requirement will help to better identify those areas of the State that are underserved or unserved by EMS – the so-called "ambulance deserts." Collection of the information generated through the enactment of this requirement will undoubtedly assist the Legislature and Maine EMS in better targeting available funding to those areas of critical need.

Recommendation C-2: The Legislature should enact legislation establishing a permanent EMS commission, to be charged with monitoring and evaluating the statewide EMS system on a continuing basis and providing recommendations to Maine EMS and the Legislature regarding necessary changes to that system.[49]

As previously described, the establishment of this commission was one of a number of implemented recommendations of the 2022 commission. While the work done by both commissions has been critical in addressing many of the significant needs of the EMS system in Maine and in highlighting the scope of the problems faced by many EMS entities, due to the nature of legislative study commissions, the two commissions' time and resources were necessarily limited. Indeed, during each iteration of the commission, significant issues identified by commission members remained unresolved, most often due to a lack of time necessary to address them properly. Recognizing that there exists a continued need for this level of discussion by a diverse group of stakeholders regarding the issues facing and the future of the EMS system in Maine, commission members recommend that the Legislature enact legislation establishing a permanent EMS commission.

Such a permanent commission should be set up in a manner similar to the Maine Fire Protection Services Commission[50] and generally be charged with monitoring and evaluating the statewide EMS system on a continuing basis and providing recommendations to Maine EMS and the Legislature regarding necessary changes to that system. That commission should also be directed to consider and facilitate the implementation of measures designed to better recognize

[49] Fourteen commission members voted in support of Recommendation C-2 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[50] *See* 5 MRSA §3371.

and support the essentiality of EMS on a statewide and a regional basis as well as within each individual community.

Commission members believe that this permanent commission should have as diverse a membership as possible and that the Legislature should consider including as members any or all of the following: State legislators, Maine EMS, the EMS Board, the Department of Health and Human Services, the Maine Chapter of the American College of Emergency Physicians, the Maine Hospital Association, the Maine Ambulance Association, licensed EMS entities from both rural and non-rural areas, licensed EMS providers, Maine Municipal Association, the Maine County Commissioners Association, the Maine Community College System, the Governor's Office, the insurance industry and members of the public.

Recommendation C-3: The Legislature should enact legislation directing Maine EMS to develop and implement a public informational campaign designed to increase public awareness of and appreciation for the essential services provided by EMS providers in Maine.[51]

Commission members noted in discussions that, while most individuals expect to receive timely assistance with a medical issue after placing a 911 call requesting EMS, much of the public do not adequately understand or appreciate how that assistance is delivered, how the EMS system is designed or funded or the essentiality of the services provided by EMS entities in Maine. The commission recognized that one method of increasing public awareness of and appreciation for EMS in Maine is the development and implementation of a properly funded public informational campaign.

Commission members accordingly recommend that the Legislature enact legislation directing Maine EMS to develop and implement such a campaign and identify any funding needs that may be necessary for its successful implementation. Alternatively, if the Legislature establishes a permanent EMS commission as previously recommended, it may consider instead charging that permanent commission, in consultation with Maine EMS, with the development and implementation of the informational campaign described in this recommendation, provided that the commission has access to the resources necessary to support those efforts.

[51] Fourteen commission members voted in support of Recommendation C-3 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

Recommendation C-4: Maine EMS should collaborate with Volunteer Maine to evaluate opportunities for funding or otherwise facilitating volunteer management and leadership training for volunteer EMS providers and to support recruitment of volunteer EMS providers in Maine.[52]

As recognized by commission members, volunteer EMS providers and volunteer EMS entities provide a critical means of accessing EMS in many different communities throughout the State, particularly in many rural and hard-to-access areas. The barriers to entry, however, into the volunteer EMS field are in some ways more significant than for paid EMS and the recruitment, retention and training of volunteer EMS providers, especially those in leadership or management positions, present additional, substantial challenges.

To better address these issues and needs, commission members recommend that Maine EMS collaborate with Volunteer Maine to evaluate opportunities for funding or otherwise facilitating volunteer management and leadership training for volunteer EMS providers and to support recruitment of volunteer EMS providers in Maine.

Volunteer Maine, established in statute as the Maine Commission for Community Service,[53] describes its mission as building capacity and sustainability in Maine's volunteer and service communities by funding programs, developing managers of volunteers, raising awareness of sector issues and promoting service as a strategy.[54] Commission members believe Volunteer Maine is uniquely positioned to help identify and acquire available funding and resources and to assist in the implementation of strategies for leadership and management training and recruitment of volunteer EMS providers in Maine.

Recommendation C-5: The Legislature should support community collaboration in the development and implementation of tiered-response systems utilizing paramedic intercept programs.[55]

As identified by commission members in discussion, one particular issue faced by EMS entities is the costs and challenges associated with staffing and maintaining a paramedic level EMS. Although there exists a very real demand across the EMS system for paramedical services, many EMS calls require a lower response level. Committee members discussed opportunities for community collaboration in addressing this issue, specifically the development of tiered-response systems utilizing paramedic intercept programs within a group of municipalities or

[52] Fifteen commission members voted in support of Recommendation C-4 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Montejo, Petrie and Senecal), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

[53] *See* Title 5, Chapter 373.

[54] *See* https://volunteermaine.gov/commission.

[55] Fourteen commission members voted in support of Recommendation C-5 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

region, whereby one or more paramedic providers are shared within that service area. These types of programs allow the EMS entities operating in a multi-community area or region to more efficiently and cost-effectively target the use of paramedic level EMS to those calls where paramedical services are actually required.

While these programs hold significant potential in increasing the efficiency and sustainability of one important facet of the EMS system in Maine, the initial capital, start-up and operational costs for implementation can potentially be prohibitive. Commission members recommend the Legislature support community collaboration in the development and implementation of tiered-response systems utilizing paramedic intercept programs and identify and consider options for funding such programs, including, but not limited to, funding under the Maine Emergency Medical Services Community Grant Program and the Emergency Medical Services Stabilization and Sustainability Program.

Recommendation C-6: The Legislature should enact legislation amending the Maine Emergency Medical Services Act to authorize an EMS provider to render EMS within a hospital or health care facility where the EMS provider is a contractor of the hospital or facility but not an employee.[56]

The Legislature in 2023 enacted Public Law 2023, chapter 132, which clarified a number of laws regarding the delegating authority of a physician or physician assistant to EMS personnel or others as a medical assistant.[57] That law, among other things, amended the Maine Emergency Medical Services Act of 1982[58] as follows:

> **7. Delegation.** This chapter may not be construed to prohibit a person licensed as an emergency medical services person from rendering medical services in a hospital or other health care facility setting if those services are:
>
> A. Rendered in the person's capacity as an employee of the hospital or health care facility;
>
> B. Authorized by the hospital or health care facility; and
>
> C. Delegated in accordance with section 2594-A or, section 2594-E, subsection 4, section 3270-A or section 3270-E, subsection 4.
>
> Unless otherwise provided by law, an emergency medical services person licensed under this chapter may not simultaneously act as a licensee under this

[56] Fourteen commission members voted in support of Recommendation C-6 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), one commission member voted in opposition (Montejo), one commission member abstained (Roberts) and one commission member was absent (Hildreth).

[57] *See* P.L. 2023, ch. 132 (LD 1396) (available at https://legislature.maine.gov/billtracker/#Paper/1396?legislature=131).

[58] 32 MRSA §85(7).

chapter and an assistant performing medical services delegated by a physician in accordance with section 2594-A or section 3270-A or by a physician assistant in accordance with section 2594-E, subsection 4 or section 3270-E, subsection 4.

Commission members were notified during the commission process that an additional amendment to this section of law may be necessary to allow EMS providers who are contractors but not employees of a hospital or health care facility to render EMS within that hospital or facility. While acknowledging there might be potential concerns or unintended consequences of implementing such an amendment, which would undoubtedly be evaluated as part of the legislative process, commission members believe such a change could better support the retention of EMS providers by EMS entities and potentially in some cases benefit both the hospital and EMS system by better facilitating interfacility transfers.

Accordingly, commission members recommend the Legislature enact legislation amending 32 MRSA §85(7)(A) as follows to authorize an EMS provider to render EMS within a hospital or other health care facility setting where the EMS provider is a contractor of the hospital or facility but not an employee:

Sec. 1. 32 MRSA §85, sub-§7, ¶A is amended to read:

A. Rendered in the person's capacity as an employee or contractor of the hospital or health care facility;

Recommendation C-7: Using LD 1515 or other available legislative instruments, the Legislature should enact legislation necessary to better support and fund the EMS system and to better facilitate the efficient and sustainable delivery of EMS services in Maine.[59]

LD 1515, "An Act to Fund Delivery of Emergency Medical Services," was introduced in 2023 and referred to the Joint Standing Committee on Criminal Justice and Public Safety (CJPS).[60] The bill as printed provides General Fund appropriations to the Department of Public Safety to support existing transportation costs of EMS, which must be reduced to the maximum extent possible through the use of public and private Medicaid match programs. The CJPS Committee ultimately decided to carry the bill over to the 2024 session and the commission understands the bill is intended to be used as a potential vehicle for proposals relating to the EMS system that will be considered and discussed during the 2024 session.

As described in this report, the commission has proposed a variety of measures designed to better support and fund the EMS system and to better facilitate the efficient and sustainable delivery of EMS services in Maine. Moreover, as previously described, there are a number of other proposals that will be under consideration by the Legislature in 2024 that commission members

[59] Fourteen commission members voted in support of Recommendation C-7 (Senator Curry, Speaker Talbot Ross, Senator Farrin, Representative Blier, Representative Cyrway, Representative Salisbury and commission members Chase, Damon, Dow, Howell, Kellner, Kipfer, Petrie and Senecal), two commission members abstained (Montejo, Roberts) and one commission member was absent (Hildreth).

[60] More information on LD 1515 is available at https://legislature.maine.gov/billtracker/#Paper/1515?legislature=131.

support legislative action on. Although the commission recognizes that the CJPS Committee, upon receipt of this report, is authorized to report out a committee bill to implement recommendations set forth in this report, commission members recommend that the Legislature consider all potential options, including use of bills like LD 1515, in evaluating those recommendations and in taking actions to support and fund the EMS system. Commission members recognize that the use of existing legislation, such as LD 1515, presents an expedient option for consideration and implementation of these actions early in the 2024 session.

V. CONCLUSION

While the publication of this report brings to an end the work of this Blue Ribbon Commission to Study Emergency Medical Services in the State, commission members recognize that the need to better fund, support and plan the EMS system in Maine remains. The many recommendations included in this report will help to ensure a more efficient and resilient EMS system and a more sustainable future for EMS entities. Accordingly, commission members remain committed to ensuring the consideration and implementation of these critical reforms and initiatives by the Legislature, by Maine EMS and the EMS Board and within their respective communities.

The commission would like to extend its thanks to its members for committing their time, expertise and guidance in tackling the many complex issues facing the EMS system. The development and refinement of the recommendations included in this report would not have been possible without their diverse perspectives and vital input. Lastly, the commission would like to thank the EMS providers and entities that tirelessly dedicate their time and energy to ensuring the continued success of the EMS system in their respective communities and across the State.

APPENDIX A

Authorizing Legislation: Resolve 2023, c. 99

LAW WITHOUT GOVERNOR'S SIGNATURE

JULY 19, 2023

CHAPTER 99

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

H.P. 1090 - L.D. 1701

Resolve, to Reestablish and Continue the Work of the Blue Ribbon Commission to Study Emergency Medical Services in the State

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

Whereas, this resolve reestablishes the Blue Ribbon Commission to Study Emergency Medical Services in the State; and

Whereas, the study must be initiated before the expiration of the 90-day period in order to provide sufficient time for the study to be completed and a report submitted in time for submission to the next legislative session; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Establishment of Blue Ribbon Commission to Study Emergency Medical Services in the State. Resolved: That the Blue Ribbon Commission to Study Emergency Medical Services in the State, referred to in this resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 17 members:

1. Seven members appointed by the President of the Senate as follows:

A. Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;

B. Two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;

C. One member who represents a statewide association of emergency medical services providers;

D. One member who represents a private, for-profit ambulance service; and

E. One member who represents a statewide association of municipalities;

2. Eight members appointed by the Speaker of the House as follows:

A. Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;

B. One member who represents a tribal emergency medical service;

C. One member who represents a volunteer emergency medical service;

D. One member who represents a county government; and

E. One member who represents a statewide association of hospitals;

3. The Commissioner of Health and Human Services or the commissioner's designee; and

4. The director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the commission.

Sec. 4. Appointments; convening of commission. Resolved: That, notwithstanding Joint Rule 353, all appointments must be made no later than 15 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. Within 15 days after appointment of all members, the chairs shall call and convene the first meeting of the commission, which must be no later than 30 days following the appointment of all members.

Sec. 5. Duties; meetings. Resolved: That the commission shall examine and make recommendations on the structure, support and delivery of emergency medical services in the State. The commission shall maintain communication and coordinate with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission may look at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support. The commission is authorized to hold a maximum of 6 meetings.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, notwithstanding Joint Rule 353, no later than December 6, 2023, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Criminal Justice and Public Safety.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership List: Blue Ribbon Commission to Study Emergency Medical Services in the State

Blue Ribbon Commission to Study Emergency Medical Services in the State

Resolve 2023, Chapter 99

Membership List

Name	Representation
Senator Chip Curry (Senate Chair)	Member of the Senate
Speaker of the House Rachel Talbot Ross (House Chair)	Member of the House of Representatives
Senator Brad Farrin	Member of the Senate
Representative Suzanne Salisbury	Member of the House of Representatives
Representative Scott Cyrway	Member of the House of Representatives
Representative Mark Blier	Member of the House of Representatives
Robert Chase	Member who is employed or volunteers in the field of emergency medical services and represents a community of 10,000 residents or more
Scott Dow	Member who is employed or volunteers in the field of emergency medical services and represents a community of fewer than 10,000 residents
Joe Kellner	Member representing a statewide association of emergency medical services providers
Rick Petrie	Member representing a private, for-profit ambulance service
Kevin Howell	Member representing a statewide association of municipalities
Mike Hildreth	Member representing a tribal emergency medical service
Beth-Anne Damon	Member representing a volunteer emergency medical service
Carrie Kipfer	Member representing a county government
Mike Senecal	Member representing a statewide association of hospitals
Bill Montejo	Commissioner of Health and Human Services or the commissioner's designee
Anthony Roberts	Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee[1]

[1] Maine EMS Director Sam Hurley served as a commission member for the purposes of the October 23rd commission meeting. After that meeting and before the November 6th meeting, Director Hurley designated Maine EMS Deputy Director Anthony Roberts as his designee to the commission and Deputy Director Roberts served as a commission member for the remainder of the commission's meetings.

APPENDIX C

2022 Report of the Blue Ribbon Commission to Study Emergency Medical Services in the State

State of Maine
130th Legislature, Second Regular Session

Blue Ribbon Commission To Study Emergency Medical Services in the State

December 2022

Office of Policy and Legal Analysis

STATE OF MAINE
130th LEGISLATURE
SECOND REGULAR SESSION

Blue Ribbon Commission To Study Emergency Medical Services in the State

Members:
Sen. Chip Curry, Chair
Rep. Rachel Talbot Ross, Chair
Sen. Bradlee Farrin
Rep. Suzanne Salisbury
Rep. Richard Mason
Rep. Tim Theriault
Christopher Baker
Scott Dow
Kevin McGinnis
Richard Petrie
Melissa Doane
Brad Morris
Katelyn Damon
Carrie Kipfer
Joe Kellner
Lisa Letourneau
Sam Hurley

Staff:
Hillary Risler, Legislative Analyst
Daniel Tartakoff, Principal Analyst
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Executive Summary

The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Public Law 2021, chapter 749 (Appendix A).[1] Pursuant to the public law, the commission consisted of the following 17 members: two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature; two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents; one member who represents a statewide association of emergency medical services providers; one member who represents a private, for-profit ambulance service; one member who represents a statewide association of municipalities; four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature; one member who represents a tribal emergency medical service; one member who represents a volunteer emergency medical service; one member who represents a county government; one member who represents a statewide association of hospitals; the Commissioner of Health and Human Services or the commissioner's designee; and the Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

A list of commission members may be found in Appendix B.

The duties of the commission are set forth in Public Law 2021, chapter 749 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

Over the course of six meetings, the commission developed the following findings and recommendations:

Funding

Finding A-1: Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to support transporting EMS services in the State.

[1] Public Law 2021, chapter 749 also amends the Maine Emergency Medical Services Act of 1982 by including a legislative finding that emergency medical services provided by an ambulance service are essential services.

Recommendation A-1: The Legislature should fund the delivery of EMS in Maine by appropriating $70 million per year for the next five years from the General Fund to support existing transporting EMS services, with such appropriation amount to be reduced to the maximum extent possible through the utilization of public and private Medicaid match programs.

Recommendation A-2: The Legislature should initially allocate $25 million of that $70 million appropriation to specifically target transporting EMS services at immediate risk of failing and leaving their service area without access to adequate EMS.

Recommendation A-3: The Legislature should further fund the delivery of EMS in Maine by appropriating $6 million per year for the next five years from the General Fund for non-transporting emergency medical services.

Workforce Development, Education and Training

Recommendation B-1: The Legislature should explore options for providing staff of non-municipal, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.

Recommendation B-2: The Legislature should fully fund the Length of Service Award Program.

Recommendation B-3: The Legislature should direct Maine EMS, the Maine Community College System, and University of Maine System to convene a stakeholder work group to explore EMS career pathways and educational opportunities in the State.

Community Paramedicine

Recommendation C-1: To facilitate the growth of community paramedicine programs in Maine, the Legislature should explore options for addressing a potential disparity created by the statutory definition and licensure requirements of home health care providers and community paramedic requirements.

Continued Study of Emergency Medical Services in the State

Recommendation D-1: During the 131st Legislature, the Legislature should reestablish the Blue Ribbon Commission To Study Emergency Medical Services in the State.

I. Introduction

The Blue Ribbon Commission To Study Emergency Medical Services in the State, referred to in this report as the "commission," was established by Public Law 2021, chapter 749 (Appendix A).[2] Pursuant to the public law, the commission consisted of the following 17 members:

- Two members of the Senate, including one member of the party holding the largest number of seats in the Legislature and one member of the party holding the 2nd largest number of seats in the Legislature;
- Two members who are employed or volunteer in the field of emergency medical services, including one member who represents a community of 10,000 residents or more and one member who represents a community of fewer than 10,000 residents;
- One member who represents a statewide association of emergency medical services providers;
- One member who represents a private, for-profit ambulance service;
- One member who represents a statewide association of municipalities;
- Four members of the House of Representatives, including 2 members of the party holding the largest number of seats in the Legislature and 2 members of the party holding the 2nd largest number of seats in the Legislature;
- One member who represents a tribal emergency medical service;
- One member who represents a volunteer emergency medical service;
- One member who represents a county government;
- One member who represents a statewide association of hospitals;
- The Commissioner of Health and Human Services or the commissioner's designee; and
- The Director of Maine Emergency Medical Services within the Department of Public Safety or the director's designee.

A list of commission members may be found in Appendix B.

The duties of the commission are set forth in Public Law 2021, chapter 749 (Appendix A) and charge the commission to: examine and make recommendations on the structure, support and delivery of emergency medical services in the State; and maintain communication and coordinate

[2] Public Law 2021, chapter 749 also amends the Maine Emergency Medical Services Act of 1982 by including a legislative finding that emergency medical services provided by an ambulance service are essential services.

with Maine Emergency Medical Services as defined in the Maine Revised Statutes, Title 32, section 83, subsection 16-A so that Maine Emergency Medical Services is informed of the work of the commission and the commission is informed of the strategic planning work of Maine Emergency Medical Services. The commission was charged with looking at all aspects of emergency medical services, including but not limited to workforce development, training, compensation, retention, costs, reimbursement rates, organization and local and state support.

The commission was directed to submit a report, with findings and recommendations, including suggested legislation, to the joint standing committee of the Legislature having jurisdiction over public safety matters.

II. Commission Process

The commission was authorized to hold a maximum of six meetings, which were held on the following dates: September 1st, September 15th, October 6th, October 25th, November 14th, and December 5th. Meetings were conducted using a hybrid format, through which commission members could choose to attend each meeting in person or remotely. Members of the public were afforded an opportunity to attend each meeting in person or view a livestream or archived video recording of each meeting through the Legislature's website. Meeting materials, including meeting agendas and background materials can be found at https://legislature.maine.gov/emergency-medical-services-study.

At the first meeting[3] of the commission on September 1st, members gave extended introductions, including information about their background and involvement in or experience with EMS in Maine, the organization or interests they are representing on the commission and any additional information that members felt relevant to share with the commission. Commission staff reviewed the commission's authorizing legislation, Public Law 2021, chapter 749, including the commission's duties, process and timeline for the commission's work. In addition, commission member and Director of Maine Emergency Medical Services (Maine EMS) Sam Hurley provided an overview of EMS in Maine and Dia Gainor, Executive Director of the National Association of State EMS Officials (NASEMSO) provided an overview of EMS nationally. The meeting concluded with commission member discussion regarding the charge and duties of the commission, commission goals and desired outcomes.

The second meeting[4] of the commission took place on September 15th and began with an overview of historical funding requests by Maine EMS and the Department of Public Safety provided by Commissioner of Public Safety Michael Sauschuck. The commission also received an overview on the cost of the provision of services by commission member Joe Kellner. The commission further discussed EMS funding across the State and, at the chairs' request, commission members Carrie Kipfer, Joe Kellner, Chris Baker, Scott Dow and Katelyn Damon provided specific funding information on their respective agencies or organizations. Butch

[3] The archived video of the first meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86335&startDate=2022-09-01T12:30:00-04:00
[4] The archived video of the second meeting is available at the following link: https://legislature.maine.gov/audio/#127?event=86439&startDate=2022-09-15T13:00:00-04:00

Russell, President and CEO of North East Mobile Health, provided EMS funding information as well from his organization's perspective.

The third meeting[5] of the commission took place on October 6th and began with an overview on EMS workforce development and training programs provided by Eric Wellman, Emergency Medical Services Project Director at the Maine Community College System and Dennis Russell, Dean, Education Department Manager and Community Paramedicine Manager at United Training Center. The commission next received a presentation on the EMS workforce provided by Glenn Mills, Deputy Director of the Department of Labor's Center for Workforce Research and Information and a presentation on community paramedicine in Maine provided by Karen Pearson, Policy Associate at the Catherine Cutler Institute at the University of Southern Maine. The final presentation of the day was an update on the Maine EMS Strategic Planning Process provided by SafeTech Solutions consultant John Becknell. At the end of the third meeting, commission members discussed the process by which future commission discussion could be narrowed to focus on potential findings and recommendations. To prepare for that discussion at the next meeting, the chairs requested that commission members suggest potential findings and recommendations prior to the next meeting, to be compiled by staff.

The fourth meeting[6] was held on October 25th and began with a presentation by the consulting firm Sellers Dorsey on behalf of the Maine Ambulance Association regarding the potential implementation of an ambulance Medicaid supplemental payment program in Maine. The commission next heard from member Chris Baker regarding the operation of and challenges unique to a joint fire and ambulance service from his perspective serving with the joint fire/EMS in Old Town. Following these presentations, the discussion turned to the potential findings and recommendations to be included in the commission's final report. Prior to the meeting, the commission had received a document prepared by staff compiling what members had identified as potential findings and recommendations and which served as a framework for this discussion. Members opted to begin the discussion by addressing the EMS funding shortfall and potential solutions. Member Joe Kellner provided the commission with a brief presentation that both sought to identify the amount of that shortfall and provide a number of options for addressing it through State funding. Following additional discussion, the members present unanimously voted to recognize that there exists a funding shortfall in the EMS industry in Maine of roughly $70 million per year and that the shortfall should be addressed through the provision of State funding in that same amount annually over a 5-year period. Although members largely agreed that reporting and accountability mechanisms needed to be built into any such distribution of State dollars, there remained a difference of opinion over whether the funds should be distributed directly, through a Maine EMS-administered grant program or through some other method. Further discussion of the specific method of distributing these funds was accordingly deferred until the next meeting.

[5] The archived video of the third meeting is available at the following link:
https://legislature.maine.gov/audio/#228?event=86506&startDate=2022-10-06T13:00:00-04:00
[6] The archived video of the fourth meeting is available at the following link:
https://legislature.maine.gov/audio/#228?event=86527&startDate=2022-10-25T13:00:00-04:00

The fifth meeting[7] was held on November 14th, during which the commission continued its consideration of suggested findings and recommendations and voted on which findings and recommendations to include in the final report. Staff was assigned to draft a preliminary report including those findings and recommendations receiving a majority of votes from the members present and voting at the November 14th meeting, and information regarding the substantive discussions around those findings and recommendations.

The sixth and final meeting[8] was held on December 5th, during which the commission reviewed the draft report and provided suggestions and clarifications on its substance, including re-voting one recommendation to include an additional, substantive component. The findings and recommendations, and underlying votes, of the commission are described in detail in Part IV of this report. Members who were absent at the time of the votes were given the opportunity to submit their votes and those votes are reflected accordingly. Those who were not in attendance and did not subsequently submit a vote are reflected as absent.

III. Background Information

A. Overview of EMS in Maine

The Maine Emergency Medical Services program in Maine was initially established as the result of the federal Highway Safety Act of 1966, which provided that each state must formulate an emergency medical services program or lose a percentage of its national highway funds allocated for highway construction. Previously, funeral directors had been the primary providers of ambulance services. As funeral directors were ceasing to provide this service, citizens began to create volunteer ambulance services in their place. With the new federal law, the first state-sponsored EMS medical training was developed and by 1970, the Department for Licensure of Ambulance Services, Vehicles and Personnel had been created and began to initiate licensing. Over the next few years, federal grants were awarded to fund various city and regional EMS structures and in 1982, the Maine Legislature enacted the Maine Emergency Medical Services Act of 1982, establishing the basis for the current State EMS laws.

Today, EMS in Maine is comprised of three basic entities: the Bureau of Emergency Medical Services (Maine EMS), which is based within the Department of Public Safety; the Board of Emergency Medical Services (Board), which has statutory authority for EMS system oversight; and the EMS system itself, which is the collection of clinicians, first responders, dispatch centers, resources and medical directors throughout the State.

Maine EMS provides regulatory oversight of a variety of entities. These regulated entities include emergency medical dispatchers (EMD) and EMD centers; EMS ambulance operators, emergency medical responders (EMRs), emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics; non-transporting, transporting and air medical services and

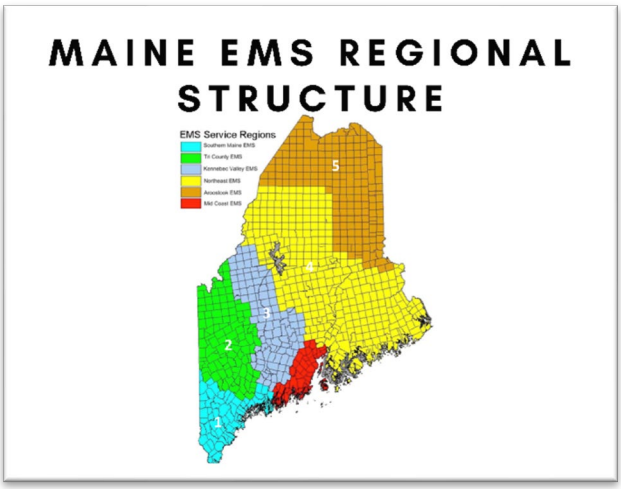
[7] The archived video of the fifth meeting is available at the following link: https://legislature.maine.gov/audio/#228?event=86572&startDate=2022-11-14T13:00:00-05:00
[8] The archived video of the sixth meeting is available at the following link: https://legislature.maine.gov/audio/#126?event=86678&startDate=2022-12-05T13:00:00-05:00

emergency vehicles (ambulances, response vehicles and air ambulances); and EMS training centers, which include instructors and coordinators and initial and continuing education courses.

As of January 2021, Maine has over 276 licensed services responsible for delivering emergency medical services throughout the State, including:

- 173 fire departments;
- 41 nonprofit, community-based EMS services;
- 35 independent municipal EMS services;
- 11 private EMS services;
- 11 hospital-based EMS services;
- 3 college-based EMS services;
- 2 tribal EMS services; and
- 1 air medical service.[9]

The State is divided into six EMS regions, each with a regional council, office and medical director. The regional EMS offices are each independent not-for-profit 501(c)(3) corporations that contract with Maine EMS to coordinate the EMS system in their respective region. Those six regions are shown in the chart on the left.[10]

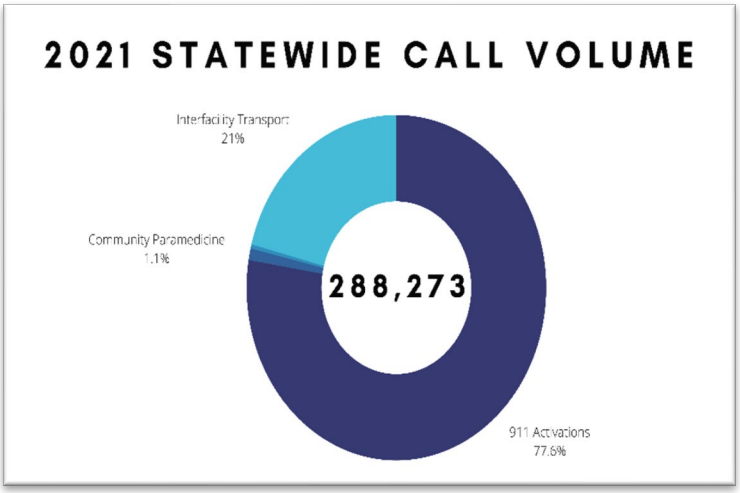


The delivery of emergency medical services, however, is exclusively provided at the local level. Accordingly, how the delivery of EMS is organized and financed varies significantly from community to community. Some communities rely on municipal fire departments or dedicated EMS departments, while others may contract with private, non-profit community-based, or hospital-based EMS services. Each service model has its own challenges and advantages but regardless of the type of service and service mix, in each community EMS provides coordinated response and emergency medical care involving multiple people and agencies and has to be ready at all times to respond a call. All of these components as a whole constitute what we think of as "EMS" in Maine.

[9] *See* https://www.maine.gov/ems/whatisems.
[10] *See* Maine EMS September 1st presentation materials, which can be found at https://legislature.maine.gov/doc/8817.

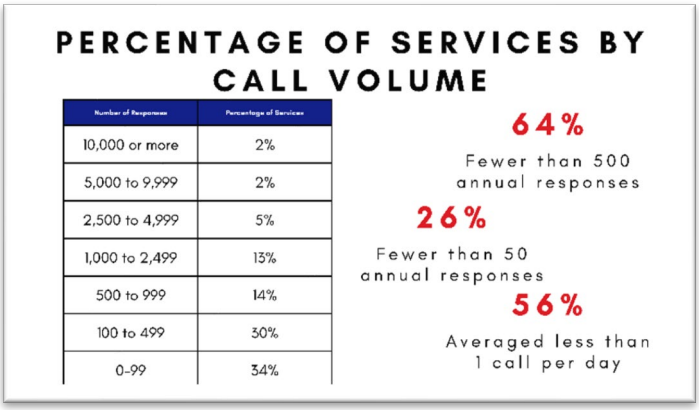
B. Costs of EMS and Reimbursements

Funding of EMS is complicated, partly because each EMS service has different service mixes as previously noted, but also because of varying call volumes, geographic areas and service structures. Statewide, EMS is funded primarily through insurance reimbursement – both public and private. Public Medicare and Medicaid reimbursement is the largest funding source, although reimbursement may also be provided through hospitals or medical facilities, commercial insurers, and self-pay patients.[11] Reimbursement, and especially Medicare and Medicaid reimbursement is particularly complex.



To understand EMS costs and reimbursements, it can be helpful to start first with an understanding call volume. In 2021, there were approximately 288,273 calls for EMS. As shown in the chart on the right,[12] 911 activations accounted for 77.6% of those transports. Interfacility transport (IFT), which is the transport of a person from one medical facility to another medical facility, accounted for 21% of those transports. Community paramedicine, which represents an expanded role for EMS providers to assist with both public health and primary healthcare to underserved populations without the duplication of services, accounted for 1.1% of those transports.

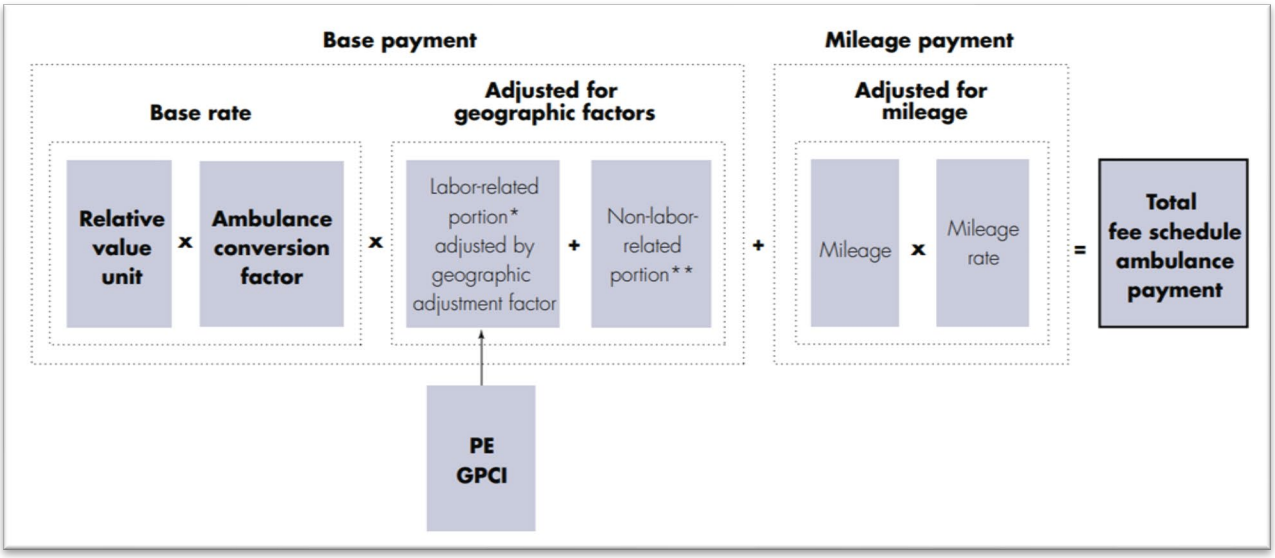
Most EMS services in Maine do not respond to a large call volume. The chart to the left shows the percentage of services by call volume.[13] Even EMS services that have a low volume of calls, however, must have the staff and equipment necessary to be able to provide a continuous, 24/7 ambulance response and services must be geographically dispersed so as to be able to respond to those calls in a timely manner. This is what is commonly referred to as the "cost of readiness." By using call volume as an indicator of "cost-per-call," a service with a low call volume will necessarily have a higher cost-per-call because all of the overhead costs to run an EMS service are spread amongst fewer calls.



[11] The commission estimates that only approximate 18-20% of funding comes from private reimbursement, although that percentage can be expected to vary from region to region and service to service.
[12] *See id.*
[13] *See id.*

There is limited data on the cost of providing ambulance services, which is contributing to low reimbursement rates. It can also be difficult to calculate the exact cost of EMS where, for example, a municipality has a joint fire/EMS department. The commission did receive information from members regarding EMS budgets from a variety of different service types, including services representing a large city service, a joint fire/EMS department, a small/rural service, a volunteer service and a regional service. In addition, commission member Joe Kellner presented on the cost of EMS and provided an illustrative sample ambulance budget.[14] For each service, a number of factors contribute to the cost of providing ambulance services, including, but not limited to: general budget items, such as salaries and wages, supplies, dispatch and billing, equipment, repairs and maintenance and fuel costs; population density; call volume and volume of transports; types of services provided; grants and fundraising; and staffing and level of staff training and use of volunteers. Of course, underlying all of these costs, is the "cost of readiness," as previously described.

Reimbursement through Medicare and Medicaid is based on the ambulance fee schedule, which has two components: a base payment, which contains seven distinct levels of ground transport ambulance service representing varying levels of service intensity, and a mileage payment. There are also add-on payments tied to the mode of ambulance transportation and/or geographic location, which include rural and super rural add-ons as determined by zip code. Rates are updated annually by the ambulance inflation factor, which is an amount equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) reduced by the 10-year moving average of multi-factor productivity. The update for 2021 was 0.2 percent. Ambulance add-on payments, which will expire at the end of 2022, include: 2% for urban, 3% for rural and 22.6% for super-rural. MaineCare pays at average Medicare rates based on the lowest geographic practice cost index (GPCI).[15] This equation can also be mapped out as follows.



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[14] *See* September 15 meeting materials, which can be found at https://legislature.maine.gov/ems-study-meeting-9152022.
[15] *See id.*
[16] *See id.*

It is vitally important to consider, however, that a call which does not result in transport does not result in payment, further exacerbating the gap between the cost of delivering EMS and the reimbursement received. Using the data that is available and by making a few assumptions,[17] the difference between the cost-per-call and reimbursement-per-call can be estimated as follows.

Call Volume	300	600	900	1200	1500	1800	2100
Cost per Call	$2,522.06	$ 1,301.37	$ 894.47	$ 1,177.20	$ 958.99	$ 813.51	$ 709.60
Reimbursement per Call	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99	$ 491.99
Loss per Transport	$ 2,030	$ 809	$ 402	$ 685	$ 467	$ 322	$ 218
Total Gap	$609,020.97	$485,625.81	$362,230.65	$822,253.61	$700,496.45	$578,739.29	$456,982.13

Thus, although the cost per call is much greater for a service with a low call volume, the reimbursement per call remains the same, and even for those services with the greatest call volume, the reimbursement is still not sufficient to cover the costs. This is because the reimbursement through Medicare and Medicaid is antiquated and woefully inadequate, made worse in a state as rural and geographically diverse as Maine.

C. Subsidies

The difference between an EMS service's cost-per-call and reimbursement must be made up through subsidies. Current subsidies take many forms and no EMS services in the State use the exact same model. Subsidies that are utilized include taxpayer support, municipal contributions, commercial payers, philanthropy and grants. One of the biggest subsidies underwriting EMS, however, is volunteer and underpaid labor.

EMS in Maine has been highly dependent on and values the role of volunteerism and service in the creation of locally-developed EMS services. While recognizing that volunteerism will always have a role in EMS, it is admittedly not a reliable solution to the central challenges to the long-term sustainability of the EMS system. Declining volunteerism coupled with a dependence on an underpaid workforce that hampers recruitment and retention has necessarily required greater reliance on other subsidies, thereby increasing costs to local municipalities and taxpayers. Declining volunteerism has also helped to reveal the true cost of EMS, which comes as a shock to many communities now struggling to provide those services locally.

Absent a subsidy, transporting EMS services cannot break even in the State, regardless of service mix, and all transporting EMS services are currently operating at a loss. As demonstrated in the previous chart, to break even, a high-efficiency (1,800 transports per year) service would need a subsidy of approximately $322 per transport; for a more rural, low-volume service (300 transports per year), a subsidy of $2,030 per transport is needed. Relying on current subsidies without additional State assistance is insufficient to meet the existing need for transporting EMS

[17] *See id.*

services and, as the commission heard throughout its work, all EMS services in Maine are currently operating at a loss.

D. EMS Workforce, Education and Training

As mentioned above, one of the largest subsidizations of EMS services in Maine is a volunteer and underpaid workforce. Volunteerism, however, is declining and struggles with EMS employee recruitment and retention have exacerbated problems for a workforce that is already stretched too thin. A primary contributor to these recruitment and retention issues is the generally inadequate compensation and benefits offered to many EMS employees. As noted by the Maine Department of Labor (MDOL), the average annual salary for an EMT in Maine varies, depending on location, from $29,225 to $35,542, while the annual average salary for a paramedic varies from $38,836 to $53,244. Due to the significant funding problems that all EMS services face in Maine, the compensation, benefits and working conditions generally offered to EMS employees are often insufficient to recruit and retain the workforce needed to effectively and efficiently deliver EMS across the State. Per a 2021 MDOL survey, EMS services generally reported difficulties hiring EMTs, AEMTs and paramedics and consequently have had to rely on per diem staffing and volunteer positions to fulfill their workforce needs.

At the same time that EMS services are reporting such significant staffing issues, the commission also received information suggesting an increasing recent demand for EMS educational and training programs in the State. There are multiple EMS training centers in Maine provided through regional EMS offices, private ambulance services and the Maine Community College System, which offer education and training opportunities for EMRs, EMTs, AEMTs and paramedics. Additionally, the MDOL has also partnered with other State agencies and the University of Maine System to offer continued healthcare training and career advancement opportunities for EMS staff through the Healthcare Training for ME program. Funding for many of these programs for both participants and educators remains an outstanding need and it was noted to the commission that the retention of individuals completing those programs in the traditional EMS field has been problematic.

All of these factors are contributing to bringing EMS in Maine to a breaking point. Legislative action will be necessary to ensure the short-term and long-term future of EMS in the State. Accordingly, the commission makes the following findings and recommendations.

IV. Findings and Recommendations

A. Funding

From the very first meeting of the commission, members expressed grave concern that EMS in the State is not only at the edge of a cliff but that in many areas of the State, particularly rural areas, EMS is already over that cliff. The primary issue facing EMS is a lack of funding. As established by the Legislature pursuant to Public Law 2021, chapter 749, which also authorized this commission, emergency medical services provided by an ambulance service are essential

services.[18] Funding is necessary and vital to delivering those essential services. That funding comes down to two key components: the cost of providing services – including the cost of readiness – and the funds necessary to cover those costs, currently fulfilled through Medicare and Medicaid and private insurance reimbursement and other subsidies.

The federal Centers for Medicare and Medicaid Services is currently conducting a cost study on ground ambulance services. This study is anticipated to more accurately identify how much it costs to actually deliver EMS and to result in a corresponding increase in reimbursement rates. That cost study will take time, however, and it is unlikely that any of those reimbursement rate increases will be implemented within the next five years.

In the meantime, it is critical that the State support EMS in Maine to avoid EMS service closures and to ensure that, when Mainers call for EMS, there are services able to respond wherever they are needed in a timely manner. Accordingly, the commission makes the following findings and recommendations relating to the funding of EMS in Maine.

Finding A-1: Recognizing that EMS reimbursements are not keeping pace with the cost of providing services and that current subsidies are increasingly insufficient to fund the gap between those figures, the commission finds that, in addition to existing subsidies, there is a need for $70 million in funding a year for the next 5 years to support transporting EMS services in the State.[19]

While it is apparent to those involved in EMS that current funding is woefully inadequate, it is harder to determine exactly what the actual need is to ensure that EMS services have the funding necessary to provide their critical services. The commission recognized from the beginning of its work that funding this need is crucial to ensuring the survival of EMS services in Maine.

As noted previously in this report, there is limited data on the cost of providing ambulance services. Additionally, even with examining the actual cost data available, that data is necessarily deficient because it relies on the provision of EMS through volunteerism, low wages and donated labor. Without subsidies and with reimbursement rates only covering 60-80% of the cost of service, it is clear that the shortfall between cost of service and revenue is greater than $70 million.

Nevertheless, a majority of commission members recognize the importance and immediate need of funding transporting services in a way that will make a meaningful difference. Those members accordingly determined that, at a minimum, there is a need for $70 million in funding each year for the next five years – in addition to current subsidies – to support transporting EMS services in Maine.

[18] *See* Appendix A.

[19] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris and Kellner. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

To determine the amount of this need, the commission utilized the calculation of loss per transport as explained in a presentation by commission member Joe Kellner.[20] Essentially, this calculation begins with a base rate, suggested at what is deemed to be a high-efficiency EMS service with about an 1,800 call volume annually. At that annual call volume, it is estimated that such a service will lose approximately $325 per transport, including all types of transport, such as 911 calls, interfacility transport, etc. Not all EMS services operate with that level of call volume, however, and in fact many services in Maine are rural services with a much lower annual call volume. Accordingly, the commission included a "rural adjustment" utilizing the USDA zip-code-based rurality scores to determine a multiplier. Thus, for each EMS service, the commission was able to roughly determine the amount of need per call necessary to better support that service.

The commission used this calculation method to determine that the total need throughout the State for transporting EMS services is $70 million per year, which can be broken down, depending on the chosen disbursement method, either by transporting service, by service mix or using some other methodology. This total number is essentially the minimum amount necessary to support transporting EMS services in Maine over the next five years until increased Medicare and Medicaid reimbursement rates are expected to be available.

Recommendation A-1: The Legislature should fund the delivery of EMS in Maine by appropriating $70 million per year for the next five years from the General Fund to support existing transporting EMS services, with such appropriation amount to be reduced to the maximum extent possible through the utilization of public and private Medicaid match programs.[21]

A majority of commission members recommend that the Legislature fund this identified need over a five-year period, with the funding limited to those EMS services that are currently operating in the State – or their successor organizations, if for example, services seek to regionalize or otherwise improve their efficiency – rather than be used to provide funding to new services. The commission, also emphasizes and recommends that this amount be offset through the use of federal funds. In particular, the Legislature should pursue the use of the Medicaid Supplemental Payment Program for non-municipal ambulance services and Certified Public Expenditure (CPE) programs for municipal services to maximize Medicaid matching.

For non-municipal ambulance services (for-profit, non-profit and volunteer services), federal Medicaid law allows states to establish a program under which a state collects an assessment from those services and uses that money as that state's share for federal Medicaid matching funds, thus increasing Medicaid rates by making supplemental payments to those services. Similar assessment programs have been used to benefit hospital and nursing home industries here in Maine and nationally. To establish such an assessment program, the Legislature should direct the Maine Department of Health and Human Services to collect the assessment from each

[20] *See* Maine Ambulance Association EMS Funding Proposal presentation from the October 25th Meeting, which can be found as Appendix C and at https://legislature.maine.gov/doc/9181.

[21] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, McGinnis and Morris. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

non-municipal ambulance service (for-profit, non-profit and volunteer service) and, with the funds generated from the assessment, match available federal Medicaid dollars. MaineCare would then make the corresponding supplemental Medicaid payments to these non-municipal ambulance services. Draft legislation provided by consultant Sellers Dorsey, which presented to the commission at its October 25th meeting, is included as Appendix D. Sellers Dorsey estimates that the net gain – the increase in supplemental payments minus the assessment paid – to each service will vary but, for the industry as a whole, the supplemental payments should be at least two times the amount of the assessments paid by all such services, which will help offset the funds needed from the State to meet the identified need.

For municipal EMS services, the commission recommends the use of CPE programs to help offset the identified need. A CPE program is a Medicaid financing approach by which a governmental entity, including a governmental service such as a municipal EMS service, incurs an expenditure eligible for federal financial participation (FFP) under the state's approved Medicaid State plan. The governmental entity is required to certify that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the State then claims FFP.[22] To maximize the use of the federal funds available under a CPE program, the Legislature should direct the Department of Health and Human Services to include such a program in its Medicaid State plan and to provide the support, resources and education necessary for municipal EMS services to most effectively take advantage of the program.

Recommendation A-2: The Legislature should initially allocate $25 million of the recommended $70 million appropriation to specifically target transporting EMS services at immediate risk of failing and leaving their service area without access to adequate EMS.[23]

The commission consistently recognized that there are two components to funding EMS needs in the State: (1) immediate crisis funding for EMS services at the highest risk of failing and (2) long-term funding for the sustainability of the future of EMS in the State. Accordingly, a majority of commission members recommend that of the $70 million in funding identified in the prior recommendation, during the first two years in which that funding is available, $25 million in each year should be immediately set aside in a non-lapsing fund to be targeted specifically to those EMS services at immediate risk of failing and leaving residents of those service areas without adequate EMS.

When a person calls 911, the person expects that an EMS service will provide an immediate response and be able to provide the necessary medical care and transport, if required, to the patient. There are EMS services in this State, however, that are in danger of failing due to a lack of funding, not only from low reimbursement rates but from difficulty in finding volunteers and a high workforce turnover. These services need immediate assistance and, without that assistance, their service areas will no longer have necessary EMS coverage. By specifically targeting this

[22] *See* https://www.macpac.gov/subtopic/non-federal-financing/#:~:text=A%20CPE%20is%20a%20statutorily,Act%3B%2042%20CFR%20433.51).

[23] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, Morris and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

funding initially to those services with the greatest need, the residents of those areas will not lose access to EMS and the immediate influx in funding will allow those services to better plan for long-term sustainability.

Recommendation A-3: The Legislature should further fund the delivery of EMS in Maine by appropriating $6 million per year for the next five years from the General Fund for non-transporting emergency medical services.[24]

In addition to the 171 transporting EMS services in the State, there are 103 non-transporting EMS services. A non-transporting EMS service is defined as any organization, person or persons who hold themselves out as providers of emergency medical treatment and who do not routinely provide transportation to ill or injured persons, and who routinely offer or provide services to the general public beyond the boundaries of a single recreational site, business, school or other facility. Non-transporting services generally respond to a location of a medical emergency to provide immediate medical care but do not provide patient transport. Examples may include fire apparatus, response cars or other non-transport vehicles.

The commission identified that non-transporting EMS services are also in need of funds. Accordingly, a majority of commission members recommend that the Legislature fund $6 million per year over the next five years for non-transporting EMS services. This infusion of funding will help non-transporting EMS services with their immediate need, thereby allowing them to put plans in place for their long-term sustainability following the five-year period.

B. Workforce Development, Education and Training

The commission dedicated a substantial portion of its time discussing and identifying potential solutions to EMS workforce issues, which are significantly impacting the delivery of EMS in Maine, leading to delayed emergency response times and to an overworked and overstressed workforce.

Recommendation B-1: The Legislature should explore options for providing staff of non-municipal, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.[25]

As previously noted, a primary contributor to the EMS employee recruitment and retention issues faced by EMS services across the State are the insufficient compensation and benefits offered to EMS employees. Although the provision of supplemental funding for EMS services

[24] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Morris, McGinnis and Kellner. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

[25] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Doane, Damon, McGinnis, Morris and Kellner. Commission member Hurley abstained from the vote and commission members Mason, Theriault and Letourneau were absent. Commission member Dow voted in opposition to this recommendation because, although he has no concerns with access to the Maine State Retirement System, he is concerned that he, as most municipal employees, have the same coverage as most other services, which is a group plan, and that municipal services will begin to lose people, and that this will just be shifting the problem around, not solving it.

proposed in the prior recommendations will allow for enhancement of employee compensation and benefits during the period in which that funding is available, the commission recognized that there are other mechanisms that might be employed to address those same concerns. One such mechanism, which was supported by a majority of commission members at the fifth meeting, is for the Legislature to explore options for providing staff of non-governmental, nonprofit licensed EMS services access to the Maine State Retirement System and to State of Maine healthcare benefits.

Many of the 272 licensed EMS services in Maine are governmental services and are therefore able to provide staff with access to the Maine State Retirement System. Staff of non-governmental EMS services may be offered access to a retirement benefits package through their employer although the benefits offered to such individuals varies across Maine. Offering access to State retirement benefits and State healthcare benefits to employees of licensed non-governmental, nonprofit EMS services may serve to boost employee recruitment and retention for those services, which fill a critical need for the delivery of EMS in many areas of the State. The commission is committed to supporting the Legislature as it explores this recommendation, recognizing that facilitating this change will require the consideration of a myriad of factors and, potentially, the expenditure of State funds.

Recommendation B-2: The Legislature should fully fund the Length of Service Award Program (5 MRSA §3372).[26]

The Length of Service Award Program (LOSAP), 5 MRSA §3372, was enacted in 2015 to provide paid length of service awards to eligible volunteers. Under the program, an "eligible volunteer" is an active part-time or on-call member of a fire department or a volunteer firefighter or a licensed EMS person or ambulance operator who provides on-call, part-time or volunteer emergency medical response under the direction of a fire department chief or for an ambulance service or a non-transporting EMS. The LOSAP rewards these eligible volunteers for the service to their communities with contributions to a retirement program. Participants are generally eligible for such benefits at the earlier of attaining sixty-five years of age or 20 years of service credit.

The LOSAP can accept funding from the federal government, the State or a municipality; however, when it was established in 2015, no State funds were provided and since that time, there have only been three one-time funding initiatives enacted totaling $2 million.[27] At this time, there is no dedicated funding source for the LOSAP and it is unclear what the anticipated needs of the program currently are or are anticipated to be beyond the $2 million already appropriated. Commission members, however, believe that the benefits that can be provided through the LOSAP represent another important mechanism by which EMS staff recruitment and retention rates can be improved. Consequently, a majority of commission members at the fifth

[26] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris and Kellner. Commission member Hurley abstained from the vote and commission members Mason, Theriault and Letourneau were absent.

[27] *See* Public Law 2021, Chapter 444, which provided a one-time General Fund appropriation of $500,000 in Fiscal Year 21-22; Public Law 2021, Chapter 721, which provided a one-time General Fund appropriation of $500,000 in Fiscal Year 22-23; Public Law 2021, Chapter 635, Section A-16), which provided a one-time General Fund appropriation of $1,000,000 in FY 22-23.

meeting support the Legislature funding the LOSAP at a level necessary to meet that program's current and anticipated future needs, with consideration given to the establishment of a dedicated funding source.

Recommendation B-3: The Legislature should direct Maine EMS, the Maine Community College System, and University of Maine System to convene a stakeholder work group to explore EMS career pathways and educational opportunities in the State.[28]

Although, as the commission heard, there exist a number of public and private educational and training programs for EMS providers in Maine that have seen an increasing demand for services, the retention of the individuals completing those programs in the traditional EMS field has been problematic. To ensure that the educational and training options available in the State are best designed and coordinated to enhance the recruitment and retention of EMS service employees in the traditional EMS field and where the staffing demands of EMS services are the greatest, a majority of commission members at the fifth meeting stated their support for the Legislature directing the convening of a stakeholder workgroup to explore EMS career pathways and educational opportunities in the State.

To ensure that a broad spectrum of experiences and backgrounds are present on the workgroup, it should include representatives of Maine EMS, the Maine Community College System, the University of Maine System, other public and private entities that provide EMS educational or training programs in the State and other individuals with relevant backgrounds and experiences in EMS education and training and in the delivery of EMS generally. To facilitate consideration of any findings or recommendations that may arise out of this workgroup, the Legislature should consider requiring the submission of a report by the workgroup outlining the activities of the workgroup and any recommendations proposed by its members, including proposed legislation where appropriate.

C. Community Paramedicine

As the commission heard during their October 6th meeting, community paramedicine is an evolving model of healthcare delivery in both rural and urban areas as EMS services look to reduce the use of EMS for non-emergency 911 calls, the overcrowding of emergency departments and healthcare costs. Community paramedicine is an important part of the EMS system in the State and has been proven to be impactful and to reduce healthcare costs. The commission supports opportunities to expand community paramedicine programs, including exploring reimbursement models and revenue streams that would support these programs.[29] There is no single model of community paramedicine – rather programs are based on community needs and services. Community paramedicine pilot projects were authorized by the 125th Maine Legislature and expanded during the 128th Maine Legislature. There have been additional

[28] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, McGinnis, Morris, Kellner and Hurley. Commission members Mason, Theriault, and Letourneau were absent.

[29] Commission member and Director of Maine EMS, Sam Hurley, noted that this is an issue that Maine EMS is currently working to address through facilitating modifications to the State's MaineCare plan to allow reimbursement for community paramedicine services.

studies, including the Lincoln County Community Paramedicine Data Collection Initiative in 2019 and, in 2022, Maine EMS contracted with the Catherine Cutler Institute to expand this pilot study and evaluate programs in Maine. The commission believes in the importance of community paramedicine but identified a potential disparity in statutory and licensing requirements and accordingly makes the following finding and recommendation.

Recommendation C-1: To facilitate the growth of community paramedicine programs in Maine, the Legislature should explore options for addressing a potential disparity created by the statutory definition and licensure requirements of home health care providers and community paramedic requirements.[30]

One of the challenges with growing community paramedicine programs is the potential overlap between community paramedics and other home health care professionals. The commission identified a potential disparity in the statutory definition and licensure requirements of home health care providers and community paramedic requirements that jeopardizes the community paramedic programs that the Legislature should address.

Title 22, section 2143 of the Maine Revised Statutes prohibits a home health care provider from providing home health services without a license. A home health care provider is defined as "any business entity or subdivision thereof, whether public or private, proprietary or not for profit, that is engaged in providing acute, restorative, rehabilitative, maintenance, preventive or health promotion services through professional nursing or another therapeutic service, such as physical therapy, home health aides, nurse assistants, medical social work, nutritionist services or personal care services, either directly or through contractual agreement, in a client's place of residence."[31] This term does not apply to any sole practitioner providing private duty nursing services or other restorative, rehabilitative, maintenance, preventive or health promotion services in a client's place of residence or to municipal entities providing health promotion services in a client's place of residence.[32] It also does not apply to a federally qualified health center or a rural health clinic as defined in 42 United States Code, Section 1395x, subsection (aa) (1993) that is delivering case management services or health education in a client's place of residence.[33] Beginning October 1, 1991, "home health care provider" includes any business entity or subdivision thereof, whether public or private, proprietary or nonprofit, that is engaged in providing speech pathology services."[34]

Community paramedicine, on the other hand, is established as "the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically

[30] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Doane, Damon, Kipfer, McGinnis, Morris, and Kellner. Commission member Letourneau abstained from the vote and commission members Mason and Theriault were absent. Commission member Dow voted in opposition to this recommendation, with the question of why community paramedics are not currently in the home health sector and that that would solve many of the problems.
[31] 22 MRSA §2142(3).
[32] *Id.*
[33] *Id.*
[34] *Id.*

requested or directed by a physician" and operates under the rules established by the Maine EMS Board.[35]

These overlapping concepts have created confusion over the licensure requirements for community paramedics and the licensure requirements for home health care providers and a majority of commission members believes that there needs to be clearer delineation between the requirements applicable to these two categories of regulated entities.

Accordingly, a majority of commission members recommend that the Legislature further explore this potential disparity with the goal of better delineating in statutory definitions and licensure requirements, the differences between the two roles, which will, in turn, grow and further enable community paramedicine programs in the State. Members of the commission noted that community paramedic programs do not have, and should not need, home health service licenses, as they are licensed separately under the rules established by the Maine EMS Board. Some members did caution, however, about potential unintended consequences of simply exempting community paramedics from home health service licensure requirements.

D. Continued Study of Emergency Medical Services in the State

Through six meetings, the commission heard from its members, stakeholders and others about EMS in Maine and many of the challenges to the funding, support and delivery of EMS services and regarding how all aspects of EMS, including workforce development, training, compensation, retention costs, reimbursement rates, organization and local and state support, contribute to the system. Although many of these aspects are touched on in the commission's findings and recommendations, there remain many aspects of that system and identified issues the commission was not able to fully explore or examine in its limited time.

In addition, as recognized in the commission's duties, the commission's work was conducted parallel to the strategic planning work undertaken by Maine EMS. Maine EMS contracted with a consultant, SafeTech Solutions, to engage in strategic planning process of Maine EMS and the EMS Board to put forward a vision and plan for the future of Maine EMS and to make recommendations on its short-term and long-term sustainability. The commission heard from the consultant, John Becknell, during its October 25th meeting, however, the work of the strategic planning process was not completed by the time the commission held its final meetings and voted on findings and recommendations. Accordingly, a majority of commission members make the following recommendation.

Recommendation D-1: During the 131st Legislature, the Legislature should reestablish the Blue Ribbon Commission To Study Emergency Medical Services in the State.[36]

A majority of commission members do not feel that the commission's work is complete and recognizes that there are still outstanding issues that need to be addressed to ensure the short-

[35] *See* 32 MRSA §84(4).

[36] Commission members voting to support this recommendation were Curry, Talbot Ross, Farrin, Salisbury, Petrie, Baker, Kipfer, Dow, Doane, Damon, Kellner, Morris and McGinnis. Commission members Hurley and Letourneau abstained from the vote and commission members Mason and Theriault were absent.

term and long-term sustainability of EMS in Maine. This can best be accomplished by continuing to bring together legislators, experts and EMS providers to collaborate and advise the Legislature on the best paths forward. This need is particularly acute as the Maine EMS strategic planning process concludes and makes its recommendations to Maine EMS, the EMS Board, the Department of Public Safety and ultimately the Legislature.

From the beginning of its work, the Legislature and the commission recognized the need for the strategic planning process to inform the work of the commission and vice-versa. The commission believes that reestablishing this commission in the 131st Legislature will allow that communication to continue. A reestablished commission would be better positioned to evaluate the strategic planning recommendations as well as progress made on EMS as identified in this report. The commission discussed that the State needs to build a better, more supportive structure, but that this commission was not at a place to make specific recommendations. However, it is anticipated that the strategic plan will include recommendations on the structure of Maine EMS and the delivery of EMS in the State. Commission members noted how important it is that everyone who is involved in EMS have a voice in the structure of the delivery of services and that those voices be heard by policy- and decisionmakers. A reestablished commission will be better positioned to evaluate recommendations regarding system structure and sustainability. It is critical that the State continue to support the structure, at the state and local level, and the delivery of EMS in the State and continuing the work of this commission as proposed above will help to fulfill that important purpose.

V. Conclusion

The commission's work and publication of its report comes at a time when EMS in the State is in crisis. EMS services in Maine are at the edge of a cliff, or over it, and changes must occur to ensure that when someone calls with a medical emergency, EMS services are able and ready to assist. This requires, first and foremost, increased funding for the delivery of EMS. Current subsidies, especially volunteerism, are declining and revealing the true cost of EMS, and the State must step in to ensure that EMS does not disappear in parts of this State.

Of course, this work does not end with the commission's report and the commission hopes that the findings and recommendations contained in this report demonstrate not only the dire need within the EMS system but also the first steps towards ensuring both the short-term and long-term sustainability of the system. Members of the commission look forward to working with the 131st Legislature to refine the details of these recommendations and maintain focus on this critically important issue and Maine's EMS workforce.

Finally, the commission would like to thank all of its members and presenters for generously offering their time, expertise and advice on the complicated issues involved in funding and supporting EMS in the State. Their knowledge and perspectives were invaluable in developing the findings and recommendations of the commission. Additionally, the EMS system in Maine would not exist without EMS providers and the commission would like thank all of them who dedicate their time – often overburdened and underpaid – to serving their communities and the State.

APPENDIX D

Bills Related to EMS Considered During the 131st Legislature (OPLA)

Bills Related to EMS Considered During the 131st Legislature, First Regular and First Special Sessions

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
EMS FUNDING				
LD 258, An Act Making Unified Appropriations and Allocations from the General Fund and Other Funds for the Expenditures of State Government and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2023, June 30, 2024 and June 30, 2025	AFA	Enacted, P.L. 2023, c. 412	Public Law 2023, chapter 438, Part A, section A-38 provides a $31,000,000 appropriation to fund an Emergency Medical Services Stabilization and Sustainability Program. Part GGGGG establishes the Emergency Medical Services Stabilization and Sustainability Program within the Department of Public Safety, to be administered by Maine Emergency Medical Services in consultation with the Emergency Medical Services' Board and the Department of Health and Human Services, and transfers $31,000,000 from the unappropriated surplus of the General Fund to the Emergency Medical Services Stabilization and Sustainability Program, Other Special Revenue Funds account. Public Law 2023, chapter 438 broadened eligibility for grants under the program to all entities providing ambulance service or non-transporting emergency medical service or licensed emergency medical services training centers.	Recommendation A-2 Recommendation A-3
LD 526, An Act to Amend the Laws Governing the Emergency Medical Services Stabilization and Sustainability Program	CJPS	Enacted, P.L. 2023, c. 438	This enacted law amends the definition of "emergency medical services entity" in the Emergency Medical Services Stabilization and Sustainability Program laws to include all ambulance services, nontransporting emergency medical services and emergency medical services training centers licensed under the Maine Emergency Medical Services Act of 1982.	Recommendation A-2 Recommendation A-3
LD 1515, An Act to Fund Delivery of Emergency Medical Services	CJPS	Carried Over	This bill provides General Fund appropriations to the Department of Public Safety to support existing transportation costs of emergency medical services. These appropriations must be reduced to the maximum extent possible through the use of public and private Medicaid match programs.	Recommendation A-1
LD 1602, An Act to Implement the Recommendations of the Stakeholder Group Convened by the Emergency Medical Services' Board on Financial Health of Ambulance Services	HCIFS	Enacted, P.L. 2023, c. 468	Public Law 2023, chapter 468 makes the following statutory changes related to the financial health of ambulance services based on recommendations from a stakeholder group convened by the Emergency Medical Services' Board pursuant to Public Law 2021, chapter 241. 1. It continues the requirement that health insurance carriers are required to pay specified reimbursement rates for covered services provided by an ambulance service provider and makes clear that carriers may not limit reimbursement to only covered emergency services.	Recommendation A-3

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
			2. Beginning January 1, 2024, it requires health insurance carriers to reimburse ambulance service providers for nontransporting services at the same reimbursement rates for covered services. 3. It prohibits health insurance carriers from requiring an ambulance services provider to obtain prior authorization before transporting an enrollee to a hospital, between hospitals or from a hospital to a nursing home, hospice care facility or other health care facility and requires carriers to reimburse for those services. 4. It requires health insurance carriers to consider the requirements of the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services related to medical necessity when establishing the carrier's own policies for medical necessity. 5. It specifies the cost and performance metrics for the program for collecting and reporting cost and performance metrics related to emergency services that must be established by the Emergency Medical Services' Board in rule and adds one limited-period position to the Emergency Medical Services' Board to facilitate that program. 6. It requires the Maine Health Data Organization to report information on payments for ambulance services on its publicly accessible website.	
LD 1751, An Act to Maximize Federal Funding in Support of Emergency Medical Services	HHS	Carried Over	This bill establishes an ambulance service assessment fee on ambulance service providers in order to maximize federal funding for reimbursement to ambulance service providers under the MaineCare program. It also increases the reimbursement rates under the MaineCare program for ambulance services, neonatal transport, no-transport calls and community paramedicine.	Recommendation A-1
LD 1832, An Act to Require Reimbursement of Fees for Treatment Rendered by Public and Private Ambulance Services	HCIFS	Carried Over	This bill requires an ambulance service to be reimbursed for the cost of treating a person, regardless of whether the ambulance service transports the person to a hospital.	Recommendation A-3
WORKFORCE DEVELOPMENT, EDUCATION AND TRAINING				
LD 244, Resolve, Directing Maine Emergency Medical Services to Convene a Stakeholder Group to Explore Emergency Medical Services Career Pathways and Educational Opportunities in the State	CJPS	Enacted, P.L. 2023, c. 15	This enacted law directs the Department of Public Safety, Maine Emergency Medical Services to convene a stakeholder group to explore career pathways and educational opportunities for emergency medical services providers in the State. Maine Emergency Medical Services must submit a report to the Joint Standing Committee on Criminal Justice and Public Safety by January 15, 2024 that outlines the activities of the stakeholder group and includes any recommendations or proposed legislation. The committee may report out legislation to the Second Regular Session of the 131st Legislature.	Recommendation B-3

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
LD 588, An Act to Promote Public Safety and Retain Essential First Responders by Funding the Maine Length of Service Award Program	CJPS	Enacted, P.L. 2023, c. 439	This enacted law provides one-time funding in the amount of $500,000 in fiscal year 2024-25 for the Maine Length of Service Award Program, which provides length of service awards to eligible volunteer firefighters and emergency medical services personnel.	Recommendation B-2
LD 882, An Act to Allow Nonmunicipal Emergency Medical Services Providers to Be Considered State Employees for Purposes of Certain Benefits	LBHS	ONTP	This bill proposed to allow an ambulance service or nontransporting emergency medical service to participate in the State's Participating Local District Consolidated Retirement Plan as a local district so that its employees who are emergency medical services providers may receive state retirement benefits, death benefits and disability retirement benefits. The bill also proposed to allow these employees to be eligible for the state group health plan.	Recommendation B-1
LD 981, An Act to Require All Emergency Medical Services Persons to Be Trained to Administer and Dispense Naloxone Hydrochloride	CJPS	Enacted, P.L. 2023, c. 92	Effective July 1, 2024, Public Law 2023, chapter 92 requires an emergency medical services person to administer and dispense naloxone hydrochloride in compliance with protocols and training.	Not related to a specific report recommendation
LD 1409, An Act to Require Reimbursement When a Municipality Hires First Responders Whose Training Costs Were Incurred by Another Municipality	SLG	Carried Over	This bill establishes a formula to reimburse municipalities for training costs for training full-time first responders if the first responder is hired by another municipality within 4 years of the first municipality's initial incurrence of training costs.	Not related to a specific report recommendation
LD 1859, An Act to Reimburse Training Costs for Emergency Medical and Public Safety Dispatchers	CJPS	Majority ONTP Report Accepted	This bill proposed to require the Emergency Medical Services' Board in consultation with the Public Utilities Commission, Emergency Services Communication Bureau to establish a reimbursement schedule for the cost of training an emergency medical dispatcher or a public safety dispatcher when the dispatcher is hired by another governmental entity as an emergency medical dispatcher or public safety dispatcher within 5 years of the first governmental entity's incurring expenditures for the training. The bill also proposed to require a governmental entity to provide reimbursement for training costs in accordance with the reimbursement schedule.	Not related to a specific report recommendation
COMMUNITY PARAMEDICINE				
LD 883, An Act to Exempt Emergency Medical Services Community Paramedicine Programs from Home Health Care Provider Licensing Requirements Under Certain Circumstances	HHS	Enacted, P.L. 2023, c. 195	This enacted law adds community paramedicine services to the list of services exempted from home health licensing and includes conditions for the exemption. It also directs the Emergency Medical Services Board to adopt rules consistent with the home health exemption conditions.	Recommendation C-1

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
CONTINUED STUDY OF EMS				
LD 1701, Resolve, to Reestablish and Continue the Work of the Blue Ribbon Commission to Study Emergency Medical Services in the State	CJPS	Enacted, P.L. 2023, c. 99	Resolve 2023, chapter 99 reestablishes the Blue Ribbon Commission to Study Emergency Medical Services in the State for the purpose of examining and making recommendations on the structure, support and delivery of emergency medical services in the State. Resolve 2023, chapter 99 was finally passed as an emergency measure effective July 19, 2023.	Recommendation D-1
OTHER EMS RELATED BILLS				
LD 47, An Act to Amend the Law Governing Licensing Actions of the Emergency Medical Services' Board	CJPS	Enacted, P.L. 2023, c. 111	This enacted law removes an outdated reference to the revocation of a license in the laws governing the licensing actions of the Emergency Medical Services' Board.	Not related to a specific report recommendation
LD 439, An Act to Allow Death by Suicide to Be Considered a Death While in the Line of Duty	CJPS	Enacted, P.L. 2023, c. 433	This enacted law requires the applicable authority, when determining whether a law enforcement officer, firefighter, emergency medical services person, Department of Corrections law enforcement office or corrections officer has died while in the line of duty, to evaluate whether an individual who died by suicide has died as a result of events or actions experienced by the individual while in the line of duty. It also gives the Commissioner of Corrections rather than the Chief of the State Police the authority to make that determination for Department of Corrections law enforcement officers.	Not related to a specific report recommendation
LD 601, An Act to Reduce the Shortage of Municipal Emergency Medical Services Personnel by Removing Certain Vaccination Requirements	HHS	Died on Adjournment	This bill proposed to allow emergency medical services persons to provide treatment within the scope of their licenses without having been vaccinated against the COVID-19 virus or the influenza virus	Not related to a specific report recommendation
LD 727, An Act Regarding Workers' Compensation Benefits for First Responders Injured in the Line of Duty	LBHS	ONTP	This bill proposed to amend the Maine Workers' Compensation Act of 1992 to provide that if an employee employed as a first responder is injured and is also employed at an additional place of employment, the employee's average weekly wages are computed by combining the wages, earnings or salary received by the employee from each place of employment.	Not related to a specific report recommendation
LD 783, An Act to Protect Certain Private Emergency Services Personnel from Liability Under the Maine Tort Claims Act	JUD	Enacted, P.L. 2023, c. 311	This enacted law adds "mutual aid emergency response personnel" to the definition of "employee" under the Maine Tort Claims Act and also creates a definition of "mutual aid emergency response employer" under the Maine Tort Claims Act. The law provides that mutual aid emergency response personnel employed by the Bath Iron Works Corporation or its successor are considered employees for the purposes of the Maine Tort Claims Act, and also provides protection for the Bath Iron Works Corporation or its	Not related to a specific report recommendation

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
			successor under the Maine Tort Claims Act, only when the personnel are acting pursuant to a mutual aid agreement with a state or municipal entity or in response to a request for aid from a state or municipal entity.	
LD 919, An Act Regarding Licensure in the Field of Emergency Medical Services	CJPS	Enacted, P.L. 2023, c. 166	This enacted law amends the Maine Emergency Medical Services Act of 1982 to provide that the Emergency Medical Services' Board may by rule establish appropriate licensure levels and qualifications for emergency medical services persons, emergency medical dispatchers, emergency medical services educators, emergency medical dispatch centers, emergency medical services training centers, ambulance services and nontransporting emergency medical services.	Not related to a specific report recommendation
LD 1119, An Act to Clarify the Criminal Statutes with Regard to Assaults on Emergency Medical Services Persons	CJPS	Enacted, P.L. 2023, c. 455	This enacted law amends the crime of assault on an emergency medical care provider by specifying that it is a Class C crime if a person causes bodily injury to a person licensed pursuant to the Maine Emergency Medical Services Act of 1982 regardless of the location where the emergency medical care is being provided and by changing the name of the crime to reflect this amendment. The law also creates the new crime of assault in an emergency room, which a person commits if that person intentionally, knowingly or recklessly causes bodily injury to a person employed or contracted by a licensed hospital and the injury occurs in the hospital's designated emergency room.	Not related to a specific report recommendation
LD 1142, An Act to Eliminate Motor Vehicle Registration Fees for Volunteer Firefighters and Volunteer Emergency Medical Services Providers	TRA	ONTP	This bill proposed to exempt a volunteer firefighter and a volunteer emergency medical services provider from paying registration fees for a vehicle that is the primary means of transportation. The bill proposed to direct the Secretary of State to define "volunteer firefighter" and "volunteer emergency medical services provider." The bill also proposed to provide for the Secretary of State to adopt rules related to this exemption.	Not related to a specific report recommendation
LD 1268, An Act to Provide for a Local Motor Vehicle Excise Tax Exemption for Qualifying Volunteer Firefighters and Emergency Medical Services Persons	TAX	ONTP	This bill proposed to allow a municipality to provide an exemption from annual excise tax for one vehicle owned, separately or jointly, by a resident of that municipality who is a volunteer firefighter or volunteer emergency medical services person, as long as that vehicle is used to perform those volunteer services.	Not related to a specific report recommendation

LD/Title	Committee	Final Disposition	Bill/Enacted Law Summary	Related EMS Study Report Recommendation
LD 1396, An Act to Clarify the Laws Regarding Delegating Authority for Services Performed by Emergency Medical Services Personnel or Others as a Medical Assistant	HCIFS	Enacted, P.L. 2023, c. 132	This enacted law makes the following changes to clarify the laws regarding the delegating authority of a physician or physician assistant to emergency medical services personnel or others as a medical assistant. 1. It clarifies that a licensed emergency medical services person may not simultaneously act as an assistant performing medical services delegated by a physician or physician assistant. 2. It adds cross-references clarifying the authority of a physician assistant to delegate medical services to a licensed emergency medical services person in a hospital or health care facility. 3. It clarifies the laws regarding the delegating authority of a physician and a physician assistant.	Not related to a specific report recommendation

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APPENDIX E

States that Designate EMS as an Essential Service: Structure and Funding (OPLA)

States that Designate EMS as an Essential Service: Structure and Funding

State	Essential Service Designation	EMS Structure	EMS Funding
California	CA. Health and Safety Code§1797.1 and §1797.2 • The Legislature finds and declares that it is the intent of the [Emergency Medical Services System and the Prehospital Emergency Care Personnel Act] to provide the state with a statewide system for EMS by establishing the Emergency Medical Services Authority within the State Health and Welfare Agency, which is responsible for the coordination and integration of all state activities concerning EMS. • It is the intent of the Legislature to maintain and promote the development of EMT-P paramedic programs where appropriate throughout the state and to initiate EMT-II limited advanced life support programs only where geography, population density, and resources would not make the establishment of a paramedic program feasible.	Each county may develop an emergency medical services program; the local EMS agency plans, implements, and evaluates an emergency medical services system consisting of an organized pattern of readiness and response services based on public and private agreements and operational procedures.	CA. Health and Safety Code 1797.98a Maddy Emergency Medical Services Fund Each county may establish an emergency medical services fund, upon the adoption of a resolution by the board of supervisors. Source of the fund is a penalty assessment imposed by counties on criminal offenses. 17 percent of fund distributed to counties to use to support EMS services.
Colorado	Co. Rev. Stat. §5-3.5-102 **(**1) The general assembly hereby declares that it is in the public interest to provide available, coordinated, and quality emergency medical and trauma services to the people of this state. It is the intent of the general assembly in enacting this article to establish an emergency medical and trauma services system, consisting of at least treatment, transportation, communication, and documentation subsystems, designed to prevent premature mortality and to reduce the morbidity that arises from critical injuries, exposure to poisonous substances, and illnesses.(2) To effect	• Department of Public Health and Environment provides resources and technical assistance to EMS providers in the state with the assistance of a state emergency medical and trauma services advisory council. • Colorado Board of health regulates EMS and paramedic services • Local emergency medical and trauma service providers include local governing boards, training centers, hospitals, special districts, and other private and public service providers that have as their purpose	Co. Rev. Stat. §25-3.5-603 **Emergency Medical Services Account** • A special account within the highway users tax fund; source of fund is an additional $2 fee on vehicle registrations; fees collected 3 for provisional certifications or licenses of emergency medical service providers, and fees collected for provisional registration of emergency medical responders. • Funds are used for distribution as grants to local emergency medical and trauma service providers pursuant to the emergency medical and trauma services (EMTS) grant program for training of EMS personnel and for distribution to each Colorado county for planning and coordination of emergency

State	Essential Service Designation	EMS Structure	EMS Funding
	this end, the general assembly finds it necessary that the department of public health and environment assist, when requested by local government entities, in planning and implementing any one of such subsystems so that it meets local and regional needs and requirements and that the department coordinate local systems so that they interface with an overall state system providing maximally effective emergency medical and trauma systems.(3) The general assembly further finds that the provision of adequate emergency medical and trauma services on highways in all areas of the state is a matter of statewide concern and requires state financial assistance and support.	the provision of emergency medical and trauma services. • Counties are conferred with the statutory authority to license ground ambulance services.	medical and trauma services in the county and between counties when such coordination would provide for better service geographically. There are 4 types of funding available through the EMTS funding program: • CREATE education grants - The Colorado Resource for EMS and Trauma Education (CREATE) program supports initial training and continuing education for EMS and trauma service providers working for eligible organizations in Colorado. • Provider grants - Grant funds are available to help purchase: medical and rescue equipment, communications, data collection equipment and response vehicles. Support for personnel, recruitment and retention projects and other projects is also available. Grantees must provide matching funds if funded for a provider grant. • System improvement funding -System improvement funding supports regional or statewide projects to improve the emergency medical and trauma services system. These projects address a need identified by data with clearly defined activities and evaluation measures. • Emergency grant funding -The emergency grant program assists Colorado EMS and trauma organizations that experience an emergency that seriously jeopardizes the level of EMS or trauma services within their service area.
Delaware 218	Del. Code 16§ 9701 The purposes of the emergency medical services systems legislation are to establish and/or identify specific roles and responsibilities in regard to emergency medical services in Delaware in order to reduce morbidity and mortality rates for the citizens of Delaware and to ensure quality of emergency care services, within available resources, through the effective	EMS statewide system is overseen by the Office of Emergency Medical Services within the Division of Public Health; EMS services are provided by volunteer fire and ambulance companies at the local or county level	Del. Code 16 §9814 **Statewide Paramedic Funding Program** • General Assembly appropriates annually an amount sufficient to reimburse 30 percent of approved costs of the statewide paramedic program; this appropriation is made in the annual Grants-In-Aid Act and is appropriated to the Office of Emergency Medical Services, Division of Public Health, Department of Health and Social Services.

State	Essential Service Designation	EMS Structure	EMS Funding
	coordination of the emergency medical services system.		• Funds distributed to a county for the purpose of supporting a county component of the statewide paramedic system may be used for direct operating costs or as debt service and financing for bond issuance for that purpose. For those capital projects with a total cost greater than $200,000, the State reimburses on a debt service basis. In no instance does reimbursement include the cost of indirect services provided by the county.
Hawaii 219	H.R.S. §321-221 The legislature finds that the establishment of a state emergency medical services system, including emergency medical services for children, is a matter of compelling state interest and necessary to protect and preserve public health. A system designed to reduce medical emergency deaths, injuries, and permanent long-term disability through the implementation of a fully integrated, cohesive network of components, the legislature further finds, will best serve public health needs. Accordingly, the purpose of this part is to establish and maintain a state emergency medical services system in communities that can be most effectively served by the State, and to fix the responsibility for the administration of this state system, which shall provide for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of health care services under emergency conditions, whether occurring as the result of a patient's condition, from natural disasters, or from other causes. The system shall provide for personnel, personnel training, communications, emergency transportation, facilities, coordination with emergency medical and critical care services, coordination and use of available public safety agencies, promotion of consumer	The Department of Health oversees EMS statewide with the consultation of an advisory committee and determines the levels of EMS to be implemented in each county within the service area. Ambulance service is either operated by the county or the state contracts with an ambulance service in those counties that do not provide ambulance service.	H.R.S. §321-234 **Emergency Medical Services Special Fund** • Fund consists of fees remitted from vehicle registration ($5), cigarette tax revenues, interest and investment earnings attributable to the moneys in the special fund, legislative appropriations, and grants, donations, and contributions from private or public sources. • Beginning with fiscal year 2021-2022, $3,500,000 is distributed each fiscal year to counties operating a county emergency medical services system for the operation of that system. • The remainder of the fund is distributed to the Department of Health for operating the EMS system, including enhanced and expanded services.

State	Essential Service Designation	EMS Structure	EMS Funding
	participation, accessibility to care, mandatory standard medical recordkeeping, consumer information and education, independent review and evaluation, disaster linkage, mutual aid agreements, and other components necessary to meet the purposes of this part.		
Indiana	IC 16-31-1-1 a) The general assembly declares that the provision of emergency medical services is a matter of vital concern affecting the public health, safety, and welfare of the people of Indiana.**(**b**)** It is the purpose of this article:**(**1**)** to promote the establishment and maintenance of an effective system of emergency medical service, including the necessary equipment, personnel, and facilities to ensure that all emergency patients receive prompt and adequate medical care throughout the range of emergency conditions encountered;**(**2) that the emergency medical services commission established shall cooperate with other agencies empowered to license persons engaged in the delivery of health care so as to coordinate the efforts of the commission and other agencies; and **(**3) to establish standards and requirements for the furnishing of emergency medical services by persons not licensed or regulated by other appropriate agencies.	EMS is overseen by the Emergency Medical Services Commission that is responsible for the development of a statewide EMS that must include state, regional, and local emergency ambulance service plans; promotion of statewide EMS facilities by developing minimum standards, procedures, and guidelines for personnel, equipment, supplies, communications, facilities and location of centers; and the promotion of programs for training of EMS personnel	IC 16-46-16.5-4 **Health Issues and Challenges Grant Program** • The fund consists of:(1) money appropriated for the program or to the fund by the general assembly;(2) money received from state or federal grants or programs; and (3) gifts, money, and donations received from any other source, including transfers from other funds or accounts. • More than $4 million has been awarded for community paramedicine.
Iowa	Iowa Code §422D.1 A county board of supervisors can adopt a resolution declaring emergency medical services to be an essential county service. The resolution declaring emergency medical services to be an essential service is considered and voted on for approval at two meetings of the board prior to the meeting at which the resolution is to be finally approved by a majority of the board.	EMS is overseen by the Department of Health with the assistance of an EMS Advisory Council; emergency medical service districts coordinate with local emergency medical services agencies to provide EMS services; district advisory councils recommends a funding level for the EMS services.	Iowa Code §357F.8 • Allows Emergency Medical Services Districts to impose an additional annual property tax levy on residents if a majority of residents vote to approve one. • Allows counties that adopt a resolution by majority vote of the county board declaring EMS to be an essential county service the authority to have optional taxes, including local option income surcharges and ad valorem property taxes (must be voted in an election).

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State	Essential Service Designation	EMS Structure	EMS Funding
Louisiana	LA. Rev. Stat. 40:1139.1 The legislature hereby finds and declares the following: (1) Emergency medical services constitute an invaluable part of the healthcare delivery system of Louisiana and are an essential element of Louisiana's emergency preparedness system. (2) Emergency medical services will be a key element in any healthcare reform initiative. (3) Emergency medical services are a key component of any economic development program as they are essential to recruiting and retaining industry. (4) The cost of funding the Medicaid program and healthcare for the poor and uninsured in the state must be carefully managed in a manner which recognizes the challenges associated with appropriate reimbursement for services under the program. (5) Emergency medical service providers want to assure that emergency medical services are available to all residents of Louisiana. (6) It is in the best interest of the state that there exist sufficient resources to assure the availability of emergency ambulance services to the citizens of Louisiana and the creation of a statewide ambulance service district will help to ensure this goal. (7) The Louisiana Ambulance Alliance and the Louisiana Department of Health are interested in exploring the use of local revenues to enhance the delivery of emergency ambulance services through the use of certified public expenditures, intergovernmental transfers or other financing mechanisms that are in accordance with the applicable state and federal regulations.	• The Department of Health is responsible for establishing and maintaining a program for the improvement and regulation of emergency medical services in the state. • The responsibility for implementation of the program is vested in the Bureau of Emergency Medical Services. The bureau is responsible for the development of a state plan for the prompt and efficient delivery of adequate emergency medical services to acutely sick and injured individuals, and serves as the primary agency for participation in any federal program involving emergency medical services and may receive and disburse available federal funds to implement any service program. The bureau sets minimum standards for course approval, instruction, and examination.	LA. R.S. 46:2626 **Emergency Ground Ambulance Service Provider Trust Fund Account** • The Department of Health assesses each emergency ground ambulance service provider a percentage fee not to exceed the percentage of net patient service revenues permitted by federal regulations. • Funds from the Trust Fund Account are used to achieve the maximum reimbursement under federal law and appropriated solely to fund the reimbursement enhancements in the most recent formula adopted by the legislature or the secretary and distributed exclusively among emergency ground ambulance service providers for emergency and nonemergency ambulance transportation services provided.
Nebraska 221	Neb. Rev. Stat. §38-1203 The Legislature finds: (1) That emergency medical care is a primary and essential health care service and that the presence of an adequately	Nebraska is divided into four separate EMS regions: Western, Central, Northeast and Southeast. A dedicated EMS Specialist supports each region. The EMS Specialists provide are	Neb. Rev. Stat. §71-51-103 **Nebraska Emergency Medical Systems Operation Fund** The fund may receive gifts, bequests, grants,

State	Essential Service Designation	EMS Structure	EMS Funding
	equipped ambulance and trained emergency care providers may be the difference between life and death or permanent disability to those persons in Nebraska making use of such services in an emergency; (2) That effective delivery of emergency medical care may be assisted by a program of training and licensure of emergency care providers and licensure of emergency medical services in accordance with rules and regulations adopted by the board; (3) That the Emergency Medical Services Practice Act is essential to aid in advancing the quality of care being provided by emergency care providers and by emergency medical services and the provision of effective, practical, and economical delivery of emergency medical care in the State of Nebraska; (4) That the services to be delivered by emergency care providers are complex and demanding and that training and other requirements appropriate for delivery of the services must be constantly reviewed and updated; and (5) That the enactment of a regulatory system that can respond to changing needs of patients and emergency care providers and emergency medical services is in the best interests of the residents of Nebraska.	resource for every EMS service, EMS provider and hospital for training and technical assistance including system development, rules and regulations, statutes, protocol and policy development, documentation, quality improvement, recruitment and retention, recognition, mandatory reporting regulations, education, significant exposure procedures and systems of care.	fees, or other contributions or donations from public or private entities. • The fund is used to carry out the purposes of the Statewide Trauma System Act and the Emergency Medical Services Practice Act, including activities related to the design, maintenance, or enhancement of the statewide trauma system, support of emergency medical services programs, and support for the emergency medical services programs for children. • Any money in the fund available for investment is invested by the state investment officer.
Nevada 222	NRS 450.B.015 The Legislature hereby declares that prompt and efficient emergency medical care and transportation is necessary for the health and safety of the people of Nevada, and that minimum standards for such care and all persons providing it must be established.	EMS is overseen by the State Board of Health and District Boards of Health with assistance from a Committee on Emergency Medical Services; the board adopts regulations establishing minimum standards for ambulance and EMS services; health authorities adopt regulations to establish certification and licensure of EMS personnel	NRS 450B.1505 • Any money the Division receives from a fee set by the State Board of Health for the issuance or renewal of a license; an administrative penalty imposed or an appropriation made by the Legislature for the purposes of training related to emergency medical services: (a) Must be deposited in the State Treasury and accounted for separately in the State General Fund;

State	Essential Service Designation	EMS Structure	EMS Funding
			(b) May be used only to carry out a training program for emergency medical services personnel who work for a volunteer ambulance service or firefighting agency, including, without limitation, equipment for use in the training; and (c) Does not revert to the State General Fund at the end of any fiscal year. • Any interest or income earned on the money in the account must be credited to the account. Any claims against the account must be paid in the manner that other claims against the State are paid.
North Carolina	10 NCAC 13P.0201; N.C. Gen. Statutes §143-507 - §143-518 County government shall ensure that EMS are provided to its citizens; minimum service area for an EMS System shall be one county; care must be offered to residents within a service area 24 hours a day, seven days a week; personnel credentialed to perform within the scope of practice for all EMS personnel functioning in the EMS System	• Statewide EMS coordination is the responsibility of the Division of Public Health, Office of Preparedness and Response, Division of Emergency Management and the Division of Health Service Regulation, Office of Emergency Medical Services • The Regional Advisory Committees (RACs) provide direction, guidance, and coordination for each region. • There are 100 county EMS systems and one tribal EMS system consisting of multiple responders from rescue squads, critical care transport, and standard EMS providers. On the county level, planning efforts take place at the Local Emergency Planning Committee (LEPC). These LEPCs consist of stakeholders from law, fire, EMS, hospitals, Public Health, and private industry. LEPCs answer to the local Emergency Management.	N.C. §58-87-5 **Volunteer Rescue/EMS Fund** • Created in the Department of Insurance to provide grants to volunteer rescue units, rescue/EMS units, EMS units that are volunteer fire departments that are a part of a county's EMS system plan, and EMS units providing rescue or rescue and emergency medical services to purchase equipment and make capital improvements. • Department shall to the extent possible select applicants from all parts of the State based upon need. • State Treasurer invests the Fund's assets according to law, and the earnings shall remain in the Fund.
Pennsylvania 223	35 Pa. C.S. §8102 The General Assembly finds and declares as follows: • Emergency medical services are an essential public service and frequently the health care safety net for many Commonwealth residents. • Emergency medical services should be acknowledged, promoted and	• The Department of Health is responsible for planning, coordinating and guiding programs to promote effective and efficient operation of Statewide and regional EMS systems • State EMS Advisory Board advises the Department of Health concerning manpower and training, communications, EMS agencies,	35 Pa. C.S. §8153 **Emergency Medical Services Operating Fund** • Sources of the fund are a $20 surcharge on traffic violations; $50 fee for a person to participate in the Accelerated Rehabilitative Disposition program; appropriations and contributions. • 75% of the fund is dispersed to EMS agencies for costs related to contracts and grants, 30% of the fund allocated to EMS

State	Essential Service Designation	EMS Structure	EMS Funding
	supported as an essential public service. • The emergency medical services system should fully integrate with the overall health care system, and in particular with the public health system, to identify, modify and manage illness and injury and illness and injury risks.	regulations, and standards and policies. • Regional emergency medical services councils assist the Department of Health in carrying out the implementation of the EMS system.	agencies to provide training to underserved rural area; at least 10% of the fund provided to Ems agencies to assist with medical equipment purchases for ambulances and to regional EMS councils for the development, maintenance and improvement of EMS systems and for training, education and licensure.
South Carolina 224	South Carolina Act 164, 2021 Section 6-1-2020. (A) As used in this section: (B)(1) Ambulance service is hereby designated as an essential service in this State. (2) Each county governing body in this State shall ensure that at least one licensed ambulance service is available within the county. This may be provided as a county service, but also may be accomplished through other means including, but not limited to: (a) providing a license or franchise to a private company; (b) contracting with a public, private, or nonprofit entity for the service; (c) entering into an intergovernmental agreement with one or more local governments; or (d) entering into an agreement with a hospital or other health care facility. (3) A county is not required to appropriate county revenues for ambulance service if the service can be provided by any other means. (C) Municipal governing bodies also are authorized to make provisions for ambulance service within the boundaries of the municipality. A municipality may not provide and maintain, license, franchise, or contract for ambulance service outside its corporate boundaries without the approval of the county governing body, in the case of unincorporated areas, or the municipal	• Division of EMS and Trauma is under the Department of Health and Environmental Control and monitors and develops protocols, designates trauma centers, and certifies Emergency Medical Technicians, Paramedics and Athletic Trainers. • There are 4 EMS Regional Councils that provide training, consulting, and technical assistance to emergency services agencies and other allied health agencies and personnel. • Local EMS teams are the primary providers of EMS to residents.	• South Carolina EMS Association (SCEMSA) and Public Consulting Group (PCG) have partnered to develop and implement an Ambulance Supplemental Payment Program (ASPP) that will provide significant relief to South Carolina's public ambulance providers. • The ASPP program will enhance federal funding and help cover the Medicaid shortfall that exists between the cost of providing services and what Medicaid currently reimburses providers. • Upon the Centers for Medicare and Medicaid Services (CMS) approval, participation in the ASPP will allow government owned or operated ambulance providers to recover up to the federal share of the cost of providing transports that are currently paid through Medicaid Fee-for-service (FFS) and Medicaid Managed Care Organization (MCO) delivery systems. • The mechanism by which payments will be made to providers will vary based upon the Medicaid service delivery system. • Medicaid FFS - Implementation requires the submission of a Medicaid State Plan Amendment (SPA) to CMS. Once implemented, providers that wish to participate will be required to submit an annual cost report and sign a Certification of Public Expenditures in order to receive provider-specific cost-based reimbursement for Medicaid FFS transports. • Medicaid MCO - Implementation requires the submission of a Medicaid Section 42 CFR § 438.6(c) Preprint outlining the state

State	Essential Service Designation	EMS Structure	EMS Funding
	governing body if the area to be served lies within the boundaries of another municipality. (D) A county may not provide and maintain, license, franchise, or contract for ambulance service within the boundaries of a municipality that has made provisions for ambulance service without the approval of the municipal governing body of the area to be served. (E) The governing body of any county or municipality may adopt and enforce reasonable regulations to control the provision of private or nonprofit ambulance service. (F) Two or more counties and municipalities may enter into agreements with each other and with persons providing both emergency and nonemergency ambulance service for a county or counties on a countywide basis, for joint or cooperative action to provide for ambulance service."		directed payment arrangement and associated quality measures. • Once implemented, incremental enhancements for Medicaid MCO transports will be achieved through development of a per trip add-on rate that is tied to the average cost per trip for all providers submitting annual cost reports under the Medicaid FFS program. • Unlike the Medicaid FFS program, public providers will transfer the state share via an Intergovernmental Transfer (IGT) in advance of the supplemental payments being disbursed by MCOs.
Tennessee 225	TN Code 7-61-102 Ambulance service is hereby designated as an essential service in the state of Tennessee.	• Emergency Medical Services Board is empowered to approve schools and prescribe courses for EMS personnel, promulgate regulations governing licenses and permits, and establish standards for the activities and operation of emergency medical and ambulance services. • All county governing bodies are authorized and directed to make provisions to ensure that at least one (1) licensed ambulance service is available within their county. This may be provided as a county service, but can also be accomplished through other means, including, but not limited to: providing a license or franchise to a private company; contracting with a public, private, or nonprofit entity for the service; entering into an interlocal agreement with one (1) or	Public Chapter 1052, 2022 **Ambulance Service Assessment Revenue Fund** • Sources of the fund are quarterly assessments on ground ambulance service providers; penalties for not paying the assessment; donations from private sources and investment earnings. • Money in the fund may only be used to create directed payments for qualified ground ambulance services and to reimburse qualified Medicaid transports.

State	Essential Service Designation	EMS Structure	EMS Funding
		more local governments; or entering into an agreement with a hospital or other healthcare facility.	
Virginia 226	Va. Code § 32.1-111.3 The objectives of a statewide EMS Plan is: 1. Establishing a comprehensive statewide emergency medical services system, incorporating facilities, transportation, manpower, communications, and other components as integral parts of a unified system that will serve to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality; 2. Reducing the time period between the identification of an acutely ill or injured patient and the definitive treatment; 3. Increasing the accessibility of high quality emergency medical services to all citizens of Virginia; 4. Promoting continuing improvement in system components including ground, water, and air transportation; communications; hospital emergency departments and other emergency medical care facilities; health care provider training and health care service delivery; and consumer health information and education; 5. Ensuring performance improvement of the emergency medical services system and emergency medical services and care delivered on scene, in transit, in hospital emergency departments, and within the hospital environment; 6. Working with professional medical organizations, hospitals, and other public and private agencies in developing approaches whereby the many persons who are presently using the existing emergency department for routine, nonurgent, primary medical care will be	• Office of Emergency Service is responsible for the development of a comprehensive, coordinated, statewide emergency medical services plan. • The State Board of Health has designed 11 Regional EMS Councils to serve specific geographic areas of the Commonwealth. Each council is charged with the development and implementation of an efficient and effective regional emergency medical services delivery system. • Any county, city or town may provide EMS to its citizens by establishing an EMS agency.	Va. Code §46.2-694 **Four-for-Life Fund** • Source of the fund is a $4 per year charge that is collected at the time of vehicle registration • 32% of the fund is distributed to the Rescue Squad Assistance Fund for training of EMS personnel and equipment purchases. • 30% is distributed through contracts and other procurements to support EMS training programs, recruitment and retention programs, EMS development, local, regional and statewide performance contracts for EMS, technology and radio communications enhancements. • 2% is distributed to the Virginia Association of Volunteer Rescue Squads to conduct volunteer recruitment, retention and training activities. • 26% is allocated to the “Return to Locality” fund to provide local funding for training of EMS personnel and the purchase of equipment and supplies for EMS and rescue services.

State	Essential Service Designation	EMS Structure	EMS Funding
	served more appropriately and economically; 7. Conducting, promoting, and encouraging programs of education and training designed to upgrade the knowledge and skills of emergency medical services personnel, including expanding the availability of paramedic and advanced life support training throughout the Commonwealth with particular emphasis on regions underserved by emergency medical services personnel having such skills and training; 8. Consulting with and reviewing, with agencies and organizations, the development of applications to governmental or other sources for grants or other funding to support emergency medical services programs.		
West Virginia 227	W. Va. Code §16-4C-2 The Legislature finds and declares: (1) That the safe and efficient operation of life-saving and life-preserving emergency medical service to meet the needs of citizens of this state is a matter of general public interest and concern; (2) to ensure the provision of adequate emergency medical services within this state for the protection of the public health, safety and welfare, it is imperative that minimum standards for emergency medical service personnel be established and enforced by the state; (3) that emergency medical service personnel should meet minimum training standards promulgated by the commissioner; (4) that it is the public policy of this state to enact legislation to carry out these purposes and comply with minimum standards for emergency medical service personnel as specified herein; (5) that any patient who receives emergency medical service and who is unable to consent thereto should be	• Office of EMS is created in the Bureau of Public Health • Emergency Medical Services Advisory Council develops, with the commissioner, standards for emergency medical services personnel and for the purpose of providing advice to the Office of Emergency Medical Services and the commissioner with respect to reviewing and making recommendations for the establishment and maintenance of adequate emergency medical services for all portions of this state. • Each of the 55 counties provides some EMS services. • The state is divided into 10 EMS regions.	W. Va. Code §16-4C-24 **Emergency Medical Services Equipment and Training Fund** • The fund may only be used for the purpose of providing grants to equip emergency medical services providers and train emergency medical services personnel. • Commissioner of Bureau of Health establishes a grant program for equipment and training of EMS personnel and providers; priority given to rural and volunteer EMS providers. • Allocated $10 million in federal coronavirus relief funding to “EMS WV: Answer the Call” program to fund strategic initiatives that will bolster the state’s EMS workforce and equip communities to better care for West Virginia citizens.

State	Essential Service Designation	EMS Structure	EMS Funding
	liable for the reasonable cost of such service; and (6) that it is the public policy of this state to encourage emergency medical service providers to do those things necessary to carry out the powers conferred in this article unless otherwise forbidden by law.		

Maine declaration of EMS as an essential service:

MRSA 32 §81-A

It is the purpose of this chapter to promote and provide for a comprehensive and effective emergency medical services system to ensure optimum patient care. The Legislature finds that emergency medical services provided by an ambulance service are essential services. The Legislature finds that the provision of medical assistance in an emergency is a matter of vital concern affecting the health, safety and welfare of the public.

It is the intent of the Legislature to designate that a central agency be responsible for the coordination and integration of all state activities concerning emergency medical services and the overall planning, evaluation, coordination, facilitation and regulation of emergency medical services systems. Further, the Legislature finds that the provision of prompt, efficient and effective emergency medical dispatch and emergency medical care, a well-coordinated trauma care system, effective communication between prehospital care providers and hospitals and the safe handling and transportation, and the treatment and non-transport under appropriate medical guidance, of the sick and injured are key elements of an emergency medical services system. This chapter is intended to promote the public health, safety and welfare by providing for the creation of a statewide emergency medical services system with standards for all providers of emergency medical services.

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APPENDIX F

November 6th, 2023 Commission Member Presentations:

- **EMS System Funding (Joe Kellner)**
- **EMS Regionalization, One Optimization Approach (Kevin Howell)**
- **NorthStar EMS (Mike Senecal)**

EMS SYSTEM FUNDING

Blue Ribbon Commission (v2)

November 6th, 2023

BACKGROUND AND DISCLOSURES

- 12 years EMS experience, 10 directly responsible for billing and finance
- Former oversight over an EMS billing agency ($70M in annual charges)
- Currently serve as CEO – LifeFlight of Maine

PROVIDER AND CALL VOLUME DATA

- 166 Licensed Transporting EMS Services (data 1 year old)

All Transporting Agency Transport Volume					
Year	Average	25th Percentile	50th Percentile	75th Percentile	Maximum
2018	1123.6	147.5	384.0	1186.5	17400.0
2019	1272.8	167.0	374.0	1290.0	19965.0
2020	1104.1	158.8	329.0	1083.0	15658.0
2021	1211.6	191.0	399.0	1241.0	14795.0
2022	849.2	140.8	288.5	884.8	9892.0
All Transporting Agency Call Volume					
Year	Average	25th Percentile	50th Percentile	75th Percentile	Maximum
2018	1390.3	195.0	536.0	1634.0	19593.0
2019	1591.1	216.8	529.5	1760.8	21789.0
2020	1447.6	227.0	499.0	1516.0	17009.0
2021	1760.1	267.0	607.0	1950.0	20294.0
2022	1150.9	186.0	402.0	1142.0	13167.0

VEHICLE UTILIZATION

The median transports per ambulance vehicle per year in Maine is ***115***

NON-TRANSPORTS

On Average, 26% of requests do NOT result in transport and do NOT result in payment

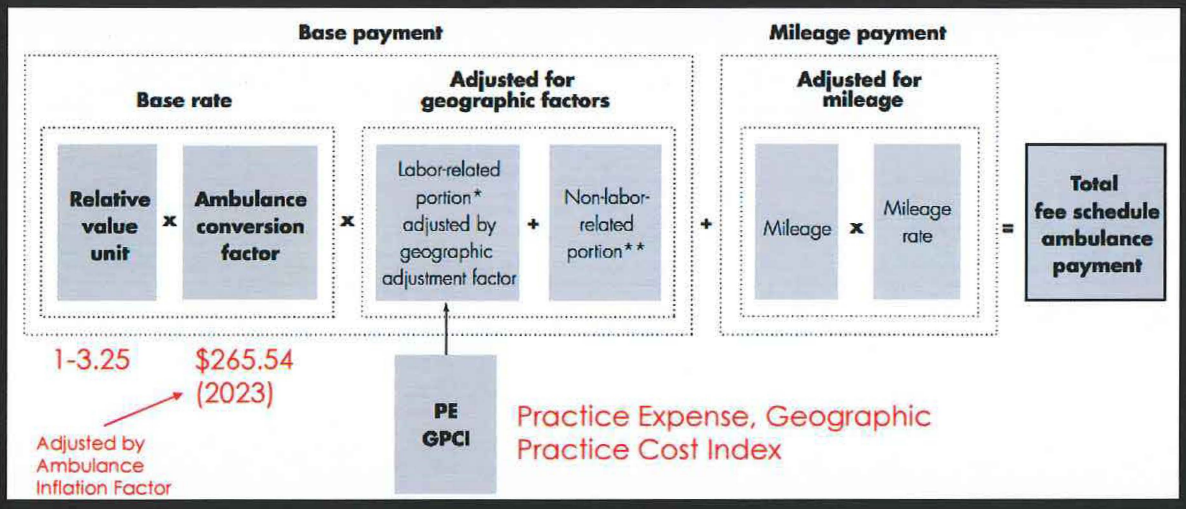
LD1602 now requires commercial payers to reimburse non-transport scenarios

STARTING AN AMBULANCE

A One-Ambulance service requires approximately $1,100,000 in cash to begin and sustain operations. Payment won't start coming until up to six months from startup

UNDERSTANDING AMBULANCE REIMBURSEMENT

AMBULANCE PAYMENT



RATE ADJUSTMENTS

This factor is an amount equal to the percentage increase in the consumer price index for all urban consumers (CPI–U) reduced by the 10-year moving average of multi-factor productivity.

2015	1.5
2016	-0.4
2017	0.7
2018	1.1
2019	2.3
2020	0.9
2021	0.2
2022	5.1
2023	8.7
2024	*2.6*

*MEDpac Ambulance Payment Basics

AMBULANCE ADD-ON PAYMENTS

- 2% Urban (urban, for example, includes all of Penobscot County)**
- 3% Rural
- 22.6% (lowest 25th percentile of all rural areas in US)

** This 2% offsets the long-standing 2% monies that are sequestered

MAINECARE

MaineCare pays at average Medicare rates **based on the lowest GPCI,** and includes ambulance add on payments based on the zip code in which the services are rendered

COMMERCIAL PAYERS

- LD1258
  - 180% of Medicare (plus rural and super rural add ons) for out of network
  - 200% of Medicare (plus rural and super rural add ons) for in network

  Methodology expires 12/31/2023. Without this, carriers' payment to out of network ambulance services will decrease dramatically, though it will introduce an independent dispute resolution process.

- LD1602 made these changes permanent and included non-emergency transportation.

FINANCIAL DEMONSTRATION

25th Percentile Transport Volume: 191 (267 requests)
50th Percentile Transport Volume: 399 (607 requests)
75th Percentile Transport Volume: 1,241 (1,950 requests)
Highest Transport Volume: 14,795 (20,294 requests)

Reimbursement averages ~$500 per transport, yet the 50th percentile cost is estimated to be over $1,900 per transport

Percentile	Volume	Net Income	Ambulances	FTEs	Net Income Per Call	Cost Per Transport
25th	191	$ (653,854.54)	1	9.8	$ (3,423.32)	$ 3,915.31
50th	399	$ (568,300.56)	1	9.8	$ (1,424.31)	$ 1,916.30
75th	1241	$ (805,613.47)	2	18.6	$ (649.16)	$ 1,141.15
Maximum	14795	$ (201,752.76)	9	83.2	$ (13.64)	$ 505.63

Percentile	No Transports	Additional Revenue if non-transports were funded*	Additional loss to adjust wages	Additional Revenue if Rural	Additional Revenue if Super Rural
25th	67	$ 29,527.50	$ (899,972.41)	$ 1,061.05	$ 23,979.74
50th	140	$ 55,416.09	$ (814,418.44)	$ 2,216.54	$ 50,093.81
75th	436	$ 172,359.30	$ (1,010,096.46)	$ 6,894.05	$ 155,805.56
Maximum	5,198	2,054,839.56	$ (2,416,813.61)	$ 82,189.76	N/A

Wage Adjustment Mid Points
EMT: 20, AEMT: 25, Paramedic: 35

*Assumes paying base rates with no mileage

The 50th percentile ambulance service, performing 399 calls per year, requires $570,000 in subsidy to break even

This number has increased to over $800 for most services, depending on payer mix

MUNICIPAL AMBULANCE SERVICES

	Urban, 1334 Calls per year (Old Town)	Super Rural (Madawaska)
Charges	$ 1,359,369.20	
Contractual Allowances / BD	$ (608,842.31)	
Payments	$ 683,003.70	$ 393,784.78
Personnel	$ 1,097,991.00	$ 431,125.00
Purchased Services	$ 26,319.00	$ 57,000.00
Supplies and Materials	$ 69,817.00	$ 40,050.00
Repairs and Maintenance	$ 36,550.00	$ 14,200.00
Utilities	$ 30,140.00	$ 2,300.00
IT	$ 4,000.00	$ 2,520.00
Other	$ 552.00	$ 16,550.00
Depreciation	$ 98,485.00	
Insurances	$ 51,477.00	
Net Income Before Allocation	$ (732,327.30)	$ (169,960.22)
Not included	Rent, Capital Equipment, Additional Personnel. Expenses split 50/50 with fire, however 86% of demand is EMS	Insurances, capital equipment, rent

501(C)3 AMBULANCES

DELTA

		Prior Year	Current Year	Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)		1,512,684	1,086,885	0
	9 Program service revenue (Part VIII, line 2g)	7,710,421	6,972,577	7,030,742	6,453,653
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	259,728	94,413	849,626	69,991
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		0		0
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	7,970,149	8,579,674	8,967,253	6,523,644
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)		0		0
	14 Benefits paid to or for members (Part IX, column (A), line 4)		0		0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	5,913,295	6,259,027	6,648,442	6,963,628
	16a Professional fundraising fees (Part IX, column (A), line 11e)		0		0
	b Total fundraising expenses (Part IX, column (D), line 25) ▶0				
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	2,352,604	2,353,150	2,529,448	2,555,243
	18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	8,265,899	8,612,177	9,177,890	9,518,871
	19 Revenue less expenses. Subtract line 18 from line 12	-295,750	-32,503	-210,637	-2,995,227
Net Assets or Fund Balances		Beginning of Current Year	End of Year		
	20 Total assets (Part X, line 16)	10,372,172	11,011,395		
	21 Total liabilities (Part X, line 26)	2,336,729	2,683,185		
	22 Net assets or fund balances. Subtract line 21 from line 20	8,035,443	8,328,210		

NORTHERN LIGHT

		Prior Year	Current Year	Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)		0	14,173.	173,515.
	9 Program service revenue (Part VIII, line 2g)	7,679,258	8,343,088	8,099,598.	8,270,453.
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	-8,031	-755	-5,287.	298.
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)		0		
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	7,671,227	8,342,333	8,108,484.	8,444,266.
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)		0		
	14 Benefits paid to or for members (Part IX, column (A), line 4)		0	5,948,616.	6,673,025.
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)		4,589,894		
	16a Professional fundraising fees (Part IX, column (A), line 11e)		0	2,699,491.	2,959,487.
	b Total fundraising expenses (Part IX, column (D), line 25) ▶0			8,648,107.	9,632,512.
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	8,289,140	3,930,943	-539,623.	-1,188,246.
	18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	8,289,140	8,520,837	Beginning of Current Year	End of Year
	19 Revenue less expenses. Subtract line 18 from line 12	-617,913	-178,504	2,616,379.	2,394,467.
				4,835,458.	5,634,932.
				-2,219,079.	-3,240,465.

UNITED

		Prior Year	Current Year	Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)	0	44,853	0	0
	9 Program service revenue (Part VIII, line 2g)	8,977,856	8,463,961	7,698,525	8,240,307
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	7,585	-2,088	10,958	102,325
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	0	0	10,048	-14,542
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	8,985,441	8,506,726	7,719,531	8,328,090
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	4,559	3,270	2,094	0
	14 Benefits paid to or for members (Part IX, column (A), line 4)	0	0	0	0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	6,350,066	6,254,834	5,731,643	6,340,670
	16a Professional fundraising fees (Part IX, column (A), line 11e)	0	0	0	0
	b Total fundraising expenses (Part IX, column (D), line 25) ▶0				
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)	2,833,459	2,264,369	2,071,638	2,400,220
	18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	9,188,084	8,522,473	7,805,375	8,740,890
	19 Revenue less expenses. Subtract line 18 from line 12	-202,643	-15,747	-85,844	-412,800
Net Assets or Fund Balances		Beginning of Current Year	End of Year		
	20 Total assets (Part X, line 16)	5,683,121	5,666,558		
	21 Total liabilities (Part X, line 26)	637,649	636,833		
	22 Net assets or fund balances. Subtract line 21 from line 20	5,045,472	5,029,725		

CURRENT SUBSIDIES

- Municipal contributions (space, overhead)
- Tax contributions
- Volunteer hours
- Per Capita Contributions
- Purchased Services

APPENDIX WITH ASSUMPTIONS

LIST OF ASSUMPTIONS

- Median Pay Rates
  - EMT: 17.50, AEMT: 19, Paramedic: 25
- Charge Structure 2-3x Medicare Rates
- Service Mix:
  - BLS Non-Emergency: 20%
  - BLS Emergency: 31%
  - ALS Non-Emergency: 5%
  - ALS Emergency: 41%
  - ALS II Emergency: 3%

LIST OF ASSUMPTIONS

- Ambulance Acquisition
  - Vehicle base cost: $185,000
  - Patient Securement: $50,000 (Cot and loading system)
  - Ambulance lifespan: 225,000 miles
  - Ambulance MPG: 8
  - Maintenance Cost: $0.13/mile driven
  - General medical equipment: $35,000

Mileage Factor

- Ambulance will drive 3.5 miles for every miles of patient transport

LIST OF ASSUMPTIONS

Required Ambulances

- 0-1000 Transports: 1 ambulance
- 1000-2000 Transports: 2 ambulances
- Each additional 2000: 1 more ambulance

Staffing

- EMT/Paramedic team
- 1 leadership position per three trucks, minimum of 1
- 1 senior leader for five or more trucks

LIST OF ASSUMPTIONS

Required Ambulances

- 0-1000 Transports: 1 ambulance
- 1000-2000 Transports: 2 ambulances
- Each additional 2000: 1 more ambulance

Staffing

- EMT/Paramedic team
- 1 leadership position per three trucks, minimum of 1
- 1 senior leader for five or more trucks

LIST OF ASSUMPTIONS

Payer Mix

- Medicare / Mainecare: 65%
- Commercial Insurers: 20%
- Self-pay: 15%

LIST OF ASSUMPTIONS

Billing and Dispatch

- $20.00 per call

- Average Reimbursement per Transport: $491.99
- Average Charge: $1,072.50
- Average Transport Mileage - 12

Several other assumptions of cost are included, but are based off actual data

EMS REGIONALIZATION

ONE RURAL OPTIMIZATION APPROACH

A CASE STUDY

PREPARED FOR

EMS BLUE RIBBON COMMISSION

NOVEMBER 6, 2023

Introduction

Presenter:

Kevin Howell, Town Manager – Town of Carmel

2016 – Present

CERTIFIED:

- TOWN MANAGER
- TOWN CLERK
- TREASURER
- TAX COLLECTOR
- CODE ENFORCEMENT OFFICER
- LOCAL PLUMBING INSPECTOR

CURRENTLY SERVING:

- MMA LEGISLATIVE POLICY COMMITTEE
- BOARD OF DIRECTORS, MUNICIPAL REVIEW COMMITTEE
- MAINE STATE EMERGENCY RESPONSE COMMISSION – MUNICIPAL REPRESENTATIVE

Town of Carmel, Maine, U.S.A

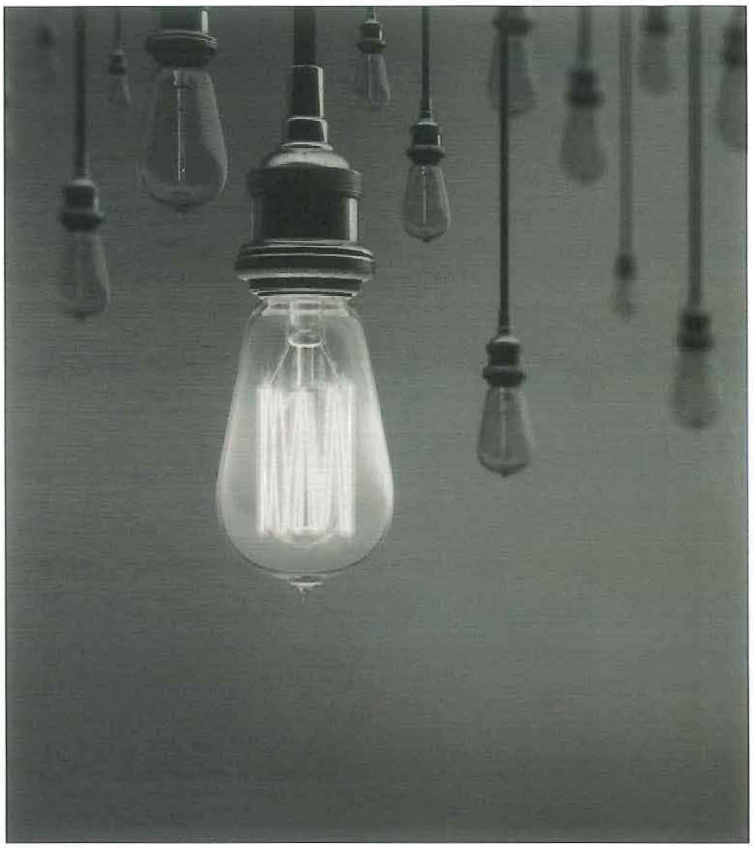
"Your Rural Community"

- Population of approx. 2,900
- Bedroom community to the Greater Bangor Economic Region
- Town Meeting / Board of Selectmen / Town Manager form of gov.
- Active paid fire department – voluntary response operation
- Centrally located in Southern Penobscot County along I-95

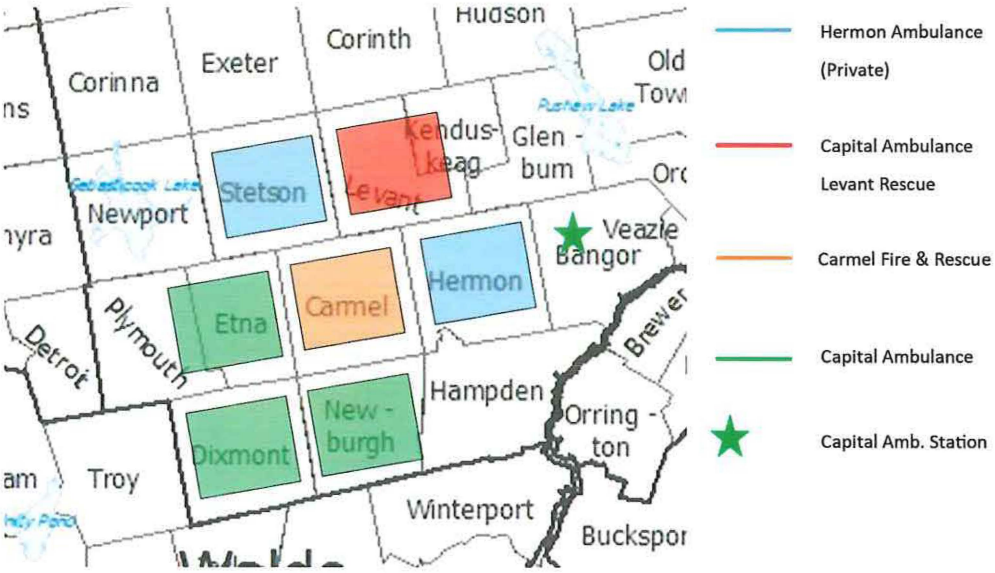
GENESIS....

WHAT'S ALL THE RUCKUS ABOUT???

- **FRAGMENTATION IN REGIONAL EMS**
- COMPETING SERVICES
- LIMITED MUNICIPAL RESOURCES
- RURAL LOGISTICAL CHALLENGES
- FUNDING SHORTFALLS
- STAFFING CHALLENGES

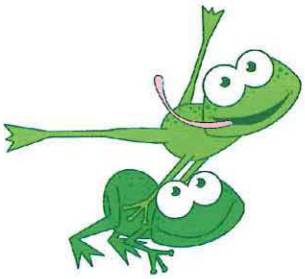


WHERE WE STARTED - 2018 EMS MAP



LIFE SAFETY

IS NOT A GAME OF LEAPFROG



Challenges of small-town EMS

CALL VOLUME

Insufficient call volume to create offsetting revenue relative to cost of readiness

STAFFING

Small service, limited advancement opportunity, noncompetitive wages and benefits, no back up staff for vacation/sick/training and turnover

FUNDING

Shortfalls in funding creates local tax burden

LOGISTICS

Rural logistics create lengthy ALS aid response

ADMINISTRATION

No full time FIRE/EMS administration.

What is OPTIMIZATION?

The action of making the best or most effective use of a situation or resource.

Broadly speaking, optimization is the act of changing an existing process in order to increase the occurrence of favorable outcomes and decrease the occurrence of undesirable outcomes.

8

Optimization Process

Research

- OPEN MIND
- If you don't ASK – you'll NEVER KNOW!
- Consider ALL options
- THINK outside the box
- ANYTHING is possible

Testing / Implementation

- Rubber meets the road
- Staffing
- Expectations
- Logistics
- Protocol

Analysis

- How's it going?
- Quality Control
- $$$ - Is it what we thought it was?
- Is it sustainable?
- What did we miss?

9

OPTIMIZATION GOALS

IDENTIFY THE DESTINATION

Local (Town) priorities

- Provide quality sustainable EMS service
- Achieve manageable financial balance
- Manageable expectations (understand your limits)
- Ask for help when you need it
- Offer help when you have it

Systematic priorities

- Regional continuity
- Closest available resource
- Systematic transparency
- One common goal
- Share resources

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CHALLENGE #1

CALL VOLUME

Lack of call volume results in lack of transports which results in lack of revenue.....

HOW DO WE OVERCOME LOW CALL VOLUME IN A SMALL TOWN???????

LOOK AROUND.....

NEIGHBORS IN NEED.....

11

CHALLENGE #2

NOT OUR CUSTOMERS

CARMEL IS NOT THE CONTRACT EMS PROVIDER FOR OUR NEIGHBORS IN NEED.... NOR ARE WE LICENSED TO BE....

HOW DO WE OVERCOME THIS???

LOOK AROUND.....

IF YOU DON'T ASK... YOU'LL NEVER KNOW.....

12

CHALLENGE #3

STAFFING

SMALL TOWNS STRUGGLE TO RECRUIT AND RETAIN EMS STAFF... WE CAN'T COMPETE!!

HOW DO WE OVERCOME THIS???

WAIT A SECOND... WHAT IF....

WE HAVE AN AMBULANCE, STATION, AND FAVORABLE LOCATION (HUB)....

AND YOU HAVE....

13

TOGETHER IS BETTER

TOWN OF CARMEL

WE HAVE:

- AMBULANCE
- AMBULANCE DRIVER
- FAVORABLE LOCATION
- AMBITION
- WILLING ADMINISTRATION
- MUNICIPAL SUPPORT SERVICES

NORTHERN LIGHT

YOU HAVE:

- EMS STAFF
- CALL VOLUME
- TRAINING
- ALS BACKUP
- EXPERIENCED BILLING RESOURCES
- BACK UP AMBULANCES

TOGETHER WE HAVE....

A SOLUTION!!

14

IN JULY 2018, THE TOWN OF CARMEL SIGNED A CONTRACT WITH NORTHERN LIGHT CREATING A PRIVATE / PUBLIC PARTNERSHIP THAT WILL INITIATE A QUASI-MUNICIPAL REGIONALIZATION OF EMS SERVICES TO SOUTHERN PENOBSCOT COUNTY

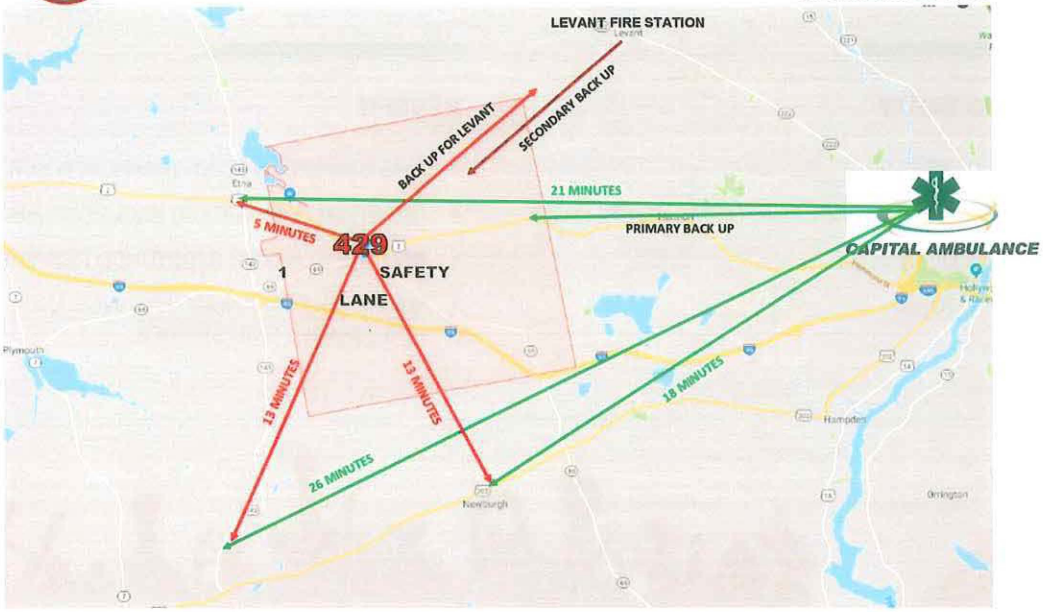
- NORTHERN LIGHT PROVIDES EMT (MIN)
  - REPORTING TO CARMEL FIRE STATION M-T 8AM-6PM
- TOWN OF CARMEL PROVIDES ALL OTHER NEEDS
  - (AMB/DRIVER/SUPPLIES/ETC)
- WHILE STAFFED, 429 REPONDS TO:
  - CARMEL, ETNA, DIXMONT, NEWBURGH
- TOWN OF CARMEL RECEIVES ALL REVENUES
  - (SPLITS PERCENTAGE ON OUT-OF-TOWN BILLS)
- NORTHERN LIGHT PROVIDES EMS TRAINING TO CARMEL STAFF

15

PROPOSAL FOR INCREASED COVERAGE TO MUTUAL AID TOWNS

- Enhanced Regional Coverage
- Increased Revenue / Offset Contracted Cost

CAPITAL AMBULANCE



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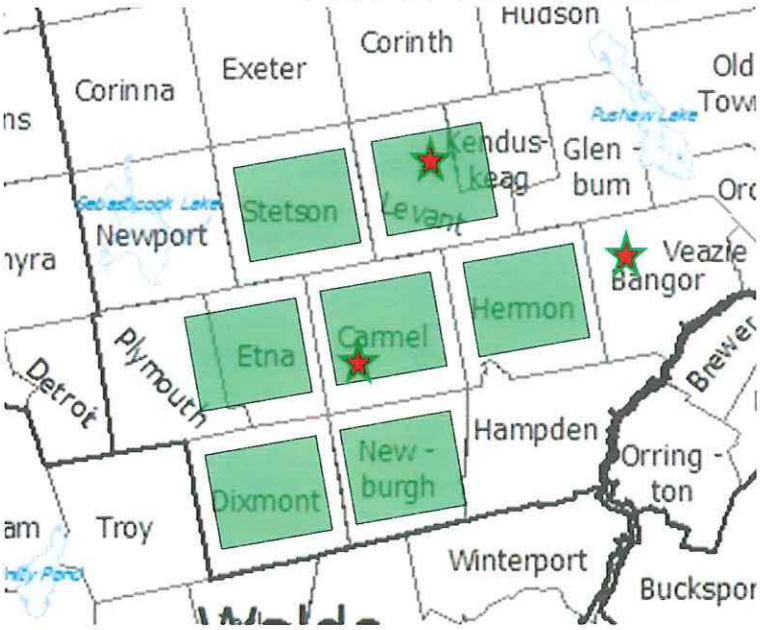
2023 EMS MAP



Northern Light Associated Service

Service Hub (amb sta.)

- CLOSEST AVAILABLE RESOURCE
- NO CONTRACTUAL CONFLICTS
- CONTINUITY IN COVERAGE
- COMMON DISPATCH PROTOCAL
  - Still fragmented (medcomm)

17 **Annual Review**

WHO WINS???

WE ALL DO....

INTERESTED PARTY

- CITIZENS OF CARMEL
- CITIZENS OF ETNA/NEWBURGH/DIXMONT/STETSON
- NORTHERN LIGHT
- TOWN OF CARMEL

BENEFIT

- EMS STAFFED IN TOWN (IMPROVED SERVICE)
- DRASTICALLY IMPROVED EMS RESPONSE TIMES
- RELIEF/HELP WITH STRETCHED RESOURCES
- MANAGABLE FINANCIAL BALANCE AND SUSTAINABLE EMS SERVICE

MANAGEABLE FINANCIAL BALANCE

OUTGOING

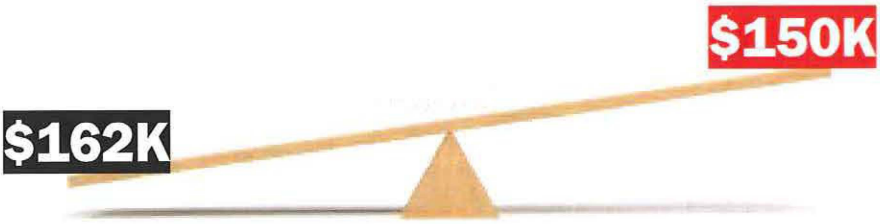
ANNUAL COSTS:

- N/L EMS CONTRACT: $50K
- AMBULANCE DRIVER: $50K
- MED. SUPPLIES: $12K
- ALS BACK UP: $16K
- AMBULANCE MAINT: $5K
- BILLING: $4K
- EMS STAFF: $25K

INCOMING

ANNUAL REVENUE:

- TRANSPORT BILLING: **$150K** (billed $175k)
  - 5 year trend of 85% capture rate



911 – WHO DO WE CALL?

DISPATCH PROTOCOL

6 TOWNS – 6 TONES

- Shift pager programed for all service towns..
- Automatic Response

BACKUP

- Closest backup stands ready
- All three hubs have situational awareness of region

Thoughts....

Fragmentation in Public Safety..

Disrupts continuity and workforce retention.

Fair Share..

Unbalanced administrative & fiscal burden.

Caution in subsidy..

Subsidies may enable sustaining an inefficient allocation of resources.

Focus on municipalities

Each town controls their own destiny

Identify and empower rural HUBS

Hub and spoke approach

Thank you

"Without change there is no innovation, creativity, or incentive for improvement. Those who initiate change will have a better opportunity to manage the change that is inevitable." - William Pollard

MaineHealth

NorthStar Emergency Medical Services

Mike Senecal Senior Director

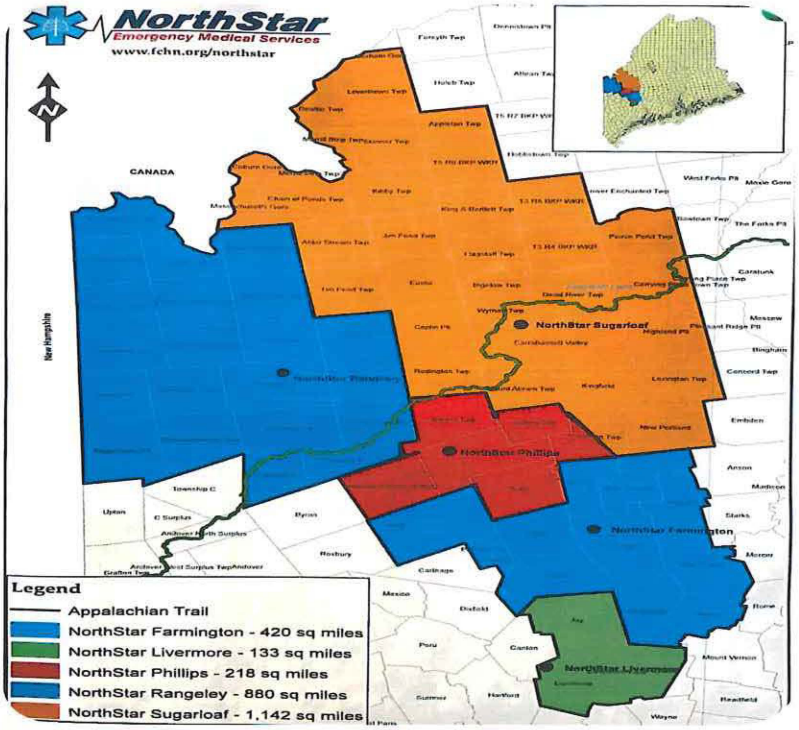
PATIENT CENTERED · RESPECT · INTEGRITY · EXCELLENCE · OWNERSHIP · INNOVATION

PATIENT CENTERED · RESPECT · INTEGRITY · EXCELLENCE · OWNERSHIP · INNOVATION

System Overview

- NorthStar is the regional ambulance service for Greater Franklin County. Our 85 EMS professionals follow their mission of positive community activities, good stewardship of resources, and respectful and excellent patient care. This mission is evident throughout NorthStar's operations with 7,000 calls per year to the 71 communities it proudly serves.
- NorthStar is dispatched out of five base locations strategically positioned throughout the region. NorthStar responds to calls ranging from medical emergencies and accidents to nursing home transfers. Average System Response Time 15:53 minutes
- Licensed to EMT level and permitted to paramedic
- In 2022 NorthStar created a Inter-facility Transport division (IFT) to support MaineHealth hospitals. IFT is a operated as a separate cost center and not part of this presentation.

Act with kindness and compassion. · Be an active listener. · Be a role model. · Set high standards. · Take responsibility. · Embrace change.



History

Starting in 1995, FMH began acquiring/operating small local ambulance services, allowing them to continue to operate independently.

- LifeStar -1995
- Sugarloaf Ambulance - 1996
- Rangeley Region Ambulance - 1999
- Community Emergency Service – 2000
- AMPS – 2000

In 2003 those five services merged into FMH-EMS under one unified set of policies and procedures, but still different departments of FMH. Shortly thereafter NorthStar was born as a regional ambulance services as a single department of FMH.

Administration

- NorthStar operates as a department of Franklin Memorial Hospital part of the MaineHealth health system.
  - Service Director
  - FMH President
  - MaineHealth System Senior Director
- NorthStar Advisory Board
  - The NorthStar Advisory Board shall review NorthStar's performance, including monitoring quality of care and service effectiveness from the perspective of patients, the communities served and emergency room providers. The Board shall make recommendations to the Board of Directors regarding long-term strategies and goals, annual operating and capital budgets, and the rationale and formula(s) for dividing public support costs between the municipalities served.

Operations

- Dispatched by Franklin County Regional Communication Center
- Staffing
  - Livermore 1- Paramedic level staffed 24 Hours/day
  - Farmington 2- Paramedic level staffed 24 Hours/day
  - Phillips 1- Paramedic level staffed 10 Hours/day
  - Sugarloaf 1- Paramedic level staffed 24 Hours/day
  - Rangeley 1- Paramedic level staffed 24 Hours/day

Note: Goal is to have all ambulances staffed at the paramedic level. Due to staffing challenges we have created strategies to coordinate responses across the system to allow the most appropriate team too answer the call i.e. determinant codes and Paramedic paradox. Some of the coverage above is covered with call shifts.

Community Serves

Community Paramedicine

- program that has emergency medical technicians (EMTs) and paramedics making house calls to vulnerable patients to educate them, monitor their condition, and if needed, provide treatment. EMTs provide patient care in the home offering services such as: vital signs and weight monitoring, high blood pressure checks, glucose testing and diabetes management, medication assistance, flu shots, and fall prevention and safety education.

Backcountry Medical Team

- NorthStar Backcountry Medical Response Team is charged with responding to ill and injured persons in an off-road environment in the forests, mountains, lakes and rivers within the NorthStar EMS response area, and, in collaboration with the Maine Warden Service and other wilderness rescue responders, providing public education as well as emergency medical care using the highest level of wilderness prehospital care providers available.

NorthStar System Status Management

- When the system is busy, crews may be strategically positioned to respond to emergency or non-emergent calls. Such standby coordination and ambulance placement for the system will be the responsibility of the Duty Supervisor or NorthStar on Call Administrator. Whenever possible, ambulance movement to standby locations should be automatic. While the majority of the responsibilities will be handled in this fashion, duty crews will provide input or assume responsibility if the Duty Supervisor is busy or unable to fulfill the duties due to call volume or location. Franklin County RCC may also assist in strategically assigning crews to cover the response area.
  - 75% of the calls are Farmington South
  - Goal is to have ambulances stage in areas statically that have the highest chance for the next call and send the closest available ambulance to the call. Dynamic versus Static
  - With increased call volumes this has resulted in the system being more responsive

First Responder Services

In the NorthStar coverage area we rely on the assistances of our 8 Licensed First Responder agencies. Wilton, Jay, New Sharon, Farmington, Eustis, Livermore, Carrabassett Valley, and Industry

- AED/CPR
- Anaphylaxis
- Bleeding control
- OD calls
- Public Assists

Factors that affect response times

- EMD
  - Utilizing 911 EMD codes to modify response for safety
    - » 2021 1171 Alpha level calls
    - » 2022 1376 Alpha level calls
- Lights and Sirens
  - 2021 55% of 911 calls
  - 2022 37% of 911 calls
- Staging for behavioral health
- Backcountry Rescues

Run Statistics

	FY23	FY22	FY21	FY20
Total Runs	7432	7399	7732	6233
Emergencies	6005	5937	5340	4891
Transfers	1240	1201	1339	1108
All others	119	176	748	107
CP Visits	68	85	305	234
Billable	5290	5285	4940	4366

Financial Summary FY23

Gross patient Revenue $12.6 million

- Contractual allowance 67 %

Net Patient Revenue $4.6 million

Other Revenue Town Subsidies $690,000

- Amount is generated from operating deficit
- Hospital has attempted to mitigate large increases

Financial Summary FY23

$6 million annual operating budget

Total Expenses $ 6 million

- $4.5 million in salaries and benefits
- $1.5 million in operating expenses
  - » Fuel
  - » Medical supplies
  - » Facilities
  - » Non-medical supplies
  - » Hospital support
  - » Capital

Financial

Year	Revenue with Subsidies	Total Expenses	Margin
2018	3,878,442	3,937,942	-59,500
2019	3,952,607	4,068,366	-115,759
2020	3,908,378	4,289,336	-380,958
2021	4,541,343	4,730,906	-189,563
2022	4,423,455	4,880,328	-456,873
2023	5,329,058	6,032,414	-703,356

Town Subsidies/Fee

The commitment to the communities we serve is to operate at a breakeven while providing a quality emergency medical transport service.

- Contracted with 29 towns to provide emergency coverage
- Contract runs from July 1 to June 30
- Advised of subsidy amount for following year by January 1
- Annual contract opt out clause
- Full disclosure of financials
- NorthStar Advisory Board

Subsidy Formula

Demographics. When the initial formula was developed, several demographic categories were considered, and the formula was narrowed down by the *NorthStar* Advisory Board to the three elements that best represented the region's diverse aspects. After reviewing the 2010 Census information, the Board felt that these elements were still valid. These are:

- **Population** (**2010** Census data). Since the ambulance business is about people, population is a broad indicator of how often the services will be used.
- **Residential Valuation** (using most current year State Equalized Values). Again, focusing on the "people" by using Residential Valuation instead of the broader Total Valuation, this is an indication of overall development in the area. This factor is weighted less than the other factors but is the only value that changes based on inflation and/or with development in the area. Use of this factor allows a small inflationary increase for *NorthStar*'s operations.
- **Housing Units** (**2010** Census data). In most towns that do not have seasonal fluctuation, the housing units correspond to the population but it is a good measure of the potential of seasonal visitors and residents (and taxpayers) and thus, along with population, is an overall measure of projected activity in the town. County Unorganized Territory (UT) information was estimated based on the latest UT annual reports and state valuation reports.

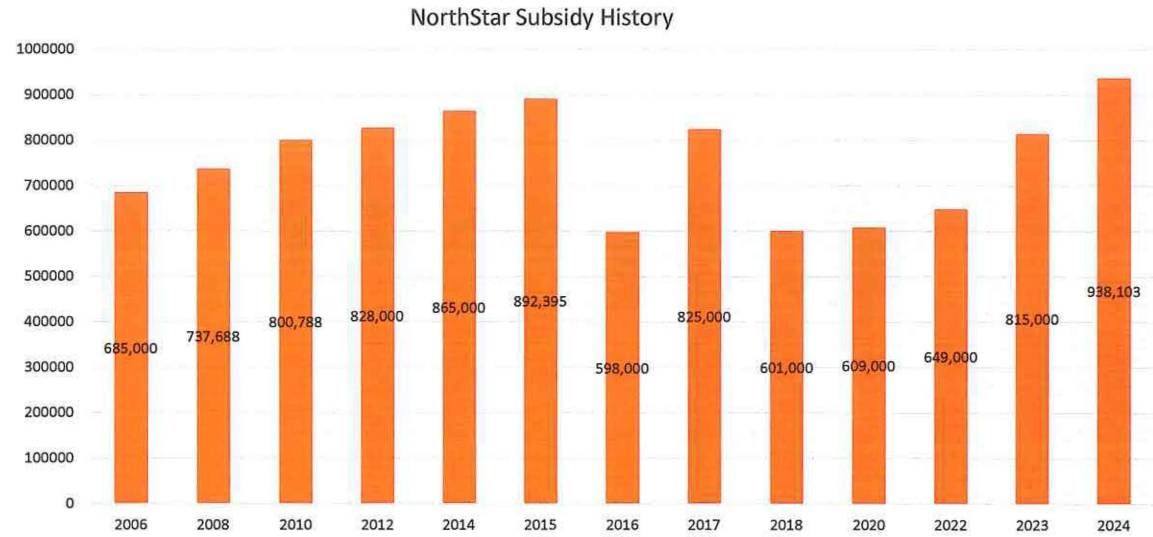
Subsidy Formula

How the Formula Works

- **Fee**. A single Flat Fee for each town and a single fee for each UT (unchanged for seven years).
- **A Dollar Value**. A dollar amount in each category is applied to each town's demographic value. Residential valuation remained flat in towns and territories serviced by NorthStar. As outlined above this factor normally allows for a small inflationary increase for operations.
- **A Distance Factor**. The center of population for the region that NorthStar serves is, in fact, in southern Franklin County. However, NorthStar has positioned crews and ambulances at strategic points around the region to assure that we respond quickly throughout the territory. Four of these five bases are crewed 24/7 to assure timely coverage of the entire area, including those in sparsely settled areas. The farther away from the center of population, there are fewer people per square mile and thus fewer runs per day. With fewer runs, there is less income to offset the expenses of keeping an ambulance ready all the time for that town.

Note: Since the subsidy is based on NorthStar's overall deficit, a distance factor is appropriate when looking at the financial impactof serving very rural areas with an ambulance always staffed and ready to respond. In this formula, the total sum of the fee and other factors described above is multiplied by this distance factor. (Specifically, the distance factor is the ratio of distance to the town from the population center point divided by the average distance). To limit the effects of both very short and very long distances the factor has been 'capped' with a minimum and a maximum ratio value.

Subsidy History



Challenges

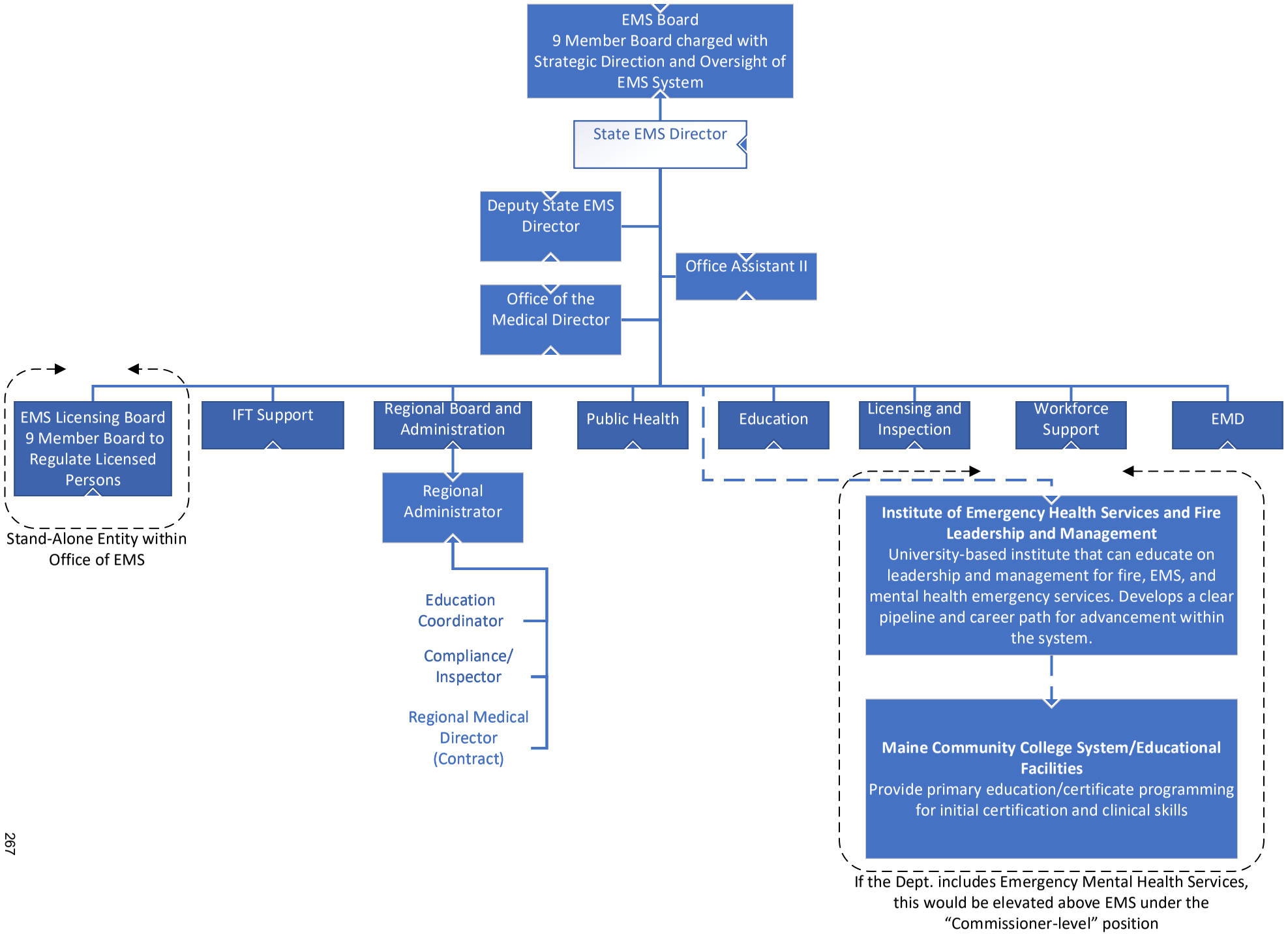
- Staffing
- Cost of readiness
- Operating expenses
- System integrity
- Reimbursement
- System Fragility
  - Cost
  - Unpredicitability

Questions?

NorthStar Emergency Medical Services

APPENDIX G

- **Maine EMS, Structural Reorganization Proposal**
- **Maine EMS, Two-Year Action Plan**


EMS Board
9 Member Board charged with Strategic Direction and Oversight of EMS System
State EMS Director
Deputy State EMS Director
Office Assistant II
Office of the Medical Director
EMS Licensing Board 9 Member Board to Regulate Licensed Persons
IFT Support
Regional Board and Administration
Public Health
Education
Licensing and Inspection
Workforce Support
EMD
Regional Administrator
Education Coordinator
Compliance/ Inspector
Regional Medical Director (Contract)
Stand-Alone Entity within Office of EMS
Institute of Emergency Health Services and Fire Leadership and Management
University-based institute that can educate on leadership and management for fire, EMS, and mental health emergency services. Develops a clear pipeline and career path for advancement within the system.
Maine Community College System/Educational Facilities
Provide primary education/certificate programming for initial certification and clinical skills
If the Dept. includes Emergency Mental Health Services, this would be elevated above EMS under the "Commissioner-level" position

Structure of the Maine EMS System

Growth and development of the statewide EMS system will require a restructuring of the regulatory, development, system planning, and leadership framework that supports the system. The attached organizational chart is a potential pathway forward that retains significant local representation and communication; provides a pathway to address interfacility transportation concerns, workforce planning, and public health planning, while maintaining efficiencies and efficacy.

Maine EMS and the Board recognizes the need to increase efficiencies in the system while also maintaining significant local input and involvement in the process and ensuring a voice for the regulated community throughout the system. This proposed structure increases accountability for all parties involved by placing the EMS Director responsible for implementing the vision and strategic plan for the system and the EMS Board becomes charged with overseeing the strategic plan, final rulemaking, and serves as the final authority for discipline and waivers. This will allow for greater innovation within the EMS system, more nimble response to challenges, and greater efficiencies in workflow.

Responsibilities will be divided among the system with a system of checks and balances that ensures competency and accountability across the statewide structure. The overarching functions of the primary components of the structure are defined below:

- State EMS Director and Bureau Staff
    - Promulgate EMS service (non-transporting, ground, air), EMD, and system-related rules;
    - Regulate/discipline based on those rules and applicable statutes;
    - Conduct investigations in response to complaints or knowledge of violations;
    - May propose personnel licensing rules to the personnel licensing board;
    - Enter into consent agreements with regulated entities;
    - Inspect entities (announced or random) for compliance with rules and statutes;
    - Manage office staff in accordance with State of Maine HR policies, to include hiring, developing, etc.;
    - Issue service licenses;
    - Execute contracts;
    - Apply for, accept, and appropriate grant funds;
    - Manage and operate regional offices; and
    - Implement the strategic plan.
- Maine EMS Board
    - Approve and direct the strategic plan
    - Approve or reject rules for comment and final approval
    - Serve as the appeals process for service-licensing waiver requests and issue final decisions on those waivers
    - Serve as the appeals process for those appealing disciplinary decisions (adjudicatory hearings would be held in front of the Board)
    - Required to take vote to approve and confirm new State EMS Director
        - In the event the Director is not effectively executing the mission, issue a no-confidence vote
- Personnel Licensing Board
    - Promulgate personnel licensing rule

    - Regulate/discipline based on those rules and applicable statutes
    - Enter into consent agreements with personnel
    - Delegate, with consent, to the executive director of the Board or staff the authority to grant personnel licenses and to enter into consent agreements
    - Grant, suspend, or revoke a license in accordance with Title 32
    - Conduct investigations in response to complaints or knowledge of violations
    - Conduct disciplinary / administrative hearings
    - Evaluate requests for waivers related to personnel licensing
    - May propose service licensing rule to the director
- Regional Council
    - Nominate one (1) person per council to the advisory board
    - Nominate one (1) person per council to the licensing board
    - Coordinate information sharing among services and the advisory board
- Regional Medical Director
    - Manage quality assurance/improvement efforts regionally
    - Enter into consent agreements as allowed by rule established by the licensing board

MAINE EMS

TWO-YEAR ACTION PLAN

2035

PLAN FOR A SUSTAINABLE EMS SYSTEM IN THE STATE OF MAINE: *A VISION FOR 2035*

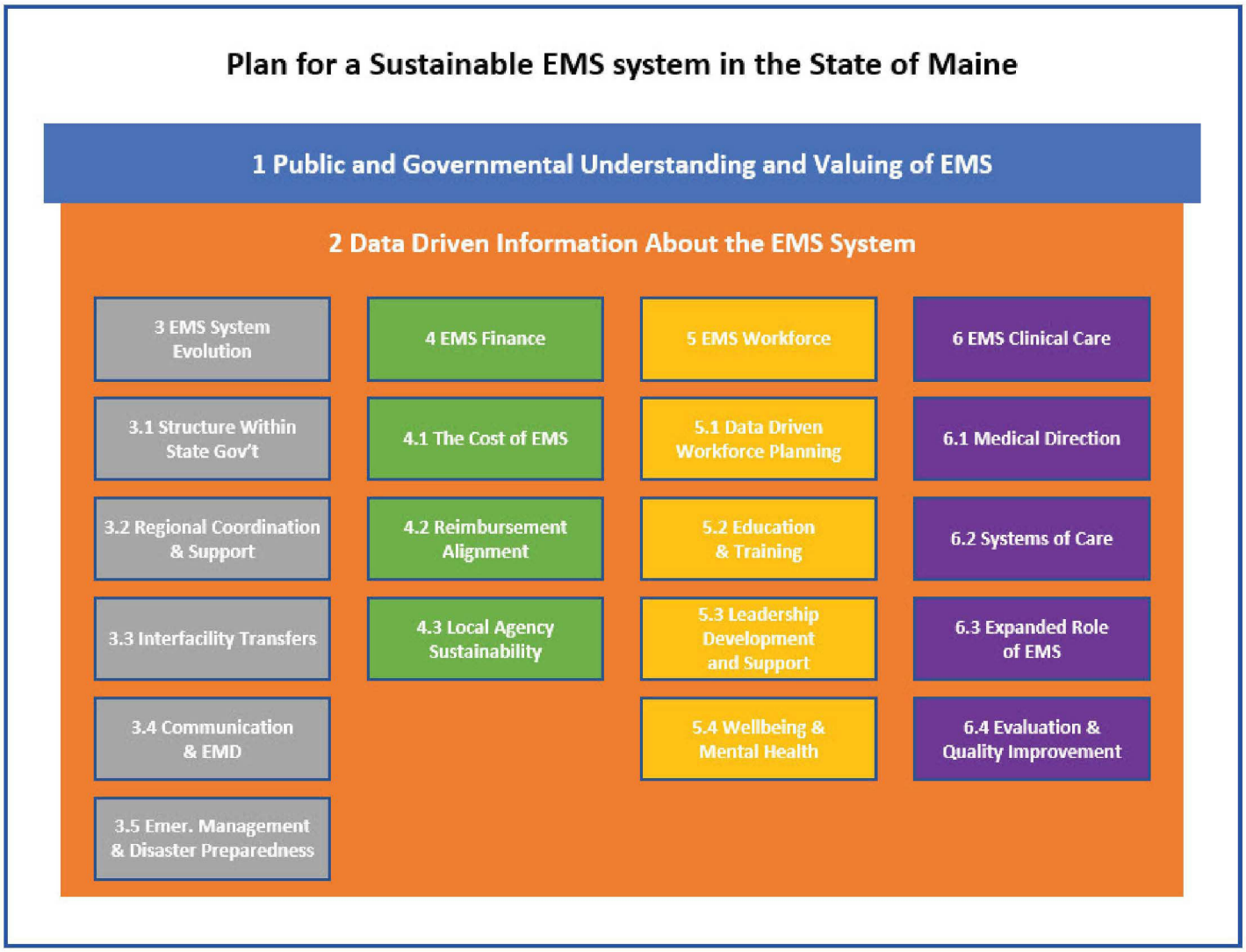
OCTOBER 27, 2023

OVERVIEW:

Maine EMS has developed this document to operationalize the *Plan for a Sustainable EMS System in the State of Maine: A Vision for 2035.* The plan has been broken down by each domain, as seen below. The Maine EMS Staff have worked for months to identify associated strategies and activities. As one might imagine, successfully implementing the Vision for 2035 will be a long road; however, we must take one step at a time to move forward. Maine EMS has also pulled out 11 strategies from across the domains to identify priorities as key areas that need to be addressed over the next two years. Beyond those 11 key strategies, the Office has also identified strategies and activities that will continue to further this plan over the next two years and beyond. Please note that the prioritized strategies represent the key areas identified by the office; however, they are not the only strategies that the office will work on.

Reference Color Coding:

Statutorialy Required Action | Statutory Change Required | Rules Change Required | Policy Required



Prioritized Strategies

The following strategies have been identified by the Maine EMS Bureau as systemic priorities for the EMS system. However, it is important to note that while these specific strategies have been identified as some of the most important systemically, there are also additional strategies and activities that will be prioritized by individual members of the office based on their individual grant requirements.

Public Government Understanding and Valuing of EMS
Strategy 3: Broaden EMS community and state/municipal/county leadership awareness of Maine EMS's work, programming, and resources.

Data Driven Information about the EMS System
Strategy 1: Improve Data Integrations
Strategy 3: Improve upon use of data for making informed decisions

EMS System Evolution
Structure in State Government - Strategy 1: Modify the EMS regulatory system structure to align with and achieve the Maine EMS Vision and Plan.
Structure in State Government - Strategy 2: Ensure reliable staffing in the Maine EMS office
Regional Coordination and Support Under a State Model - Strategy 2: Transition from the current regional model to a state-supported regional system.
Emergency Management and Disaster Preparedness - Strategy 2: Increase disaster resiliency in the Maine EMS System

EMS Finance
The Cost of EMS - Strategy 1: Enhance EMS cost reporting.

EMS Workforce
Data-Driven Workforce Planning - Strategy 3: Using data to identify workforce patterns to support sustainability and address disparities.
Mental Fitness and Wellbeing - Strategy 2: Increase access to mental health peer support and CISM trainings in all EMS Regions.

EMS Clinical Care
Evaluation and Quality Improvement - Strategy 3: Comprehensively review the Maine EMS Quality Improvement Manual to increase its relevance to EMS clinicians and encourages the use of established performance metrics.

Public Government Understanding

Notes from Plan:

Where We Want To Be: In 2035 EMS in Maine garners the attention needed to thrive and deliver the services and clinical care Mainers expect. EMS is not taken for granted. Residents and government officials regularly advocate for EMS. EMS is viewed and funded as a vital common good.1 This occurs because of ongoing efforts to inform, promote, educate and create broad awareness and shared knowledge about the EMS system, its value, the varieties of delivery models and the real and full costs of providing EMS. EMS leaders and clinicians, as well as residents and government officials, view, understand and value EMS as they do law enforcement, the fire service, public works, public health, public education, parks, emergency management and public safety answering points, etc.

Milestones/Markers of Success: a. EMS organizations, associations, agencies and clinicians across Maine have united to tell a single, powerful story about EMS and its value, cost and needs.
b. The EMS system continues to develop talking points that ensure consistent messaging is used whenever EMS is discussed in public and governmental settings.
c. EMS stakeholders always capitalize on current issues and events to deepen the public's understanding EMS, including what it does and its value, costs and needs.
d. Government officials are continuously informed and educated about the EMS system.
e. Residents of Maine understand the value of EMS, do not take EMS for granted and proactively advocate for EMS.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Ensure the EMS community within the State of Maine is knowledgeable, invested, and supportive of the Maine EMS vision and plan.							
Activity 1.1	Create an engaging 10-15 minute presentation on the vision and plan for EMS in Maine. This presentation will need to thoroughly connect the vision and plan to current issues, legislation, and the work of the Blue Ribbon Commission.	Maine EMS Staff, Maine EMS Board Leadership, Maine EMS Board, Strategic Planning Consultant (SafeTech Solutions)	Oct 31, 2023; initial review by EMS Board at July Board Meeting	Creation of work product that is easy to understand and deliver within 10-15 minutes	Maine EMS Staff Time; MS PowerPoint	Vision and Plan Overview PowerPoint Presentation; Presenter's Notes	
Activity 1.2	Deliver the presentation to EMS agencies, clinicians, educational programs, and stakeholders who are interested in the future of EMS.	Maine EMS Staff, Maine EMS Board Members	Ongoing beginning in November 2023	Documentation of each time that the presentation is delivered by members of the responsible entities to be able to try and quantify the impact of the strategy	Maine EMS Staff Time; Maine EMS Board Member Staff Time	None	
Activity 1.3	Develop a mechanism to track when, how, and to whom the presentation is delivered throughout the State of Maine.	Maine EMS Staff	31-Oct-23	Creation of a Microsoft Form that captures information about who, how, and to whom (not individual names, but general categories [e.g., EMS clinicians, EMS leadership, local political leaders, public, members of the legislature, etc.] to whom the presentation was delivered)	Maine EMS Staff Time; MS Forms	Web-based reporting tool (i.e., MS Forms) to collect information about the delivery of the presentation	
Strategy 2: Broaden community (public) awareness of EMS by facilitating relationships between EMS services and community leadership/institutions/members.							
Activity 2.1	Develop monthly press releases highlighting the work of the EMS system throughout the State of Maine	Maine EMS Staff, EMS system	Ongoing, monthly deadlines of last day of month	Count of number of press releases created per month RE positive EMS system messaging	Maine EMS Staff Time	Monthly Press Release	
Activity 2.2	Add a Public Outreach section to the Staff Update. Use this to inform agencies of opportunites to speak to their stakeholders and the public about the EMS system.	Maine EMS Staff	Ongoing, monthly deadlines two weeks before end of month	Count of number of additional sections in the Staff Update	Maine EMS Staff Time	Staff Update	
Activity 2.3	Adapt or develop trainings that teach EMS leadership and services tips and best practices for connecting with their local communities	Maine EMS	6/30/2025	Saturation of unique EMS leadership trained. Implementation of best practices.	Maine EMS Staff Time, stakeholder time, training documents/materials, grant funding	Training materials (asynchronous training, videos, handouts)	
Strategy 3: Broaden EMS community and state/municipal/county leadership awareness of Maine EMS's work, programming, and resources.							
Activity 3.1	Town hall/personal visits with MEMS staff for education and awareness about programming and the Vision	Maine EMS Staff; Maine EMS Board	Ongoing	Count the number of participants, type, and region	Maine EMS Staff Time, Stakeholder Time, Meeting Space (Virtual), SharePoint document	Survey Tool, Documentation of Participation	
Activity 3.2	Identify opportunities for Maine EMS Staff members to regularly attend and present at national/state/municipal/regional conferences, trainings, events, meetings, etc. in person.	Maine EMS Staff	Ongoing, at least one event per quarter	List of events, schedule for attendance	Staff time, travel, printing, tabling supplies, and associated fees	Presentations, swag, informational materials	

Activity 3.3	Increase audience of the monthly Maine EMS Staff Updates by creating a dedicated location on the website with a historical archive and create a separate GovDelivery optional mailing list for people to receive the updates (add opt-in option to eLicensing).	Maine EMS Staff	Ongoing, website changes by Jan. 1, 2024	Count in the number of site visits and number of subscribers	Maine EMS Staff Time, Website Developer Resources	Monthly Staff Update Newsletter	
Activity 3.4	Public information campaign to promote awareness and use of PulsePoint AED registry.	Maine EMS, EMD Committee, CARES	Ongoing beginning in November 2023	Increased number of AEDs in the registry.	Maine EMS staff time, Systems of Care Funding	AED stickers, social media, link from Maine.gov/ems, signage for training and other events.	

Strategy 4: Enhance Website presence							
Activity 4.1	Post Staff Bios on website	Maine EMS Staff	Dec-23	Current Staff Bios on website and a process during onboarding to add new employees	Maine EMS Staff Time	Bio for each staff	
Activity 4.2	Make it easy for site visitors to find and access what they need.	Maine EMS Staff	Dec-24	A staff directory having a topic table of contents	Maine EMS Staff Time	A directory to staff by topic	
Activity 4.3	Develop Frequently Asked Questions section	Maine EMS Staff	Mar-24	A frequently asked questions section with an associated table of contents	Maine EMS Staff Time	A list of FAQs	
Activity 4.4	Publish Tableau dashboards on EMS activities (Annual)	Maine EMS Staff	Jan-24	Having the tableau dashboards available on the website	Maine EMS Staff Time; DHHS Public Tableau Server	Tableau Dashboards; Website	
Activity 4.5	Define and Publish Tableau dashboards for Programs and initiatives	Maine EMS Staff	Mar-24	Having the tableau dashboards available on the website	Maine EMS Staff Time; DHHS Public Tableau Server	Tableau Dashboards; Website	

Data Driven Information about the EMS System

Notes from Plan:

In 2035 EMS in Maine is continuously improved by data-driven decision-making using trusted information. The ongoing reliability, sustainability and quality of the EMS system is dependent upon accurate information from every facet of the EMS system. A clear "why" about data and information has been established. Data-driven information is used to address the leading system issues, guide improvement and support ongoing research. Stakeholders throughout the system value datagathering processes. Clinicians are not asked to input irrelevant data. A robust, integrated data system seamlessly connects EMS with the larger healthcare system and provides and receives back valuable clinical information about EMS clinical care, from call to long-term outcome. Operational EMS is continuously provided with valuable information about system operations, including response, resources deployment, resource location, work load and costs. Because data systems continue to demonstrate value, education on data, information and data collection is routine and accurate throughout the EMS system.

As the EMS system continues to evolve (and especially in the areas of workforce, finance and clinical care), it must be able to justify decisions, costs and change with evidence and information that are rooted in data.

Milestones/Markers of Success:

a. Data collection is broadly understood and valued as necessary for improvement throughout the EMS system. Anecdotal reporting and qualitative data are supplemented by quantitative data.
b. Attention, funding, staffing and technology have been added to appropriately resource information efforts and systems. The EMS Bureau, the Regions and the entire EMS system have the technology and technological support needed to appropriately collect and analyze data.
c. Data-driven information is actually used to make informed decisions at all levels.
d. Clinicians' data entry time and efforts are respected.
e. There is robust data sharing between primary and secondary PSAPs, dispatch centers and EMS agencies, and data sharing is used to monitor and improve EMS, PSAP and dispatch center operations.
f. EMS patient care reports are connected to electronic health records and provide a feedback loop to appropriately evaluate patient outcomes at both the EMS and EMD level.
g. Data-gathering and analysis are funded and staffed appropriately.
h. All ambulances in Maine have connectivity and equipment to allow for the real-time transference of information across the healthcare system.
i. There is system-wide sharing of CAD data and real-time monitoring for best-possible resource coordination, including 9-1-1 and IFTs.
j. EMS data and information is used to monitor public health issues including bio-surveillance.
k. Systems are in place to accurately capture financial data and guide cost reporting.
l. Systems have been created to accurately capture workforce data.
m. The EMS system is actively engaged in conducting and supporting EMS research.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Improve Data Integrations							
Activity 1.1	Outcome Data Returned From Hospitals.	Data Team	31-Dec-25	Percent of EMS activations where the patient was transported having outcome data	Datasource for outcome data Willingness of hospitals/datasoruce to share	Access to outcome data for reporting and analysis	
Activity 1.2	Increase number of agencies using CAD to MEFIRS interface.	Data Team	Ongoing	Number of Agencies having CAD interface % EMS Activations having CAD Interface	ImageTrend Contract containing Interface Implementation plan/timeline from ImageTrend	Higher quality and more complete data as a result of the CAD data feed	
Activity 1.3	Migrate PCRs to NEMSIS v3.5	Data Team	31-Dec-23	100% Agency transition to NEMSIS v3.5	Staff Time; Educational Materials	v3.5 PCR Form; Educational Materials; Updated Reports/Analytics	
Activity 1.4	Migrate Community Paramedicine to Mobile Integrated Health Module	Data Team	1-Jul-24	100% Agency transition to NEMSIS v3.5 by 12/31/2023	Staff Time	MIH Form Updated Reports/Analytics	
Activity 1.5	Increase number of EMD Centers using ProQA interface to CAD	EMD Coordinator	31-Dec-25	Number of Centers having ProQA Interface	Spillman and IMC cost, IT education	Higher quality and more complete data as a result of the ProQA to CAD to MEFIRS pathway	
Strategy 2: Improve Understanding of Importance of Data and Enthusiasm for High-Quality Data Entry							
Activity 2.1	Create MEMSED training courses for NEMSIS 3.5 migration	Data Team	Oct-23	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	
Activity 2.2	Create MEMSED training courses on Data, Importance, Security and Compliance	Data Team	Apr-24	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	
Activity 2.3	Create MEMSED training courses on Data 102: MEFIRS PCR in Detail	Data Team	Jul-24	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	
Activity 2.4	Create MEMSED training courses on Data 201: Introduction to Data Analytics and Visualizations	Data Team	Oct-24	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	
Activity 2.5	Create MEMSED training courses on Data 202: ImageTrend Report Writer in Depth.	Data Team	Jan-25	Course is published and made generally available on MEMSED	Staff Time	MEMSEd Training Course Series	

Activity 2.6	Implement rule requiring standardized patient care reporting as part of licensure class	Data Team; Rules Committee	Jul-24	Completed Rule Change	Staff Time; Rules Committee	Standardized patient care reporting course for use in courses leading to licensure	Rulemaking
Activity 2.7	Implement policy that states that all continuing education courses must dedicate at least 10% of their time to covering how to appropriately document the condition(s) and/or interventions covered in the course.	Data team; Board	Jul-24	Completed data policy	Staff Time; Board Meeting Agenda Item	Policy stating 10% of continuing education shall cover documentation of the topic covered	Policy
Activity 2.9	Develop a Community Paramedicine data report that is published on the website/ social media. This will serve to provide evidence of the value of quality data markers for Community Paramedicine.	CP Coordinator/ Data team	Jan-25	Quarterly report that is published	Staff Time	Data reports	
Strategy 3: Improve upon use of data for making informed decisions							
Activity 3.1	Define measures, key performance indicators (KPIs), and goals for protocols and assess efficacy of medications and procedures	Board, MDPB, QI Committee, Systems of Care Program Manager, Community Paramedicine Program Manager, EMSC Program Manager; SUD Team	1-Jul-24	Ten Specific KPIs and Measures with associated Goals	Staff Time, Stakeholder Time, ImageTrend Report Writer, SQLServer	A defined set of meaningful measures, KPIs, and goals for protocols and to assess efficacy of medications and procedures and for which decisions and actions are able to be taken or have predetermined triggers that result in action(s) (e.g., modifications to protocols, additional training) to be taken	
Activity 3.2	Provide agency level report card for measures, KPIs, and compliance	Data Team	1-Oct-24	% of agencies sent regularly delivered reports, a defined set of meaningful measures, KPIs, and goals for protocols and assess efficacy of medications and procedures and for which decisions and actions are taken or have predetermined triggers that result in action(s)	Staff Time	Recurring report delivered via email to each agency	
Activity 3.3	Provide clinician level report card for measures, KPIs, and compliance	Data Team	1-Oct-24	% of clinicians sent regularly delivered reports, a defined set of meaningful measures, KPIs, and goals for protocols and assess efficacy of medications and procedures and for which decisions and actions are taken or have predetermined triggers that result in action(s)	Staff Time	Recurring report delivered via email to each clinician	
Activity 3.4	Provide state level report card for measures, KPIs, and compliance	Data Team; Newsletter Author	1-Sep-24	Dashboard, a defined set of meaningful measures, KPIs, and goals for protocols and assess efficacy of medications and procedures and for which decisions and actions are taken or have predetermined triggers that result in action(s)	Staff Time	Addition to Staff Update Newsletter	
Strategy 4: Standardize Policies for Information Management							

Activity 4.1	Author a policy/procedure for electronic communications, meetings, and social media messaging	Data Team, Webmaster Team; Director	1-Jul-24	Publication of an approved document	Staff Time	A policy/procedure document published on SharePoint and website	Policy
Activity 4.2	Author a policy/procedure for Information access and security	Data Team; Director	1-Apr-24	Publication of an approved document	Staff Time	A policy/procedure document published on SharePoint and website	Policy
Activity 4.3	Author a policy/procedure for responding to requests for information that involve information managed by Maine EMS containing personally identifying information (PII) and personal health information (PHI)	Data Team; FOAA Team; Licensing Team; Attorney General's Office, OIT	1-Apr-25	Publication of an approved document	Staff Time	A policy/procedure document published on SharePoint and website	Policy
Activity 4.4	Develop and adopt rule requiring Health Data Security training and MEFIRS Training	Data Team, Rules Committee; Education Coordinator; Attorney General's Office	1-Apr-24	Rule in effect and renewal process built to accomodate	Staff Time	Rule stating 10% of continuing education shall cover documentation of the topic covered	Rules
Strategy 5: Streamline data entry processes.							
Activity 5.1	Develop and Implement Change Control and Notification Policy	Data Team; Director	1-Apr-24	Development and approval of a change control policy, notification process	Staff Time	Policy document	Policy
Activity 5.2	Identify and Develop monitoring process for Data Entry KPIs	Data Team	1-Jul-24	Dashboard with KPI for time/effort required to enter, validity score	Staff Time	Dashboard with KPI for time/effort required to enter, validity score	
Activity 5.3	Streamline the ePCR user interface to improve data entry processes for clinicians.	Data Team, Data Committee	Ongoing	Improvement in KPIs from Activity 5.2	Staff Time	Dashboard with KPI for time/effort required to enter, validity score	
Activity 5.4	Streamline the licensure user interface to improve data entry processes for clinicians.	Data Team, Licensing Team	Ongoing	Improvement in KPIs from Activity 5.2	Staff Time	Dashboard with KPI for time/effort required to enter, validity score	

EMS System Evolution

Structure within State Government

Notes from Plan:

Where We Want To Be: In 2035 EMS is structured and led within government to "promote and provide for a comprehensive and effective emergency medical services system to ensure optimum patient care." EMS system leadership, planning, development and regulation are structured to provide maximum support for ongoing system evolution, ensuring the public is protected and served by reliable, sustainable and quality EMS. The structure includes significant local agency and personnel representation and ensures clear lines of communication between state EMS activities and the frontline provision of EMS. The structure provides a pathway to address current and emerging issues while maintaining efficacy and efficiencies.

Milestones/Markers of Success: a. The Bureau of EMS is positioned, empowered, funded and staffed to meet its mission of being "responsible for the coordination and integration of all state activities concerning emergency medical services and the overall planning, evaluation, coordination, facilitation and regulation of emergency medical services system."
b. The positioning, empowerment, funding and staffing of the EMS Bureau are sustainable.
c. The Bureau of EMS has a balanced and collaborative relationship with an EMS Board that provides strategic guidance, checks and balances and accountability across the statewide structure and in rule-making.
d. There is clear delineation between system planning and the regulation and licensing of personnel and entities.
e. An EMS professional licensing board is created that regulates personnel licensing rules, conducts investigations and disciplinary/administrative hearings and proposes personnel licensing rules. The Bureau of EMS regulates agencies.
f. The EMS Board is small and agile with nine members representing EMS regions and key stakeholder groups. It provides guidance on EMS system planning and development, provides representative input from various EMS stakeholders and provides a check and balance in rule-making.
g. The EMS Board has the authority to develop and submit legislation directly to the legislature.
h. Independent Regional Councils made up of representatives of local clinicians and local agencies meet regularly and effectively provide regional representation for agencies and personnel on the EMS Board, to voice local issues, needs and opportunities.
i. A State Medical Director is a fulltime EMS Bureau employee and oversees all aspects of clinical care and clinical care development.
j. The 1982 EMS Act and other statutes and rules are updated to accomplish the above.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Modify the EMS regulatory system structure to align with and achieve the Maine EMS Vision and Plan.							
Activity 1.1	Support the proposed restructuring of the Maine EMS system that was endorsed by the Maine EMS Board (e.g., presenting to the Blue Ribbon Commission, advocating for change).	Legislature, Director, Board, Maine EMS Staff	Ongoing	None	N/A	Proposed Organizational Structure of Maine EMS	Statute
Activity 1.2	Obtain state-supported staffing of a policy development position within the Office to support the development of concept rules and policies.	Maine EMS Team, Board, Legislature, Commissioner's Office; Governor's Office	1-Jul-25	Position Available and filled	Legislation; Funding	Proposed Organizational Chart; Proposed Budget; Draft Appropriation Language/Legislation	Statute
Strategy 2: Ensure reliable staffing in the Maine EMS office.							
Activity 2.1	Identify and define the structure and staffing needs to accomplish statutorily required activities and those of the Vision.	Maine EMS Team, Board, Legislature; Commissioner's Office; Governor's Office	1-Jan-24	Plan created	Staff Time	Proposed Organizational Chart; Proposed Budget; Draft Appropriation Language/Legislation	
Activity 2.2	Define all duties being performed by Maine EMS staff, and identify the appropriate personnel required to successfully complete these tasks.	Maine EMS Staff; Director; Human Resources Service Center	31-Aug-24	Comprehensive document completed	Staff time	Document stating duties and responsibilities of each staff member and appropriate number of staff necessary to complete duties.	
Activity 2.3	Add new positions and transition limited-period/grant-funded positions into permanent, state-funded positions, where possible and appropriate, to ensure adequate staffing to meet the needs of the EMS system and achieve the goals in the Vision.	Maine EMS Team, Board, Legislature; Commissioner's Office; Governor's Office	31-Dec-24	Positions funded and filled	Legislation; Funding	Draft Legislation; Budget; Position Justification Forms; Position Descriptions	Statute
Strategy 3: Foster an increase in interstate collaboration							
Activity 3.1	Encourage components of the Maine EMS system to work collaboratively with our regional state counterparts (e.g., State of New York Office of EMS, Vermont Office of EMS, etc.).	Maine EMS; Board; MDPB; Attorney General's Office; Education Committee; Community Paramedicine Committee; Trauma Advisory Committee; Maine Stroke Alliance; QA/QI Committee	Ongoing	Ongoing participation in NASEMSO meetings	Staff Time; Stakeholder Time; NASEMSO membership	TBD	

Regional Coordination and Support Under a State Model

Notes from Plan:

Where We Want To Be: Local clinicians, EMS agencies, EMDs and other local EMS stakeholders have an effective voice in the statewide EMS system and experience effective local and state support. Their unique needs, opportunities, challenges and concerns are regularly heard and addressed. This is accomplished through four EMS Regions with robust regional structures that include: true representative regional councils that meet regularly; funded regional offices staffed by state employees who provide coordination, information, facilitation, guidance, outreach, compliance and clear and regular communication between all facets of the EMS system; regional medical direction; and quality improvement guidance. The regional structure promotes EMS reliability, sustainability and quality by helping local entities understand expectations, meet regulations, collaborate, develop efficiencies and address challenges.

Milestones/Markers of Success: a. Regional councils that are truly representative and effective have been established and provide input on regional needs and goals, medical direction, operational collaboration and quality improvement.
b. Regional offices are established in each geographic region and are appropriately staffed and funded.
c. Local EMS personnel and agencies experience effective support and have known resources to turn to.
d. Communication is clear, timely and effective between the Bureau of EMS, the statewide system and local agencies and personnel.
e. Cross agency partnerships and collaboration are successful and effective.
f. Agencies have ready access to guidance and support in addressing operational challenges, regulatory questions, workforce issues, medical direction, continuing education, QA/QI and wellbeing programming.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Create the framework for a regional model incorporated into state government.							
Activity 1.1	Define and articulate the needs of the EMS system regarding a regional model, including receiving feedback from stakeholders.	Maine EMS Staff, Maine Board of EMS	12/31/2024	Report on stakeholder feedback completed, Current proposed rule implemented	Staff Time, Meeting Space,	Chapter 15 of Maine EMS Rules; Public Forum; Report	Rule
Activity 1.2	Define the regional system's structure, organization, required resources, and position within state government.	Maine EMS Staff, Maine Board of EMS	31-Dec-24	Completion of a structure model	Staff Time, Board Time,		Statute
Strategy 2: Transition from the current regional model to a state-supported regional system.							
Activity 2.1	Use the framework from Strategy 1 to create a transition plan that includes future structure, communication pathways, and steps to move from the current structure to the desired structure.	Director of Maine EMS	3/31/2025	Completion of transition plan	Staff Time	Transition Plan	
Activity 2.2	Develop a budget that supports the regional offices and the services and functions identified by key stakeholders.	Maine EMS Staff, Director, Service Center, Commissioner's Office, Governor's Office	31-Dec-25	Completion of budget	Staff Time	Budget	Statute
Activity 2.3	Secure legislative changes and funding to create regional offices and positions.	Legislature; Maine EMS Director	12/31/2025	Regional offices created in each region with sufficient personnel for implementation funded	Staff time; legislative materials (including testimony)	Legislation	Statute

Interfacility Transfers

Notes from Plan:

Where We Want To Be: In 2035 interfacility transport (IFT) is viewed as a distinct, vital and necessary element of an optimally performing EMS system. IFT is coordinated statewide through a Centralized Transfer Center (CTC) that is the result of broad collaboration between healthcare systems, healthcare facilities and EMS agencies. Data and information about transfer volumes, locations, necessity, destinations, clinical care and other specialized care are used by the CTC in real-time to ensure resources are efficiently used. Patient and healthcare system needs are effectively met without eroding 9-1-1 capacity. Healthcare systems actively participate and share responsibility in supporting IFT and the CTC through funding, training opportunities and other resources.

Milestones/Markers of Success: a. IFT is viewed by EMS agencies, leaders, clinicians and healthcare systems as important and in need of systemwide study, support and coordination to ensure optimal system operation.
b. IFTs and processes that deliver IFTs are studied and well understood in a manner that guides a statewide systems approach to IFT.
c. Healthcare systems and facilities assume a shared responsibility for the coordination of IFTs through the creation, funding and ongoing support of a Centralized Transfer Center (CTC) to facilitate and coordinate a best possible delivery model of patient movement between healthcare facilities.
d. A statewide IFT system is designed to maximize efficiency, efficacy and safety.
e. The IFT system ensures the development of adequately prepared, competent and confident resources to meet critical care, pediatric and neonatal IFT needs.
f. A licensure pathway for critical care transport has been created for both clinicians and agencies.
g. Novel solutions have been developed to move patients that do not need traditional ambulance transportation.
h. Data and information about all aspects of IFTs are gathered and analyzed with an eye on what is best for patients, healthcare systems and EMS clinician and agencies.

Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Establish a resilient, efficient, and effective system for the delivery of interfacility transportation (IFT)						

Activity 1.1	Compile evidence and data to increase the understanding of the current IFT system, and propose alternatives that can improve it.	IFT Committee, Maine EMS Staff, MAA, Maine Fire Chiefs' Association, Maine Hospital Association.	1-Jul-24	Completion of research and documentation of research, Surveys, questionnaires, subject matter expert groups, and evaluations of positives and negatives.	Maine EMS, EMS Board, Maine Ambulance Association, Fire Chiefs' Association, Maine Hospital Association	Research materials of other Interfacility Transfer Programs/Methods in other states. Written, concise descriptions of successes and failures of current program.	
Activity 1.2	Identify clearly defined goals for Interfacility Transfers, both ALS and BLS.	IFT Committee, Maine EMS Staff, MAA, Maine Fire Chiefs' Association, Maine Hospital Association.	31-Dec-24	Goals checklist written	Maine EMS, EMS Board, Maine Ambulance Association, Fire Chiefs' Association, Maine Hospital Association	Clearly established goals for the direction of Interfacility Transports in the state.	
Activity 1.3	Identify key performance indicators that can be used to measure the effectiveness and efficiency of interfaciltiy transfers	IFT Committee, Maine EMS Staff, MAA, Maine Fire Chiefs' Association, Maine Hospital Association.	31-May-25	Surveys, questionnaires, and options to develop KPIs.	Maine EMS, EMS Board, Maine Ambulance Association, Fire Chiefs' Association, Maine Hospital Association	They were written and accepted KPI's for Interfacility Transports.	
Strategy 2: Develop a new licensure level for agencies and individuals to support IFT							
Activity 2.1	Establish a Workgroup to decide the roles, responsibilities, scope of practice, credentialing, education, etc. of this licensure level.	Maine EMS, EMS Bd., MAA, Fire Chiefs' Association, Maine Hospital Association	31-Jul-24	Workgroup established	Maine EMS, EMS Board, Maine Ambulance Association, Fire Chiefs' Association, Maine Hospital Association	Licensure requirements, education requirements, competency requirements.	
Activity 2.2	Draft and initiate Rules for the implementation of critical care licensure at the individual and agency levels.	Maine EMS, EMS Board, PIFT Committee	31-Dec-25	Rules created	Staff time, committee time	Rule	Rules
Activity 2.3	Develop rules to prevent 911 services from relying on mutual aid to cover emergency calls in their coverage area while the primary service leaves their coverage area for IFT	IFT Committee, Rules Committee, Maine EMS Board	31-Dec-25	Rules created	Staff time, committee time	Rule	Rules
Strategy 3: Consider the need for a centralized/singular dispatch resource for transfers							
Activity 3.1	Evaluate resources available to support a centralized dispatch, including existing agencies and protocols.	Maine EMS, IFT Committee, MHA, Priority Dispatch	1-Jan-25	Report	Staff time, committee time	Clearly established resources.	

Communication and EMD

Notes from Plan:

Where We Want To Be: In 2035 emergency communications and emergency medical dispatch (EMD) are at the center of optimizing the EMS system's response, resource use and outcomes. The EMS system's efficiency and effectiveness continuously improve because the system's status and resource use are managed by a complete and effective feedback loop and supported by quality data. The continuous improvement is the result of: emergency communications centers and EMD telecommunicators being appropriately integrated into response planning; response plans that are designed to appropriately match the caller/patient's need with the best resource in a geographic region; uniform processing of calls across the state; EMD telecommunicators having a wide variety of emergency and non-emergency resources to draw on; telecommunicators being appropriately prepared and empowered to effectively match needs with resources; the availability of technology to continuously evaluate resource status and location in real time; the use of data elements through the entire continuum of care that are pulled together to gather reliable outcomes information; and the use of outcomes information to continuously improve outcomes, the system and resource use.

Milestones/Markers of Success: a. Emergency communications, EMD telecommunicators, response plans and response data are viewed as integral to the EMS system's efficiency and patient outcomes.
b. All of the various elements of the EMS system work together to create carefully crafted response plans aimed at maximizing efficient resource use and positive patient outcomes.
c. There is increasing collaboration and increasing uniformity between call centers. Call processing is structured to match needs with the right resources, and the technology is available and utilized to support this mission.
d. A variety of resources beyond EMS response are identified and available to meet the callers' needs. These include non-emergency resources such as mental health, nurse triage, social services, poison control, etc.
e. EMD telecommunicators are prepared, resourced, authorized and empowered to match callers with the right resources. The data elements needed to evaluate and guide best-outcome response planning have been identified.
g. The system has established a process for gathering and aggregating data elements from 9-1-1 call data, computer aided dispatch (CAD) systems, Maine EMS & Fire Incident Reporting System (MEFIRS) data and the various electronic health records (EHR) used by the healthcare systems.
h. Outcomes information is used to continuously improve system response plans and resource use.

Activity		Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Program Coordination							
Activity 1.1	Define the role and responsibilities of the EMD Program Coordinator	Maine EMS, ESCB (Emergency Services Communications Bureau)	1-Jan-24	Completion of the Report	Staff Time, historical records	Report	

Activity 1.2	Evaluate the time required to complete identified job tasks to meet the responsibilities of the EMD Program Coordinator	Maine EMS, ESCB (Emergency Services Communications Bureau)	1-Jan-24	Completion of the Report	Staff Time	Report	
Activity 1.3	Allocate staff (staff time) to meet the needs of the system	Maine EMS, ESCB (Emergency Services Communications Bureau), Legislature	31-Dec-25	Increased staffing	Legislation; funding; staff time; office restructuring	Draft Legislation; Budget; Position Justification Forms; Position Descriptions	Statute
Activity 1.4	Promote legislation recognizing the need for an Emergency Mental Health Dispatch Coordinator	Maine EMS, ESCB (Emergency Services Communications Bureau), Legislature	1-Jan-25	Increased staffing	Staff Time	Additional staff member	Statute
Strategy 2: System Evaluation							
Activity 2.1	Evaluate EMD Centers' existing resources (software versions, interfaced programs, alternative communication technologies, Automatic Vehicle Location[AVL]) and operations (24 hour capability, use of secondary dispatch, QA plan, use of response plans, EMS and EMD feedback mechanisms) through surveys and on site inspections	Maine EMS, ESCB (Emergency Services Communications Bureau)	1-Jul-24	Completion of the Report	Staff time, travel expenses, EMD center time, survey tools and inspection checklist	Report	
Activity 2.2	Evaluate and promote the use of the 911-988 transfer policy.	Maine EMS, ESCB (Emergency Services Communications Bureau), Maine Crisis Line	1-Nov-23	User and patient feedback from direct contact.	Staff time	Data, QI, Continuing education	
Strategy 3: Quality Assurance Support							
Activity 3.1	Measure the available staff at each EMD Center qualified to perform QA and encourage under resourced Centers to send staff to Q training	Maine EMS, ESCB (Emergency Services Communications Bureau)	1-Jul-24	Increased number of qualified QA staff	Staff Time	Report	
Activity 3.2	Identify a pathway for direct access to EMD data (ProQA and AQUA software) by the EMD Coordinator	Maine EMS/ESCB (Emergency Services Communications Bureau), Priority Dispatch, OIT (Office of Information Technology), EMD Centers	1-Jul-24	MEMS and ESCB staff have direct access to EMD Centers' ProQA and AQUA software.	Staff Time, IT	Cloud based or other direct access to EMD Centers' software	
Activity 3.3	Financially support EMD Centers to meet the requirements of regular quality assurance case reviews.	Maine EMS/ESCB (Emergency Services Communications Bureau), Priority Dispatch	1-Jul-25	Increased quantity of month case reviews and increased compliance scores by Center.	Funding for staff time or QPR contract. Funds available through 911 surcharge, managed by the ESCB.	Report reflecting improved compliance with case reviews	
Strategy 4: EMD and EMS Collaboration							
Activity 4.1	Schedule regular workshops with PSAPs (Public Safety Access Points), EMS user agencies, and service-level Medical Direction to educate local systems on implementing response plans	Maine EMS Staff	Ongoing	Increased implementation of response plans.	Staff time	Workshops held and completed	
Activity 4.2	Identify opportunities for EMD representation in EMS committees and working groups	Maine EMS	1-Jul-24	Increased EMD respresentation in EMS committees	Staff time, Board approval to add representative roles as needed	List of opportunities	
Activity 4.3	Increase awareness and promote implementation of feedback mechanisms between EMS agencies and EMD centers for patient outcomes to support understanding and quality assurance	Maine EMS, EMD Centers, EMS Agencies, Hospital Liasons	Ongoing	Increased communication between EMS and EMD locally.	Staff time	Outreach, networking, websites for EMD centers, outcomes feedback for EMD centers	

Emergency Management and Disaster Preparedness

Notes from Plan:

Where We Want To Be: In 2035 the Maine EMS system is prepared and ready to meet any events that exceed the capacity of local resources. This preparation will allow the EMS system to be prepared and ready for any large-scale emergency, extraordinary event or disaster. The EMS system is no longer struggling to meet routine 9-1-1 and IFT demands, and therefore has the capacity, leadership, personnel and funding to appropriately prepare for large-scale emergencies and disasters. Planning is led at a regional level and is fully integrated with statewide emergency planning and regional healthcare coalitions. EMS in Maine is viewed as a key stakeholder in emergency management and disaster planning and has a respected place in all planning activities. Local agencies and clinicians are appropriately prepared and resourced for these activities.

Milestones/Markers of Success: a. All facets of the system actively plan for any incident, event or situation that will exceed local capacity. This planning is continuous.
b. EMS throughout Maine has an equal part in preparation, planning and response.
c. EMS throughout Maine is involved in disaster mitigation and recovery.
d. EMS throughout Maine is considered a valid and valued resource in any disaster
e. The planning for patient movement in disasters is integrated with the overall healthcare system.
f. EMS is cognizant of and prepared to respond to the disasters that are the result of climate change.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Develop and enhance relationships between State EMA and EMS							
Activity 1.1	Increase coordination and collaboration between State EMS and State EMA through regular meetings, training, and planning	Maine EMS, Maine EMA	31-Jan-24	Regularly scheduled meetings and training	Staff time	Meeting minutes	
Activity 1.2	Clarify and develop the roles and responsibilities of each agency in the State EOP.	Maine EMS, Maine EMA	31-Mar-25	Written defined roles and responsibilities of each agency in disaster response	Incident Command Training, staff time	State EOP	
Activity 1.3	Identify and train four staff members to support the State EOC as ERT members.	Maine EMS, Maine EMA	31-May-24	Develop areas where each agency may collaborate.	Incident Command Training, ERT Training and resources (WebEOC)	Training completion certificate	
Strategy 2: Increase disaster resiliency in the Maine EMS System							
Activity 2.1	Conduct a risk assessment and determine capability assessment/needs of the EMS system with MEMA current capabilities to assess assets, gaps, and/or barriers	Maine EMS, Maine EMA	30-Jun-24	Identify hazards, response needs, and gaps within the system to respond to disasters	Staff time, EMS and MEMA data	Completed capability assessment, risk assessment, THIRA	
Activity 2.2	Develop a Continuity of Operations (COOP) Plan for Maine EMS	Maine EMS	30-Jun-24	Development of a COOP Plan	Staff time	COOP Plan	
Activity 2.3	Participate in emergency preparedness exercises and training at the local or state level. Share exercise development materials with EMS services to develop and conduct their own exercises.	Maine EMS, Maine EMA, Maine CDC PHEP	30-Jun-24	Access to trainings	Staff time, exercise materials	HSEEP Resources (EXPLANs, SITMANs, Etc.)	
Activity 2.4	Develop resources and educational materials to increase knowledge in disaster preparedness and hazards, including climate change. Share information on how services can create their own continuity and disaster plans.	Maine EMS staff, Maine EMA, Maine CDC PHEP	30-Jun-24	Development of local Emergency Plans, and a plan to disseminate trainings (through regions)	Staff time, resources, local support, materials development	Educational materials, resources.	
Activity 2.5	Actively participate in and evolve from After Action Reports (AARs)/Improvement Plans	Maine EMS, MEMA, Maine CDC	Ongoing	Based on findings from AAR	Recommendation dependent	TBD based on AAR	
Strategy 3: Increase the percent of EMS agencies that have a disaster plan that addresses the needs of children.							
Activity 3.1	Determine existing disaster plans (local, county, regional) and any pediatric aspects included (or absent)	EMSC, Maine EMA, Maine EMS	31-Dec-24	Do at least 9 counties (45%) have plans that address needs of children	Staff Time	Develop template of best practices	
Activity 3.2	Evaluate gaps and opportunities to resolve	EMSC, Maine EMA, Maine EMS	31-Dec-24	Evaluate at least 9 counties (45%) for gaps in plans that address needs of children	Staff time	Determine best practices	
Activity 3.3	Evaluate current triage systems and pediatric applicability	EMSC, Maine EMA, Maine EMS	31-Dec-24	Evaluate at least 9 counties (45%) for triage plans that address needs of children	Determine current triage systems used, determine any options	Consider statewide triage system	
Activity 3.4	Encourage regional/local training exercises that integrate pediatric considerations	EMSC, Maine EMA, Maine EMS	31-Dec-24	Determine that at least 9 counties (45%) have, or have plans for, training exercises that address needs of children	Funding, committment from county, public safety agencies, hospitals, other stakeholders	Use of federal/MEMA templates for training exercise planning / implementation / review	
Activity 3.5	Evaluate pediatric tracking and reunification during disasters	EMSC, Maine EMA, Maine EMS	31-Dec-24	Determine that at least 9 counties (45%) have plans that address tracking and reunification needs of children and families	Hospital and EMS agencies	Existing methods and best practices - develop sample policies and resource lists	

EMS Workforce

Data-driven Workforce Planning

Notes from Plan:

Where We Want To Be: In 2035 the EMS system has accurate and actionable information about the EMS workforce. A proactive and ongoing data-driven, evidence-based approach to workforce planning is led by the Bureau of EMS and utilized by the EMS Regions, local agencies and communities. This process collects detailed data and information about the numbers and certification/licensure levels of needed workers, shortages and the location of shortages, the demand for workers, causes of turnover, the supply of workers and the pipeline feeding the supply, education and training issues, working conditions, compensation and benefits, the entire employment value proposition and developing workforce trends. This information is turned into actionable plans, tools and activities that support successful recruitment and retention.

Milestones/Markers of Success:

a. Workforce planning expertise has been established within the Bureau of EMS with appropriate resources and staffing.

b. EMS leaders and agencies are introduced to the concepts of workforce planning and the need for and importance of reliable data and information about the workforce.

c. Detailed workforce data is collected at state, regional and agency levels, including: the number of currently active EMS related professionals;7 geographic distribution of workers; the number of EMS related professionals working multiple EMS jobs; the number of EMS related professionals needed; the gap between the supply of EMS related professionals and the needed number of EMS related professionals; the pipeline and development of new EMS related professionals; and issues impacting turnover and retention.

d. The need, current supply, gap between need and supply and confounding factors are used to clarify the actual shortage of workers in plain numeric terms. e. Volunteerism is continuously evaluated at an agency level. This includes defining what it means to be an active volunteer, quantifying the numbers of active volunteers, assessing volunteer availability, noting an absence of a schedule or schedule shortages, and the agency trends over time. All of this is used to predict agency sustainability.

f. Systemwide predictions are made around future supply and demand based on data, information and emerging trends.

g. The EMS employment value proposition is continuously studied, talked about and addressed state-wide. The employment value proposition includes compensation, benefits, retirement programming, career paths and ladders, advancement opportunities, the subjective intrinsic satisfiers and dissatisfiers, and the general wellbeing of the workforce.

h. All of the above is regularly communicated throughout the EMS system to aid the EMS Regions in coordinating with local agencies in planning successful retention and recruitment strategies.

i. There are a variety of career paths for clinicians and growing awareness about the capacity of paramedicine as a career field and path.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Improve data collection regarding workforce							
Activity 1.1	Identify which additional workforce data (i.e., administrative staff, mechanics, etc.) we need to collect data on to better understand the capacity and needs of the EMS workforce.	Data team, Licensing Team	1-Jul-24	The existence of defined data elements/needs.	Staff, Workforce Expertise	Defining the data elements necessary to evaluate the workforce within the EMS system.	
Activity 1.2	Collect data identified in Activity 1.1 from licensed agencies as part of their licensure renewal.	Data team, Licensing Team	30-Nov-24	Adoption of a rule that requires all staff to be entered into licensure	Staff, Rules committee, Board	EMS Application (initial or renewal) collecting data elements defined in needs assessment.	
Activity 1.3	Monitor and improve logic behind delay reporting in MEFIRS, to include dispatch delays.	Data team, EMD	Ongoing	Closer alignment between anecdotal reports of staffing causing response delays aligning with measurable information	Staff, Data Committee, QA/QI Committee	Ability to assess impact of staffing on delays	
Strategy 2: Cost Reporting							
Activity 2.1	Bring on Staff Positions Allocated by the Legislature	Director	31-Mar-24	Staff Onboarded	Staff Time	Position Justification Form; New Position Number; New Job Posting	
Activity 2.2	Develop data collection form	Data team; Cost Reporting Team Member	31-Dec-24	Time to complete	Staff time, Financial Expertise	Collection instrument	
Activity 2.3	Educate about the importance of cost data reporting	Data team; Cost Reporting Team Member	2024/2025	Completion ratio	Staff time, Financial Expertise	Marketing/education materials	
Activity 2.4	Develop report from the cost data collection and identify KPIs	Data team; Cost Reporting Team Member	31-Dec-25	Reporting that provides insightful and actionable insights into the sources of reveue/funding, expenses and the balance between	Staff time, Financial Expertise	Cost Data Program(s)	
Strategy 3: Using data to identify workforce patterns to support sustainability and address disparities.							
Activity 3.1	Collect data to quantify the factors impacting work/life balance in the EMS workforce.	New Hire (Workforce Management Staff)	TBD	TBD	Legislative funding, Staff	Mechanism to measure and monitor employment factors pertaining to work/life balance.	
Activity 3.2	Collect data to quantify compensation and factors impacting compensation in the EMS workforce.	New Hire (Workforce Management Staff)	TBD	TBD	Legislative funding, Staff	Mechanism to measure and monitor employment factors pertaining to compensation.	
Activity 3.3	Identify potential career pathways and advancement opportunities within the EMS profession.	LD244 Stakeholder Group	14-Jan-24		Legislative Report		

Education and Training

Notes from Plan:

Where We Want To Be: In 2035 education and training are no longer just gateways to obtaining and keeping clinical and operational credentials but the pathway for the EMS system's future and a passport for each clinician's ongoing professional growth, development, and satisfaction. A clear distinction between education and training has been established. Not only do clinicians acquire the necessary skills and behaviors needed for their roles, a passion for knowledge and wisdom has been created that enriches the entire EMS system and its quest to improve and innovate. The quality of entry level training and education continues to be strong, locally available, affordable and adaptive to the needs of learners and Maine's geography. Education and training reach far beyond clinical and operational EMS and now includes leadership development, business administration, accounting, technology, improvement science, people and workforce management, research, and resilience and wellbeing. The EMS system has enough attention and support to have adequate educational sites, qualified educators, financial resources and technology to meet current and emerging needs. EMS education and training continues to develop in quality, availability, convenience and affordability.

Milestones/Markers of Success: a. EMS education is valued by clinicians, employers, leaders and stakeholders as an essential component not only for clinical and operational competency but for every facet of the EMS system.
b. EMS education (clinical, leadership and managerial) is available and accessible statewide, with a mechanism to provide appropriate funding for EMS education in Maine.
c. EMS education is an essential component of a career ladder, and the ladder has been connected with clear paths and credentials.
d. The academic development of leadership is recognized as essential, and programming for leadership development at all levels has been developed.
e. Possession of EMS education and credentials (clinical, leadership and managerial) are required components of EMS organizational hiring.
f. EMS education is valued as a career path. EMS clinicians wishing to expand their careers seek out education because of the multiple roles educators can fill.
g. There is a state level organization, which is seated in the college system, dedicated to the education, training, professional development and credentialing of EMS instructors.h. There is a formal, outlined training and development pipeline for EMS instructors that is phased and encompasses all levels of EMS instruction.
i. Participation in initial training for all levels is supported and not hampered by issues such as child care, lost wages and transportation. Funding for EMS education and training has become a systemwide priority.
j. The system has sustainable ways to provide continuing education hours in a manner that delivers quality, effectiveness and convenience.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Increase the percent of EMS agencies that have a process that requires clinicians to physically demonstrate clinical competency (both adult and pediatric).							
Activity 1.1	Assess EMS agencies' current practices, barriers, and opportunities for improvement as they relate to the frequency of adult and pediatric competency assessment	EMSC, Maine EMS Staff	31-Dec-24	Survey, conduct focus groups	EMS Training officers, medical directors	Summary report on barriers	
Activity 1.2	Develop awareness among EMS agencies and EMS medical directors on the importance of regular adult and pediatric clinical competency training and assessment	EMSC; MDPB	31-Dec-24	Develop quarterly promotion materials distributed statewide	Social media, website, regional distribution, conference attendance	Electornic resources and presentations to educate	
Activity 1.3	Attend statewide and regional conferences to promote clinical compentency assessments	EMSC, Maine EMS Staff	31-Dec-24	Attend/participate in state, regional and local meetings to promote adult and pediatric skills competency	Travel, build presentations	Attendance and presentations	
Activity 1.4	Analyze EMS response data to determine what types of adult and pediatric calls/skills are seen/performed by frequency	EMSC; Data Team	31-Dec-24	Evaluate at least 2 years of Maine EMS data for adult and pediatric responses	Analyze data,	Report on Maine EMS pediatric skills and responses	
Activity 1.5	Develop sample policies and resources for annual adult and pediatric clinical competencies	EMSC; Maine EMS Team	31-Dec-24	Develop a sample policy template	Eval national resources, develop policy	Sample template	
Activity 1.6	Support EMS conferences and training opportunities related to adult and pediatric clinical competency evaluation and improvement	EMSC, Maine EMS Staff	31-Dec-24	Attend at least 2 conferences annually to promote skills around adult and pediatric care	Travel, build presentations	Attendance and presentations	
Strategy 2: Improve access to initial EMS education.							
Activity 2.1	Convene a Stakeholder Group to Explore EMS Career Pathways and Educational Opportunities in the State (Resolve -- LD 244)	Maine EMS, Maine Community College System, University of Maine System, and public/private entities that provide EMS education and training	15-Jan-24	Report to Joint Standing Committee on Criminal Justic and Public Safety that outlines activities and recommendations.	Maine EMS Staff Time, Stakeholder Staff Time, Meeting Space (Virtual)	Required Report (Due 1/15/24)	
Activity 2.2	Ensure all EMR, EMT, AEMT, and paramedic classes held in Maine are posted to eLicensing at least one month before the start date so that anyone can find upcoming classes in their area.	Maine EMS Staff, Training centers, Community college system	1-Jun-24	Rates of compliance, and rates of successful course matching	Staff time, website reconfiguring, Education Committee cooperation	List of courses on MEMSEd	Rule
Activity 2.3	Identify needs to improve access to initial licensure courses.	Maine EMS Staff, Training centers	1-Jun-24	Number of EMS classes held in each region	Staff time, training center support	Needs assessment/report	
Activity 2.4	Hire additional Education staff to the Maine EMS Office	Maine EMS Staff	1-Jun-24	Successful onboarding of new staff member(s)	Staff time, grant funding	Grant application	
Strategy 3: Improve access to continued education hour opportunities for clinicians and instructor/coordinators							
Activity 3.1	Revise, standardize, and educate stakeholders on criteria for CEH course approval	Maine EMS Staff, Education Committee	1-Jul-24	Completion and validation of criteria	Staff time, Education Committee time	Criteria	Rule

Activity 3.2	Develop training(s) on how to develop and seek approval for CEH courses.	Maine EMS Staff, Education Committee	1-Jul-24	Completion of training	Staff time	Training materials and resources	
Activity 3.3	Identify and advertise grant funding opportunities for clinicians to receive compensation for attending continuing education or professional development.	Maine EMS Staff	1-Dec-25	Services access and apply for grant funding	Staff time, website, internet, grant-related expertise	List of grant opportunities posted to website	

Strategy 4: Implement and expand the Maine EMS Explorer Program.							
Activity 4.1	Identify a minimum of 3 initial Explorer sites and convene a regular cohort meeting.	Explorer Program Coordinator	Ongoing, to be completed in the Fall of 2023	Interest expressed by trial sites (verbal and written). Support from communities.	Staff time, transportation, social media	Written Statement of Interest from each site	
Activity 4.2	Develop education/training materials for Explorers, Mentors, and Services.	Explorer Program Coordinator, JMG EMS Workforce Liaison, JMG ELO team	Ongoing, to be completed by end of 2023	Completion.	Staff time, transportation, filming equipment, actors, scripts, locations, media editing software, collaboration with ELO team	Completed modules on MEMSEd and the JMG ELO	
Activity 4.3	Implement Explorer activities at trial sites.	Explorer Program Coordinator, JMG EMS Workforce Liaison, trial site personnel	Ongoing, to be completed by March, 2024	Count of Mentors and Explorers, satisfaction of all involved.	Staff time, transportation, social media, t-shirts (arranged by JMG), service time and effort	Count of Mentors and Explorers, Explorer Program Implementation Guide	
Activity 4.4	Begin subsequent rollout phases beyond the initial sites.	Explorer Program Coordinator, JMG EMS Workforce Liaison, trial site personnel, Service leaders, Educators, Schools, Towns	June, 2024	Count of services implementing Explorer Program	Staff time, transportation, social media, t-shirts (arranged by JMG), service time and effort	Count of services	
Activity 4.5	Hold monthly meetings with initial Explorer sites and the Explorer Team to promote quality improvement and share best practices.	Maine EMS staff, JMG, initial trial sites	September 2023 through May 2024	Regular meetings, discussions, and implementation of lessons learned	Staff time, service and mentor time, Zoom/Teams	Meeting minutes and recordings	

Leadership Development and Support

Notes from Plan:

Where We Want To Be: In 2035 the EMS system has an extraordinary cadre of leaders at every level. It is widely accepted that the EMS system's sustainability depends on prepared and capable leaders. The development and credentialing of leaders receive as much attention and focus as the development and credentialing of clinicians. The EMS system has identified what is needed to develop effective EMS leaders at all levels. This knowledge results in robust programming for leadership development and the ongoing encouragement, growth and support of leaders. There are clear expectations for agency leaders to have formal leadership development, and a leadership credentialing process has been developed. Leadership has become an attractive career path and the EMS system is continually looking for and preparing the next leaders.

Milestones/Markers of Success: a. Capable and prepared leaders are viewed as essential to EMS system reliability, sustainability and quality.
b. Learning leadership is no longer simply on the job, and the ability to lead is not assumed.
c. Leadership education and development are expected of all personnel who have responsibilities for coordinating, supervising, managing, directing and leading any part of an agency or the system.
d. A credentialing process has been developed, and leaders at all levels are expected to fulfill the specific competencies of the process.
e. Foundational leadership education is provided by Maine's Community College System, and Maine's colleges, universities, associations, educational organizations and agencies provide continuing education for leaders and ongoing support.
f. The EMS system is continuously developing the next generation of leaders and identifying a roadmap for EMS professionals as they advance in their careers to take on more administrative responsibilities.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Develop Course for EMS Supervision & Human Resources for Front Line Supervisors							
Activity 1.1	Identify subject matter for educational programs targeting front-line supervisors and human resources.	Maine EMS Deputy Director	1-Jun-24	Surveys, questionnaires, and meeting with stakeholders to identify subject matter needed for leadership development programs and target audiences for Front Line EMS Supervision.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Subject matter and target audiences identified.	
Activity 1.2	Develop educational programs for Front Line Supervisors and human resources	Maine EMS Deputy Director	1-Dec-24	Stakeholders review of educational programs.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Search and review for grant funding to support program. Identify subject matter experts that would be interested and participate in educational program.	

Activity 1.3	Research ways to provide educational programs with the subject area of EMS Supervision and Human Resources for current Front Line Supervisors and potential leadership.	Maine EMS	1-Jun-24	Surveys, questionnaires, and meeting with stakeholders to identify best dates and locations for programs.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Advertisement of program and distribution of educational materials.	

Strategy 2: Develop Course(s) for EMS Finance & Budget Management for EMS Administrators							
Activity 2.1	Identify subject matter for leadership educational programs for EMS Administrators and potential EMS Administrators concerning EMS Finance and Budget Management.	Maine EMS Deputy Director	1-Jun-24	Surveys, questionnaires, and meeting with stakeholders to identify subject matter needed for leadership development programs and target audiences for EMS administators for EMS Finance and Budget Management.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Subject matter and target audiences identified.	
Activity 2.2	Develop leadership educational programs for EMS Administrators and potential EMS Administrators concerning EMS Finance and Budget Management.	Maine EMS Deputy Director	1-Dec-24	Stakeholders review of educational programs.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Search and review for grant funding to support program. Identify subject matter experts that would be interested and participate in educational program.	
Activity 2.3	Research ways to provide leadership educational programs for EMS Administrators and potential EMS Administrators concerning EMS Finance and Budget Management.	Maine EMS	1-Jun-24	Surveys, questionnaires, and meeting with stakeholders to identify best dates and locations for programs.	Maine EMS, EMS Board, Maine Ambulance Association, Maine Fire Chief's Association	Advertisement of program and distribution of educational materials.	

Mental Fitness and Wellbeing

Notes from Plan:

Where We Want To Be: In 2035 clinicians across Maine enjoy high levels of subjective wellbeing and know how to balance the challenges of EMS and living well. Sacrificing one's wellbeing for EMS is no longer expected, championed or modeled. Care for the wellbeing of clinicians has become a proactive effort and not merely reactive to big events or psychological breakdown. Attending to mental health has been normalized and is no longer stigmatized. Clinicians are prepared for the rigors of EMS and expected and motivated to cultivate mental fitness. Mental fitness, like physical fitness, is developed. Mental fitness programming is systemwide and encompasses the clinician experience from initial training through retirement. Clinicians participate because selfcare and caring for one another are expectations, and there is positive social pressure in each agency to do so. This results in high levels of clinician wellbeing, resilience and satisfaction, and low rates of breakdown, stress injury and psychopathology.

Milestones/Markers of Success: a. The EMS system acknowledges EMS is a high risk, high stress and high responsibility occupation that demands more than a reactive and after-event response to support mental health.
b. EMS agency leaders have been introduced to the concepts of mental fitness, subjective wellbeing and resilience as proactive measures to cultivate a better clinician experience.
c. Systemwide mental fitness programming has been developed and is continuously taught through educational institutions, training programs and the EMS Regions.
d. Clinicians are prepared for the inherent psychological challenges of EMS through mental fitness training that aids them in creating strong self-awareness and emotional awareness, resilience training, peer-to-peer support and organizational cultures that support living well and selfcare.
e. Mental fitness training, development and support begin in initial EMS training programs and continue through one's entire career.
f. Agencies have access to mental fitness training, and instructors and agency leaders are taught how to create organizational cultures that support wellbeing, are pro-selfcare and promote fitness, work/life balance and asking for help when needed.g. The EMS system has identified mental health professionals who are first responder friendly
and knowledgeable.
h. CISM services continue, are expanded and are readily available throughout the EMS system.
i. Peer support development, education and training have become standardized and readily available throughout the EMS system and are educational opportunities for clinicians interested in mental health, mental fitness and resilience.
j. Rates of anxiety, depression, PTSD and suicide in EMS clinicians are equal to or lower than the national averages for the general public.
g. The system has established a process for gathering and aggregating data elements from 9-1-1 call data, computer aided dispatch (CAD) systems, Maine EMS & Fire Incident Reporting System (MEFIRS) data and the various electronic health records (EHR) used by the healthcare systems.
h. Outcomes information is used to continuously improve system response plans and resource use.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: EMS Explorers and Explorer Mentors receive prophylactic mental health awareness training.							
Activity 1.1	Develop training module to expand awareness of mental health and teach coping and harm reduction strategies for Mentors.	Explorer Team, Maine EMS Staff, Mental health SMEs	31-Dec-23	Holding the trainings	Time, staff, mental health experts, EMS clinicians	Training module to be adapted onto MEMSEd	
Activity 1.2	Develop training module to expand awareness of mental health and teach coping and harm reduction strategies for Explorers.	Explorer Team	31-Dec-23	Uploading the trainings to JMG LMS.	Time, staff, mental health experts, EMS clinicians, video equipment, video editing software	Training module on JMG LMS	

Activity 1.3	Create network of resources among Mentors, service leaders, JMG specialists, school employees, and communities to support mental health in Explorers	Explorer Team, trial sites	31-Mar-24	Availability of mental health supports for all Explorers	Time, staff, peer resources, counselors	List of resource network members for Explorers	

Strategy 2: Increase access to mental health peer support and CISM trainings in all EMS Regions.							
Activity 2.1	Access grant funding to pay for mental health resources and CISM trainings to make them freely accessible for all clinicians.	Maine EMS Staff	1-Aug-24	Access to funds	Time, staff, grant opportunities, SMEs	Grant funding and program infrastructure	
Activity 2.2	Increase availability for individuals to be trained in providing EMS peer support and CISM trainings.	Maine EMS Staff, contractors?	1-Aug-24	At least one training per quarter per region	Time, staff, CISM training facilitators, training spaces	CISM training resources	
Activity 2.3	Create list of chaplain resources, spiritual care services, the front-line warm-line, and other peer support groups on the Stay Healthy in EMS webpage.	Maine EMS Staff, chaplaincy and spiritual care services, Stress resiliency and response workgroup	31-Dec-23	Clicks on "Stay Healthy in EMS" website links	Time, staff, Maine EMS website, Maine EMS Stress Response and Resiliency workgroup	Website	

Strategy 3: EMS Clinicians will be able to readily access behavioral health resources as needed							
Activity 3.1	Access to a list of behavioral health clinicians that are competent/experienced in working with first responders.	Maine EMS Stress Response and Resiliency Work Group	1-Feb-24	Published list of clinicians	Time from Maine EMS stress response and resiliency group, buy in from behavioral health clinicians/entities	Published document on Maine EMS website	
Activity 3.2	Maine EMS will collaborate with local behavioral health agencies to support in connecting them with individual agencies to provide trainings on compassion fatigue, accessing mental health resources, and awareness of when coworkers may need supports.	Maine EMS staff, behavioral health agencies	1-Feb-25	Number of trainings held	Time from Maine EMS staff, behavioral health agencies, and potentially some grant funding	Courses held	
Activity 3.3	Maine EMS will work collaboratively with other first responder networks to support statewide first responder mental health initiatives (such as a training).	Maine EMS staff	1-Feb-25	Number of collaborative meetings, Number of statewide trainings	Time from Maine EMS staff, time from local agencies	Trainings	
Activity 3.4	Develop a report that identifies providers who may be at risk due to traumatic events witnessed on scene. Those identified will be provided with behavioral health resources to access should they choose.	Maine EMS staff, Data Team	1-Jul-24	Creation of report	Staff time	report and auto resources	
Activity 3.5	Develop a pathway for clinicians to self-report substance use issues that is non-disciplinary.	Maine EMS staff, legislators	Dec-25	Pathway developed	Staff time, legislature, Board	Legislative change	Statute

EMS Clinical Care

Medical Direction

Notes from Plan:

Where We Want To Be: In 2035 EMS medical direction is a defined and essential role within the Maine EMS system at all levels. The engaged leadership of medical directors is integral to clinical development and quality throughout the EMS system and has become a major motivational and developmental element in the EMS clinician's experience. Gone are the days of a medical director being a minimally involved volunteer and ad hoc paper-signer. Medical directors are prepared, active and motivated and are involved and empowered by the agencies they serve.

Milestones/Markers of Success: a. Medical direction is led by a full-time state medical director and an associate medical director.
b. Regions are supported by regional medical directors who support agency level medical directors and serve as the conduit from local medical directors to the state.
c. All transporting agencies have active and engaged medical direction.
d. Cohorts of medical directors have formed and work together to serve multiple local agencies in geographical areas, increasing continuity throughout the EMS system.
e. Agency administrators and chiefs have a robust understanding of medical direction, its roles and responsibilities and its importance to clinical operations. They support this role and view the medical director as the agency's chief medical officer.
f. The medical direction role and authority in each agency is clearly defined, with job descriptions, contracts, appropriate compensation and accountability.
g. Each medical director's span of control is right-sized to allow for appropriate engagement and ensure the role is rewarding and satisfying for the medical director, agency leader and clinicians.
h. Each medical director is appropriately prepared, has a command of evidence-based medicine and EMS protocols and protocol development and is proficient in the ongoing cyclical process that continuously uses clinical evaluation to drive clinician feedback, education, mentoring and skills development.
i. Medical directors connect with frontline clinicians and notice, inspire and motivate ongoing clinical development, research, growth and exploration. Medical directors help clinicians fully realize the rewards of best-possible clinical care.k. Medical directors are integral parts of system planning, development and integration, and work with each other to ensure EMS in Maine continues to develop as a cohesive system regionally and statewide. Because of their work in emergency departments, they are an effective bridge between EMS and healthcare.
l. Medical control has become more centralized and delivered by appropriately prepared physicians who deliver meaningful support that is consistent, knowledgeable and accountable. Medical control has evolved to provide a range of services, including simply radio advice, telemedicine video support or even infield physician intercepts.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: All agencies have active and engaged medical direction.							
Activity 1.1	Update or develop a medical director guidebook. The guidebook should contain a plan to allow a medical director to be successful.	MDPB/EMS Office Staff/ Board	1-Dec-24	Guidebook			
Activity 1.2	Develop a template for a medial director job description for all agency types.	MDPB/EMS Office Staff/ Board	1-Dec-24	Job description			
Activity 1.3	Create rules requiring medical direction for all transporitng agencies. The plan should include span of control advice to ensure medical direction is not overburdened.	Rules Committee/Maine EMS Board	31-Dec-25		Time, Support from Maine EMS Board	Updated EMS Rules	Rules
Strategy 2: Regional Medical Directors are active and supported							
Activity 2.1	Develop regional medical director job description & deliverables	MDPB/EMS Office Staff/ Board	1-Dec-24	Job Description	Time, Support from MDPB and EMS Staff	Regional Med Director Job Description w/deliverables; Bylaws	
Activity 2.2	Fund regional medical director positions	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		
Activity 2.3	Provide support staff for regional medical directors to carry out their duties	EMS Office	1-Jul-25	Funding obtained	MEMS Office and Board		
Activity 2.4	Develop educational resources for medical directors that teach the nuances of medical direction in Maine. This course should focus on the administrative aspects of medical direction and should be deliverable in person and on line.	EMS Office Staff/MDPB	31-Dec-25	Completion of the educational materials and fiirst course	Time, Support, Educational Expertise	Completed educational product and first course	
Activity 2.5	Develop education for medical drectors focusing on the clinical aspects of prehospital medicine. While these procedures are commonly taught through fellowships, it may not be feasible to require fellowship training for all medical directors, therefore, in settings where the physician is providing in-field support, this course could support those activities. In an effort to workshare, this effort could be a collaborative effort with the state's EMS Fellowship program.	EMS Office Staff/MDPB	31-Dec-26	Completion of the educational materials and fiirst course	Time, Support, Educational Expertise	Completed educational product and first course	
Strategy 3: Under the Auspices of Communication Between Agency Medical Directors and Maine EMS/State Medical Direction							
Activity 3.1	Develop expectations that agency medical directors become involved in Regional Councils, or, at a minimum, host quarterly meetings, lead by the regional medical director, that focus on the needs and input of agency medical directors. These meetings are expected to develop strong relationships between the regional medical director and agency medical directors and act as a conduit for information and communication between the state to agency medical directors and from agency medical directors to the state.	EMS Office Staff/MDPB/Maine EMS Board	31-Dec-25	Development of meeting/meeting schedule/demonstration of medical direction attendance	Time, Support, System Wide Communication	Forums in each region focused on medical direction	
Activity 3.2	Given the importance and stature of regional medical directors in the state, these positions are suported by Maine EMS at an appropriate level, allowing the regional medical directors time and energy to perform the tasks asked of them. This level of support should be around 0.25 FTE.	EMS Office Staff/MDPB/Maine EMS Board	31-Dec-25	Acheivement of RMD finacial and staff support	Time, Support, Budgetary Support	Excellent communication pathways between the EMS System and Hospitals	

Activity 3.3	Agency medical directors should be working clinically within the region and affiliated with a hospital of that region. This model allows for rish levels of communication between the regional medical director and the hospital. In addition, should need arrise for high level communication with a gien hospital in a region, the agency medical director can foster that communication between the regional medical director and/or the state medical director/state director.	EMS Office Staff/MDPB/Maine EMS Board	31-Dec-25	Demonstration of communication pathways between State, Region, Local Levels	Time, Support, System Wide Communication	Excellent communication pathways between the EMS System and Hospitals	
Activity 3.4	All hospitals have a designated EMS Physician who acts as a contact, advocate and point of communication between the hosptial the EMS System (local, regional and state). This position may be filled by and agency medical director, or could be a stand alone position.	EMS Office Staff/MDPB/Maine EMS Board	31-Dec-25	Identified hospital physician contacts with each hospital in Maine	Time, Support, System Wide Communication	Excellent communication pathways between the EMS System and Hospitals	

Systems of Care

Notes from Plan:

Where We Want To Be: In 2035 EMS in Maine is fully integrated into the overall healthcare system, as evidenced by its inclusion and participation in robust systems of care for time-sensitive conditions. The Bureau of EMS continues to oversee the trauma system of care and is given statutory oversight over other EMS dependent systems of care such as stroke, STEMI, sepsis and out-of-hospital cardiac arrest. A robust system plan identifies healthcare facilities based on their capabilities to manage time-sensitive conditions including designations, data reporting, performance improvement and outcomes. EMS's role is universally acknowledged as a keystone component in the continuum of care.

Milestones/Markers of Success: a. There has been broad recognition of EMS's vital role in time-sensitive conditions such as trauma, stroke, sepsis, STEMI, out-of-hospital cardiac arrest, prenatal and perinatal conditions, pediatric care, organ and tissue donation and traumatic brain injury. This recognition includes EMD, initial response, treatment and communication, destinations and bypass, interfacility transfers and critical care transfers, and participation in data collection and registries.
b. The Bureau of EMS has statutory oversight of the stroke, STEMI, sepsis and out-of-hospital cardiac arrest systems of care.
c. A robust system plan identifies healthcare facilities based on their capabilities to manage time-sensitive conditions including designations, data reporting, performance improvement and outcomes.
d. Standardized statewide order sets have been developed for interfacility movement of patients with time-sensitive conditions.
e. EMS protocol development and education have been integrated with clinical experts in timesensitive conditions.
f. EMS clinicians have access to routine training and educational opportunities related to timesensitive conditions.
g. Registries have been established for trauma, stroke, STEMI, sepsis, and out-of-hospital cardiac arrest, and EMS and the larger healthcare system actively participate in these registries. Registries provide feedback to EMS clinicians on their patient's 30-day outcome.
h. Performance matrices have been defined for time-sensitive conditions that allow for the appropriate QA/QI evaluation.
i. EMS clinicians are included in registry reports and case reviews.
j. Maine contributes to the national dialogue on systems of care particularly related to the rural environment.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: The office will facilitate EMS agencies in being able to acknowledge, train, educate, and evaluate time sensitive illnesses.							
Activity 1.1	Define measures, key performance indicators (KPIs), and goals for time sensitive illnesses.	Systems of Care Coordinator, QA/QI Committee	1-Jul-24	Definations along with dashboard with KPI for time/effort required to enter, validity score	Staff time	Dashboard with KPI for time/effort required to enter, validity score	
Activity 1.2	All out-of-hospital cardiac arrests will be reviewed by an internal QA/QI committee, QA/QI primary contact, and/or service level medical director.	Rules Committee/Maine EMS Board	31-Dec-25	Rule in effect and renewal process built to accomodate	Time, Support from Maine EMS Board	Rule stating that all out-of-hospital cardiac arrests will be reviewed by an internal QA/QI	Rules
Activity 1.3	CARES National Report data will be disseminated to all EMS services, and hospitals, and publically published.	Systems of Care Coordinator	1-Mar-24	All CARES reports will be published.	Staff time	Publication of CARES documents	
Activity 1.4	Each year a time sensitive illness education will be available for all clinicians faciliated by a additional staff member(s) who work with the State Medical and Associate Medical Director as well as identified clinical experts to develop this material. Additional responsibilities of this new position could include the improvement of MEMSEd in an effort to make MEMSEd a "go-to" resource that is respected for it's excellence and quality education.	Systems of Care Coordinator	Each year	Educational Program	Time, support from the education committee	Training materials (asynchronous training, videos, handouts)	
Activity 1.5	Add additional staff whose solitary function is to support the MDPB's activities, including protocol development. This position would become the primary support for protocol development and evolution and would also be the dedicated support for MDPB meetings.	Maine EMS Director, Commissioner, Maine EMS Board	31-Dec-25	Approval of the position and hiring into the position	Time, Support, Communication, Funding	Approval of the position and hiring into the position	
Activity 1.6	Regional medical directors and directors, through the support provided by Maine EMS, will function to support sysmtes of care at the regional level and work closely with hospitals to develop, improve and evolve systems of care at the regional level.	MDPB, Reional Directors, Maine EMS Director, Staff, Board	31-Dec-25	High Functioning Systems of Care	Time, Support, Communication, Hospital Collaboration and Partnerships	High Functioning Systems of Care	
Activity 1.7	Regional directors are Maine EMS employees with authority provided by the Maine EMS to and are accountable to ensure prevention of message dillution and pollution in all communication from the state to local stake holders, and vice versa.	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		
Activity 1.8	Maine EMS will add an epidemiology or data analyst to support the Maine EMS efforts in data reporting and system improvement.	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		

Activity 1.9	Similar to the TAC and the MSA, Maine EMS conviene 2 additional advisory committees covering acute cardiac care and out of hospital cardiac arrest care. These committees should be made up of clinical leaders in those domains, as well as the state medical director, associate state medical director, an MDPB member and other key stakeholders from the EMS community. The purpose of all advisory committees is to: 1) develop, support, and improve staewide systems of care 2) review and comment on the state's 911 protocols 3) develop model physician ordersets for MDPB review and approval 4) support the state offices and state medical director's oversight and management of a specific condition's care	MDPB,State Medical Directors, Maine EMS Director,	31-Dec-25	Committee established with participation from all appropriate stake holders	Support from MEMS Office		

Strategy 2: Increase the percent of EMS agencies recognized through the Maine "Always Ready for Children" EMS recongition program.							
Activity 2.1	Develop and have a Board approved "Always Ready for Children" program for EMS	EMSC, EMSC Advisory Committee, Board	31-Dec-24	Approved program	Collaborate and emulate previously approved hospital "Alwasy Ready for Children" program	Program Manual	
Activity 2.2	Promote and recognize EMS agencies	EMSC, EMSC Advisory Committee, Board	31-Dec-24	10% of EMS agencies recognized	Promotion and meetings with EMS agencies	Recognition awards and process	
Activity 2.3	Establish requirement of pediatric emergency care coordinator (PECC) into EMS agency required position.	EMSC, Maine EMS Staff, Board	31-Dec-24	Is a PECC required for each licensed EMS agency	Proposal to Rules Committee, supporting resources	Proposal, supporting resources	Rules

Strategy 3: Increase usage of a Family Advisory Network (FAN) member(s) to represent the emergency needs of children in their community.							
Activity 3.1	Develop a FAN Strategic Plan Guide	EMSC, EMSC Advisory Committee	1-Oct-23	HRSA approved plan	FAN, HRSA, submission through EHB	Approved plan	
Activity 3.2	Recruit a second volunteer FAN member for EMSC Program	EMSC, EMSC Advisory Committee	31-Dec-24	Approved FAN member	FAN, EMSC Advisory Committee	2nd FAN	

Expanded Role of EMS

Notes from Plan:

Where We Want To Be: In 2035 there is broad acceptance, appreciation and reimbursement for care and service outside the traditional emergency response and transport roles of EMS. Maine's EMS system continues to identify unmet healthcare needs that may benefit from EMS resources and for which EMS can develop the necessary knowledge, skills, competencies and reimbursement. Across Maine, many agencies have embraced mobile integrated health and community paramedicine as models to address unmet healthcare needs due to rurality and other social determinants of health. In furtherance of this, medical direction, a Board of Paramedicine, the EMS Board and regulatory oversight have all recognized the need to establish clear authority for EMS to meet certain needs without supplanting existing healthcare resources and infrastructure. Services provided under these provisions are fully reimbursed by payers, and the model for delivery is considered sustainable, effective and efficient by all involved. The Maine EMS system continues to support the expansion of these types of programs through pilot programs, education and training, quality assurance and ongoing evaluation and improvement.

Milestones/Markers of Success: a. Payers of healthcare services value and recognize the potential efficiencies and are willing to pay to have EMS provide expanded services.
b. Healthcare systems and primary care see mobile integrated health and community paramedicine as valuable, effective and efficient extensions of their services.
c. The healthcare system understands and values mobile integrated health and community paramedicine as beneficial extensions of their services.
d. Expanded EMS services such as mobile integrated health and community paramedicine are seen as valuable components of the overarching healthcare system and are not seen as competitive programming among existing components.
e. The number of Mainers who have access to Mobile Integrated Health and community paramedicine continues to increase.
f. The unnecessary use of emergency departments and 9-1-1 EMS response continues to decline.
g. Mobile integrated health and community paramedicine models and programs are consistently receiving referrals from healthcare entities.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Community Paramedicine programs will be active and collaborative with other healthcare entities							
Activity 1.1	There will be 20 EMS agencies with a CP designation or license.	Community Paramedicine Coordinator	1-Jan-24	Number of agencies with a CP designation or license. Collected from ImageTrend	Community Paramedicine Coordinator will support agencies through the Designation or licensing process.	20 Designations/ licenses	
Activity 1.2	Agencies will provide 20 or more patient visits a year.	Community Paramedicine Agencies	1-Dec-25	Number of PCRs in MEFIRS.	MEFIRS reports	Report on patient visits	
Activity 1.3	Increase collaboration of other healthcare stakeholders will be included in the CP committee to ensure new voices are heard.	Community Paramedicine Coordinator	1-Sep-23	CP committee will have a home health position and hospice/palliative care position.	Board approval	New CP membership in expanded healthcare roles.	

Strategy 2: Collect and compile data to show the value of Community Paramedicine

Activity 2.1	Cutler will complete a cost avoidance data analysis deliverable that will show potential avoided costs for CP patients.	Community Paramedicine Coordinator; University of Southern Maine (Contractor)	1-Feb-24	Completed work product from Cutler received by Maine EMS.	OMS/ EMS data being provided to Cutler	Cost avoidance analysis	
Activity 2.2	The new CP Module will go live.	Community Paramedicine Coordinator; Data Team	1-Jul-24	CP Module roll out	ImageTrend System; Work sessions with Data Team	Final CP Module.	
Activity 2.3	The office will publish a quarterly report regarding CP data.	Community Paramedicine Coordinator; Data Team	1-Jan-24	Published CP data report.	Data report creation from Data Team	Quarterly report	
Activity 2.4	EMS Explorers shadow and assist Community Paramedicine professionals	EMS Explorer Program Coordinator and Community Paramedicine Coordinator	May 2024 and onward	Collaboration between Explorer and CP services	Staff time, collaboration with Explorer and CP services	Quarterly report	
Strategy 3: Increase Community Paramedicine Sustainability by Securing MaineCare Reimbursement							
Activity 3.1	Chapter 19: Community Paramedicine rules will be updated to reflect the new scope of practices, formulary and other changes to the CP process in Maine. The rules will move through the process and be approved by the board.	Community Paramedicine Coordinator	31-Jan-25	New and approved chapter 19 CP rules.	CP committee and rules committee will need to review the CP rules.	New Chapter 19 rules	Rules
Activity 3.2	The CP formulary will be approved by the MDPB and the Board.	Community Paramedicine Coordinator	1-Dec-23	Approved CP Formulary	Review by the MDPB and Board	Formulary	Rules
Activity 3.3	There will be a scope of practice for all 3 license levels of CP providers with signaled support by the MDPB and the board.	Community Paramedicine Coordinator	1-Jul-24	3 separate scopes of practice created and approved by the MDPB and Board.	CP Committee work on completion of 3 separate scopes. Review by the MDPB and the Board.	3 Scopes of Practice	Rules
Strategy 4: Development of Critical Care Paramedic Systems of Care							
Activity 4.1	Similar to community paramedicine, Maine EMS develop an additional staff position that focuses on and coordinates all critical care transport efforts across the state.	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		
Activity 4.2	Maine EMS developes clinically rigorous pathways for interesed ground EMS agencies to perform critical care transport.	MDPB, State Medical Directors, Maine EMS Director, Key Stakeholders	31-Dec-25	System of Care Created and Approved	Support from MEMS Office and Board		
Activity 4.3	All critical care transports, via ground or air, are held to similar clinical standards and are required to demonstrate proficency on a regular basis. Medical directors supporting these effforts are adequately supported	MDPB, State Medical Directors, Maine EMS Director, Key Stakeholders	31-Dec-25	CCT Agencies submit state requested QI Metrics for review by the State Medical Director, State, CCT Coordinator	Support from MEMS Office and Board, Coordination with key stakeholders		
Activity 4.4	Similar to community paramedicine, Maine EMS develop an additional staff position that focuses on and coordinates all critical care transport efforts across the state.	EMS Office	1-Jul-25	Funding obtained	Support from MEMS Office and Board		
Activity 4.5	Through the development of increased pathways for critical care transport and embracing PIFT-level care into ALS capablities when appropriate, Maine EMS evolves beyond the PIFT scope of practice, leaving the following potential IFT scopes: EMT, AEMT, Paramedic (ALS), Critical Care. The latter may be a single tier provider type (i.e., similar to the scope of LifeFlight of Maine) or Maine EMS may choose to develop tiers of critical care transport that allow the EMS Agency and EMS Agency medical director to choose the degree of criticial care transport they provide.	MDPB, State Medical Directors, Maine EMS Director, Key Stakeholders	31-Dec-25	INterested agencies submit application packet for Agency License in CCT	Support from MEMS Office and Board, Coordination with key stakeholders		

Activity 4.6	Maine EMS, the Maine EMS Medical Directors, and the Maine EMS Regional Medical Directors work closely with the Maine Hospital Association, individual hospitals, hospital designated EMS Physician representives and others to ensure all transferring physicians have a rich understanding of the Maine EMS interfacility transport system of care and are held responsible for determining the proper scope of practice for any given transport. Errors in decision making regarding transport are identified (by the receiving hospital, the transferring hospital during routine review of these cases, or the EMS Agency/EMS Agency medical director) and these errors are examined closely to ensure similar errors do not occur in the future. Regional medical directors and directors are involved in this review process to ensure EMS System awareness and support any necessary actions resulting from the review process.	Maine EMS, the Maine EMS Medical Directors, and the Maine EMS Regional Medical Directors work closely with the Maine Hospital Association, individual hospitals, hospital designated EMS Physician representives and others	31-Dec-25	Educatoinal and Reference Products for transferring physicians	Support from MEMS Office and Board, Coordination with key stakeholders		
Activity 4.7	Transferring and receiving hospitals have means of communication surrounding IFT's and patient outcomes resulting from IFT decision making are routinely communicated to receiving hospitals.	Maine EMS, the Maine EMS Medical Directors, and the Maine EMS Regional Medical Directors work closely with the Maine Hospital Association, individual hospitals, hospital designated EMS Physician representives and others	31-Dec-25	Systems of Communication that support QI Efforts	Support from MEMS Office and Board, Coordination with key stakeholders		

Evaluation and Quality Improvement

Notes from Plan:

Where We Want To Be: In 2035 Quality Assurance/Quality Improvement (QA/QI) is a foundational component of the EMS culture and permeates every facet of the EMS system. QA/QI is enthusiastically embraced and sought by clinicians, EMDs, service leaders, medical directors and the broader healthcare community. Systemwide quality practices and measures are informed by data at all levels. Quality metrics are being gleaned from all levels of the EMS system, from call-taking and dispatch through patient discharge and the clinical outcome. These metrics are consistent, data-driven, clinician friendly and supported by robust learning, growth and development. Patients reliably receive the right care, at the right time, by the right clinician. QA/QI has been destigmatized and disentangled from disciplinary mechanisms. QA/QI is efficient and does not create unnecessary burdens or redundancies. Clinicians are performing at the top of their scopes of practice, and EMS in Maine continues to expand its capacity to care for complex patients and support the healthcare system. Clinical quality is led and overseen by the State Medical Director and an active and collaborative cohort of regional and agency medical directors. QA/QI practices are implemented by competent and motivated agency quality coordinators and are supported by the system in its entirety.

Milestones/Markers of Success: a. QA/QI has become truly valued because the improvement process has been successfully applied to the top issues and concerns of clinicians, EMDs, service leaders, medical direction and the broader healthcare community.
b. All clinicians are comfortable reporting errors and view reporting as a duty and an opportunity for growth.
c. QA/QI has genuine and real accountability.
d. There is a systemwide appreciation and understanding of quality assurance and improvement science at all levels, with education and training opportunities on how to do so.
e. QA/QI is financially supported at all levels, including at the state level.
f. The complete patient record, from CAD through hospital discharge, is available to support quality assurance and improvement initiatives as well as clinician and EMD performance.g. QA/QI is understood to entail much more than finding the bad apples. Quality assurance is truly about improving the quality of clinical care when it comes to meeting a known standard. Quality improvement is truly about emphasizing the importance of raising the standard and reducing the incidents of quality issues.
h. There are innovative models to help local agencies meet QA/QI expectations including the possible use of outside contractors.
i. All entities (EMS agencies and EMD centers) are accountable and have implemented robust evaluation plans that are routinely reviewed. Plans include specific metrics, methodologies, roles, responsibilities and pathways for bringing about meaningful, systemic changes within their organizations for the betterment of patient care.
j. The EMS system has robust dashboards that provide accurate and actionable feedback on personal, agency and system performance.
k. Clinicians have increased the accuracy of their field impressions and associated clinical treatment through robust outcomes feedback.
l. QA/QI includes operational quality, ensuring response performance, the handling of IFTs and ensuring patients arrive at the right destination.
m. QA/QI and education are inextricably connected with comprehensive feedback loops in place to ensure clinician competency and best practice.
n. Agencies are adequately resourced to support QA/QI efforts and to connect and engage with clinical operations.
o. Clinicians and EMDs see meaningful improvement that is the result of their involvement in the QA/QI process.
p. QA/QI has been applied to resource deployment and ensures the efficient use of resources statewide.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Improve quality of care by defining performance initiatives based on KPIs							
Activity 1.1	Define KPIs for Maine EMS protocols where appropriate with a minimum of 10.	MDPB, QA/QI Committee	1-Jul-24	There will be performance improvement markers developed and shared with all EMS clinicians	time, analytics	KPIs	

Activity 1.2	Identify QA/QI initiatives based upon KPIs	MDPB, QA/QI Committee	31-Dec-24	There will be available access for EMS agencies to compare themselves to like sized, or agencies with other similar characteristics	time, analytics	KPIs	
Strategy 2: Develop a process to allow for sentinel event reporting, both defined and undefined.							
Activity 2.1	Define the needs for a system of sentinel event reporting	MEMS Board/QA-QI Committee/MEMS Staff	31-Dec-24	Maine EMS has a system that allows reporting of errors or mandated reporting items, that is easily accessed and frequently used without fear of punishment	time, money	Workgroup	
Activity 2.2	Define the sentinal event reporting process to include training for EMS licensees (entities and individuals) and Service Chiefs	MEMS Rules Committee MEMS QA-QI Committee	31-Dec-24	the process to report errors is clear and defined, EMS clinicians understand the process of working to prevent errors	time, support of the committees involved,	Model Process	
Activity 2.3	Develop rules requiring sentinel event reporting	MEMS Rules Committee MEMS QA-QI Committee	31-Dec-25	Maine EMS has adopted rules to support complinace regarding error reporting	time, support of the committees involved,	Rules	Rules
Activity 2.4	Develop a model for the surveillance of trends related to Sentinel events, including the identification of emerging and/or unidentified events, that includes adequate staffing for implementation	Legislature, Maine EMS Staff, Board of EMS,	31-Dec-25	Sentinel event reporting and surveillance has been appropriately authorized and funded, and a finalized model has been developed	General Fund appropriation, staff time, authorizing language, integrated electronic reporting system	Draft model document, job description, implementation plan, draft statutory change language, budgetary documents.	Statute (Maybe)
Strategy 3: Comprehensively review the Maine EMS Quality Improvement Manual to increase its relevance to EMS clinicians and encourages the use of established perfomance metrics.							
Activity 3.1	Develop scalable quaity improvement models for EMS agencies of all sizes and types	QA/QI Committee	31-Dec-25	Maine EMS has program templates that are flexible and scalable for all Ems agencies that are continuously improved upon and updated.	time, additional staff	Revised Quality Improvement Manual	
Activity 3.2	Publish performance metrics for EMS agencies and the public.	QA/QI Committee	31-Dec-25	Maine EMS has made the defined and established performance metrics availabel for public viewing in the interest of transparency.	time, additional staff	Performance Metrics	
Activity 3.3	Publish examples on how EMS entities can migrate from an exclusively quality assurance stance to a quality improvement model	QA/QI Committee	31-Dec-25	Increases in clinical performance metrics	time, additional staff	Examples of transition from QA to QI	

EMS Finance

The Cost of EMS

Notes from Plan:

Where We Want To Be: In 2035 it is recognized that sustainable funding of EMS necessitates an accurate and ongoing accounting for the full costs of EMS. The costs of all elements such as administration, the readiness of 24/7 operations, medical direction, quality assurance and improvement, initial and continuing education and training, employee turnover, vehicle maintenance, dispatch and communications, etc. have been accurately quantified and are known. Costs are no longer obscured by a lack of accounting for donated labor or below-living-wage labor. Agencies know how to quantify their costs including the costs of preparedness, response, treatment and transport, as well as all overhead. Agency financial accounting includes an understanding of all revenue sources including reimbursement for services, tax subsidies, other public monies, grants and donations.

Milestones/Markers of Success: a. The full and true costs of providing operational EMS are known.
b. Local agencies and governments are continuously educated in how to calculate the full and true costs of providing operational EMS. Tools for financial accounting are readily available.
c. The full and true costs of EMS are utilized to appropriately establish revenue sources to fund EMS.
d. There is transparency regarding the total finances of each agency, including costs and revenues.
e. Local agencies are expected to report costs, and the EMS Bureau has the resources and staff to aid local agencies in calculating cost reporting.
f. Any funds for operational EMS provided by the state should never exceed the median cost of providing services.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Enhance EMS cost reporting.							
Activity 1.1	Bring on Staff Positions Allocated by the Legislature	Director	31-Mar-24	Staff Onboarded	Staff Time	Position Justification Form; New Position Number; New Job Posting	
Activity 1.2	Develop data collection form	Data team; Cost Reporting Team Member	31-Dec-24	Time to complete	Staff time, Financial Expertise	Collection instrument	
Activity 1.3	Educate about the importance of cost data reporting	Data team; Cost Reporting Team Member	2024/2025	Completion ratio	Staff time, Financial Expertise	Marketing/education materials	
Activity 1.4	Develop report from the cost data collection and identify KPIs	Data team; Cost Reporting Team Member	31-Dec-25	Reporting that provides insightful and actionable insights into the sources of reveue/funding, expenses and the balance between	Staff time, Financial Expertise	Cost Data Program(s)	
Strategy 2: Educate EMS Administrators about Finance Management							
Activity 2.1	Identify ways to develop and offer course in Business Models	Maine EMS Staff; University of Maine System; Maine Community College	31-Dec-25	Course Evaluation(s)	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Course Materials	
Activity 2.2	Faciliate the development and delivery of educational programming covering Administrative Accounting	Maine EMS Staff; University of Maine System; Maine Community College	31-Dec-25	Course Evaluation(s)	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Course Materials	
Activity 2.3	Faciliate the development and delivery of educational programming covering Budget Development	Maine EMS Staff; University of Maine System; Maine Community College	31-Dec-25	Course Evaluation(s)	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Course Materials	
Strategy 3: Develop Processes for Agencies to Identify and Monitor the Financial and Economic Drivers of the Healthcare System(s) and related risks and opportunities							
Activity 3.1	Develop and establish metrics to quantify baseline system costs	Data Team, Deputy Director	1-Jul-24	Develop and evaluate metrics	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association		
Activity 3.2	Establish a best practices model to determine potential expenditures, cost savings, and long-term investment needs for the agencies.	Deputy Director	31-Dec-24	Evaluation of metrics, gathering data from agencies	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association		
Activity 3.3	Develop a process for evaluating Best Practices for success or non-success	Deputy Director	31-Dec-25				

Reimbursement Alignment

Notes from Plan:

Where We Want To Be: In 2035 the Maine EMS system has maximized the revenue local EMS agencies collect in reimbursement from private insurance, Medicare, Medicaid and other payers. This maximization is the result of accurate cost reporting, the accurate documentation of services, advocacy, a deep understanding of the billing process and taking full advantage of available reimbursements.

Milestones/Markers of Success: a. EMS has a clear voice and interacts with payers through the effective advocacy efforts of associations, groups, agencies or individuals.
b. Agency leaders are continuously educated in EMS finance and the intricacies of EMS reimbursement. This will be an important part of EMS leadership development.
c. The full and true costs of providing EMS are continuously calculated and accounted for. These must be communicated in a manner that fosters a genuine understanding by government and the public about the full and true costs of providing EMS.
d. EMS clinicians understand the value and importance of their documentation in cost recovery and are consistent in collecting appropriate data. Initial and continuing education for clinicians heavily emphasize the importance of documentation and teach clinicians how to document well.
e. EMS stakeholders continue to advocate for reimbursement that accounts for the cost of providing EMS.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: EMS agencies will have resources to have a more comprehensive understanding of EMS reimbursement.							
Activity 1.1	Develop Data Collection/Measurement Tool(s)	Data Team, Deputy Director; Cost Reporting Team Member	Dec-24	Having a collection instrument available and in use by agencies	Staff time, Financial Expertise	Collection instrument	
Activity 1.2	Analyze Data to measure baseline and trends in reimbursement for agencies that perform their own billing and agencies that contract billing.	Data Team, Deputy Director; Cost Reporting Team Member	Dec-25	Reporting that provides insightful and actionable insights into the sources of reveue/funding, expenses and the balance between	Staff time, Financial Expertise	Analysis of KPI surrounding revenue, expenses and financial health	
Activity 1.3	Identify variables in Reimbursement Collections	EMS Agencies; Deputy Director; Cost Reporting Team Member	Dec-25	Surveys, questionnaires, and meeting with stakeholders	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Documentation of target issues.	
Strategy 2: Identify Alternative Revenue Streams/Sources							
Activity 2.1	Educate agencies to work with counties/cities to ensure continued and consisent funding obligations; considering alternative structure and implementation of budget-line inclusion in place of outside agency funding.	Maine EMS Staff; Deputy Director	Dec-24	Surveys, questionnaires, and meeting with stakeholders	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Public/Private Payers	Educational programs and resource documents that will provide a clear understanding for EMS Administrators to educate municipal stakeholders.	
Activity 2.2	Educate agencies about reimbursement options for patients that refuse transport.	Deputy Director, Community Paramedicine Coordinator; SUD Team	Dec-24	Research reimbursement programs for non-transport, specifically.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Public/Private Payers	Educational programs and resource documents that will provide a clear understanding for EMS Administrators to fund non-transport responses.	
Activity 2.3	Help identify potential and under utilized sources (e.g., Federal programs, grants, contracts, Community Paramedicine, and foundations)	Deputy Director, Community Paramedicine Coordinator; SUD Team	Ongoing	Research reimbursement sources that have been not utilized or recognized in the past.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Public/Private Payers	Documents that identify resources for agencies to receive funding that have not been utilized in the past and have been untapped.	
Strategy 3: Identify Best Practices in Billing that Result in Higher Collection Rates							
Activity 3.1	Educate agencies on how to assess the agency's current operational financial performance in regards to reimbursement	Deputy Director; Cost Reporting Team Member; Maine EMS Staff; Regional Coordinator	Dec-24	Surveys, questionnaires, and meeting with stakeholders	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Reimbursement Consultants; American Ambulance Association	Educational programs and resource documents for EMS administrators to understand financial performance measures in regards to reimbursement.	
Activity 3.2	Educate leaders about appropriate documentation and the importance of training field clinicans.	Deputy Director; Cost Reporting Team Member; Maine EMS Staff; Regional Coordinator	Dec-24	Evaluation of metrics, gathering data from agencies	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Reimbursement Consultants; American Ambulance Association	Educational programs and resource documents for documentation programs.	
Activity 3.3	Identify best practices in billing across Maine and encourage sharing of those practices.	Deputy Director; Cost Reporting Team Member; Maine EMS Staff; Regional Coordinator	Dec-25	Evaluation of metrics, gathering data from agencies and identifying successful agencies.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Reimbursement Consultants; American Ambulance Association	Identify successful agencies as subject matter experts and encourage sharing of materials to assist other agencies.	

Local Agency Sustainability

Notes from Plan:

Where We Want To Be: In 2035 rural communities and low volume areas continue to evolve EMS operations that are appropriately staffed and financially sustainable. Rural communities and low volume areas have help in moving from unsustainable EMS delivery models to sustainable delivery models. The help comes in the form of a process that uses EMS sustainability experts to guide communities moving from unsustainability to sustainability. The process aids communities in: determining whether their current model is sustainable; calculating the full costs of delivering EMS in their community; providing information about various delivery models; determining what the community wants, needs and what potential resources are available; and providing guidance in navigating the change process. This process is made available through state funding.

Milestones/Markers of Success: a. Wide acceptance that the delivery of operational EMS in Maine will continue to evolve and change to meet needs and that some models will not be sustainable long-term.
b. The Maine State Legislature continues to appropriate adequate funding for grants to help rural communities with EMS change.
c. The Informed Community Self Determination process and similar processes are advocated throughout Maine.
d. Experts in rural EMS are developed, and the process continues to evolve as it finds success in Maine communities.
e. Models of successful evolution and change are identified and recognized.

	Activity	Responsible Entity	Anticipated Completion Date	Evaluation/Metric	Resource Required	Work Products	Anticipated Rulemaking/Statutory Changes
Strategy 1: Improve the appropriate usage of EMS in Maine's communities to lessen the burden(s) on Services							
Activity 1.1	Identify opportunites to provide Healthcare Provider Education regarding the utilization of EMS.	Maine EMS Staff	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify education with healthcare providers about EMS.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Written documentation of educational opportunities to educate the healthcare system about EMS.	
Activity 1.2	Identify actions to improve the use of EMS by community customers, skilled nursing facilities, physician offices, and medical alarms.	Maine EMS Staff	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify inappropriate/unneeded EMS responses/uses.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Maine Hospital Association; Maine Medical Association; Maine Nursing Homes; Maine Hospice	Templated educational materials for EMS agencies and clinicians to use to educate specific community customers.	
Activity 1.3	Identify actions to eliminate the usage of ambulances for different types of EMS calls.	Maine EMS Staff	31-Dec-25	Surveys, questionnaires, and meeting with stakeholders to identify inappropriate/unneeded EMS responses.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association; Dispatch Stakeholders	Work report outlining call types that may be handled by specific alternative resources and the pathway for an EMD Center, EMS agency, and Medical Direction to obtain IAED MPDS Accredidation (ACE) to implement OMEGA-level dispatch options for alternative response and consider Nurse Triage protocols.	
Strategy 2: Assist agencies in their procurement processes to imrove financial sustainability							
Activity 2.1	Assist in best practices for vendor bidding and contracts	Maine EMS Staff; Maine Ambulance Association	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify concurrent issues with supply chain management and successful models.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Written documentation of best practices for bidding and contracts. Development of resources to support subject matter.	
Activity 2.2	Identify ways to provide annual classes on public purchasing procedures, including the use of the state bidding process.	Maine EMS Staff; Maine Ambulance Association; Maine Procurement; Maine Municipal Association	31-Dec-24	Research public purchasing procedures and state bidding process.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Course outlines, educational materials.	
Activity 2.3	Facilitate group agency discussions on buying Co-ops/Regionalized Purchasing	Maine EMS Staff; Maine EMS Regions	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify agencies that would be interesting in discussion/developing Co-ops/Regionalized Purchasing	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Meeting agenda(s) for discussions of subject matter and educational materials.	
Strategy 3: Low-Volume EMS Agencies; Moving from unsustainable EMS delivery systems to sustainable models							

Activity 3.1	Assist in identifying low-volume EMS agencies that are potentially in an unsustainable EMS system.	Maine EMS Staff; Data Team	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify low-volume EMS agencies and issues that make the agencies possiblility unsustainable.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Identified and documented issues/challenges for low-volume EMS agencies and the definition of low-volume EMS agency.	
Activity 3.2	Identify potential pathways that would direct an EMS system towards the goal of sustainability.	Maine EMS Staff	31-Dec-24	Surveys, questionnaires, and meeting with stakeholders to identify low-volume EMS agencies that find ways to make their service sustainable.	Maine EMS; EMS Board; Maine Ambulance Association; Maine Fire Chiefs Association	Identified and documented potential/successful pathways for low-volume EMS agencies.	
Activity 3.3	Provide technical assistance and training to low-volume EMS agencies on data collection, analysis, and reporting.	Maine EMS Staff; Cost Reporting Team Member	31-Dec-25	Improved data submission from low volume EMS agencies	Time, Collaboration with low volume agencies	Low Volume Agency Collaboration Report. I don't know what would be in this, but like services will have like problems.	
Activity 3.4	Support small agencies with recruitment and training of youth interested in EMS, in order to promote the EMS workforce in their area.	Explorer team	May 2024 (phase 2), and onwards	Number of services with Junior/Explorer Programming, and number of Juniors/Explorers enrolled	Staff time, Explorer + Mentor trainings, and initial cohort group mentorship	Explorer Program Implementation Guide	

State of Maine
131st Legislature, First Regular and First Special Sessions

Commission to Study Expansion of Public Preschool and Early Care and Education

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSIONS

Commission to Study Expansion of Public Preschool and Early Care and Education

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Sen. James Libby
Rep. Tavis Hasenfus, Chair
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Executive Summary

The 131st Legislature established the Commission to Study Expansion of Public Preschool and Early Care and Education (referred to in this report as the "commission") to explore options to provide full-day preschool and pathways for publicly funded early care and education programs through Public Law 2023, chapter 477 (see Appendix A). Pursuant to this law, 15 members were appointed the commission (a list of commission members can be found in Appendix B).

Guiding the commission's work is the State's goal of establishing an equitable, mixed-delivery public preschool system that provides universal access for preschool-aged children and their families by the 2026-2027 school year. The public law charged the commission with exploring: how to offer publicly funded preschool in all types of programs and classrooms; partnerships between SAUs and child care programs that meet or could be supported to meet public preschool basic approval standards; and ways to design a funding formula that can achieve the goal of 100% access to preschool programming by 2026.

The public law also provided that the commission could study and consider potential recommendations related to: aligning programs and braiding and blending funding sources; improving the coordination of early childhood programs and services; prioritizing the interests of children, parents, providers and the community; the overall funding structure; and ensuring data and information is used to improve policies and outcomes for children and families.

Over the course of four meetings, the commission learned about the growth of public preschool in the State, the incredible work being done at the State and local level to increase public preschool and early care and education access, the barriers and challenges that schools and communities face in trying to serve the pre-school age population, and the importance of strengthening the State's public preschool and early care and education system for the benefit of the students, families, providers, and communities.

This report reflects the work of the commission, including the development of the following recommendations, which were voted – unanimously of those voting – at the fourth and final meeting of the commission.

- **Recommendation 1: Provide incentives and increase funding – both for ongoing costs and start-up costs - for public preschool programs.**

- **Recommendation 2: Increase flexibility in early childhood education credentialing.**

- **Recommendation 3: Facilitate coordination and outreach to increase public preschool partnerships through the use of a statewide coordinator and regional coordinators.**

- **Recommendation 4: Direct the Department of Health and Human Services, in collaboration with the Department of Education and stakeholders, to study the alignment of standards and rules for early childhood educators and providers to reduce barriers.**

The report concludes with additional considerations, which are critical issues in moving the State towards its ultimate goal of universal public preschool access and quality care and early education that will likely require further attention from the Legislature but that the commission either did not have time to fully discuss or which fell outside the scope of the commission's work.

I. Introduction

Over the past few decades, Maine has increasingly focused on improving equitable access to public preschool and prekindergarten programs for young children and their families To further this commitment, the Legislature passed Public Law 2023, chapter 477, (Appendix A) which provided that it "is the goal of the State to establish an equitable, mixed-delivery public preschool system that provides universal access for preschool-aged children and their families in accordance with the following timeline: 60% by the 2024- 2025 school year; 80% by the 2025-2026 school year; and 100% by the 2026-2027 school year." [1]

In order to achieve this goal, Public Law 2023, chapter 477 also established the Commission to Study Expansion of Public Preschool and Early Care and Education, referred to in this report as the "commission." Pursuant to the public law, the commission consisted of the following 15 members:

- Two members of the Senate appointed by the President of the Senate, including a member from each of the 2 parties holding the largest number of seats in the Legislature;
- Two members of the House of Representatives appointed by the Speaker of the House, including a member from each of the 2 parties holding the largest number of seats in the Legislature;
- One representative from the Department of Health and Human Services involved in the provision of services for children and families of children under 5 years of age selected by the Commissioner of Health and Human Services;
- One representative from the Department of Education involved in the provision of services for children and families of children under 5 years of age selected by the Commissioner of Education;
- One representative of the public school system nominated by the Maine School Management Association and appointed by the President of the Senate;
- Two parents of children who are under 5 years of age who have used state services for their children, one appointed by the President of the Senate and one appointed by the Speaker of the House;
- One representative of family child care services appointed by the President of the Senate;
- One representative of a Head Start program appointed by the President of the Senate;
- One representative of center-based child care services appointed by the Speaker of the House;
- One representative of public preschool teachers appointed by the Speaker of the House;
- One member with expertise in school funding nominated by the Commissioner of Education and appointed by the Speaker of the House; and
- One representative from the Child Development Services System selected by the Commissioner of Education.

A list of the members appointed to the commission may be found in Appendix B.

[1] 20-A MRSA §4501, first ¶.

The commission was tasked with exploring options to provide full-day preschool and pathways for publicly funded early care and education programs and establish a plan that addresses:

- How to offer publicly funded preschool in all types of programs and classrooms where 4-year-olds are enrolled, including, but not limited to, Maine School Administrative Units (SAUs) and licensed child care programs such as Head Start programs, child care centers and family child care programs;
- Partnerships between SAUs and child care programs that meet or could be supported to meet the public preschool basic approval standards under Department of Education (DOE) rules; and
- Ways to design a funding formula that can achieve the goal of 100% access to preschool programming by 2026 and a timeline, an implementation plan and incentives to expand publicly funded preschool programming to 30 hours per week or the length of the local school day at a SAU with the goal of establishing an equitable, mixed-delivery public preschool system that provides universal access for preschool-aged children and their families that meets the State's goal of 100% access by 2026.

The public law also provides that the commission could study and make additional recommendations related to the tasks above on aligning programs and braiding and blending funding in early care and education systems and make recommendations on:

- Improving the opportunities for children under 5 years of age by ensuring the availability and coordination of early childhood programs and services through the State with a focus on child development, education and supporting the needs of working families;
- Prioritizing the interests and input of children, parents, providers and the community in designing and delivering early childhood programs and services and the equitable delivery of resources and supports for early childhood education;
- Determining whether integrating early care and education systems with a central state access point and a regional hub structure could serve as part of a funding structure;
- Examining how various funding streams can be blended and braided to provide more efficient service delivery for families and providers; and
- Ensuring that data about programs and early care and early childhood education systems are available to the public and are shared, coordinated and used by the State to improve policies and outcomes for children and families.

To inform the work of the commission, the public law also required the Department of Education to update the commission on progress relating to the expansion of public preschools, including establishing state and community partnerships for mixed-delivery of child care and early childhood education programs and services through community and school-based providers, as well as establish a departmental workgroup to develop a plan to align credentials and training earned through the Maine Roads to Quality Professional Development Network with those earned through the Department of Education early childhood certification.[2]

[2] PL 2023, ch. 477 also established a new annual reporting requirement for the Department of Education to report to the joint standing committee of the Legislature having jurisdiction over education matters on the department's initiatives, incentives, and progress to expand public preschool programs no later than February 15th of each year.

The commission was directed to submit a report with its findings and recommendations, no later than December 6th,[3] to the Joint Standing Committee on Education and Cultural Affairs and the Joint Standing Committee on Health and Human Services. The Joint Standing Committee on Education and Cultural Affairs may report out a bill based on the recommendations to the Second Regular Session of the 131st Legislature.

Accordingly, this report provides a brief history and background on the expansion of public preschool in Maine and the current status of Maine's growth towards universal public preschool, an outline of the commission's process over the course of its four meetings, and the commission's findings and recommendations to strengthen public preschool and early care and education in Maine.

II. Background Information

Studies have consistently shown that public preschool programs and investment in high-quality early care and learning increase school readiness and lead to improved outcomes for students and families. Maine's public preschool system is well regarded nationally and is one of eight states that meets nine or more of the ten benchmarks that are used by The National Institute for Early Education Research (NIEER) to rank preschool programs across the country.[4] Below is a brief overview of the history of public preschool in Maine, the federal grants and state funding that have been critical in growing and sustaining public preschool programs, and some of the initiatives being undertaken to expand public preschool that have framed the discussion and ultimate findings and recommendations of this commission.

A. Brief History of Public Preschool in Maine

The growth of public preschools in Maine dates back to 1983, when the State first enacted a law to allow 4-year-olds to enroll in kindergarten programs. By 2001-2002, approximately 10% of Maine 4-year-olds were attending a state-funded public pre-kindergarten program, and the State first released the Maine Early Learning Guidelines (MELGs). Recognizing the growth of public pre-k programs in Maine School Administrative Units (SAUs), in the following year the school funding formula was amended to include funding for prekindergarten programs.

Identifying the need for further definition and standards, in 2007, public prekindergarten was defined in statute and in 2015, the State released the Maine Early Learning and Development Standards (MELDS) – a revision of the previous Early Childhood Learning Guidelines. The MELDS are guidance developed jointly between the Maine DOE and DHHS Office of Child and Family Services (OCFS) and provide developmentally appropriate standards for whole child development for children ages 3-5, are aligned with Maine's Infant/Toddler Development

[3] Pursuant to Joint Rule 353(7), the commission requested and was granted by Legislative Council an extension of the reporting requirement to December 15, 2023.

[4] The benchmarks Maine has met include: early learning and development standards, curriculum supports, maximum class size, staff-child ratio, screening and referral process, continuous quality improvement, and teachers having a bachelor's degree specializing in early childhood education. Maine did not meet the professional development benchmark.

Standard and Maine's Learning Results (K-12) Standards, and inform instruction, assessment, and environmental considerations.

In 2015, the State adopted the Maine Department of Education Rule Chapter 124: Public Preschool Approval Standards (see Appendix F). New programs established for the 2015-2016 school year were required to adhere to Rule Chapter 124, and previously established programs had until July 1, 2017 to align their programs. Today, all public preschool programs are required to follow the unified program requirements established in the rule. Rule chapter 124 establishes school approval standards governing the SAUs that are implementing public preschool programs and adopts procedures for ascertaining compliance with all applicable legal requirements. The intent of the rule was to provide the framework for planning and growth for public preschool programs while maintaining local flexibility. The rule was developed to be aligned with Child Care Licensing and Head Start program standards. These requirements include, but are not limited to standards for:

- Class size, which may not exceed 16 children;
- Curriculum, which must be aligned with the MELDS and is appropriate for the age and developmental level of the students;
- Screening and assessment;
- Instructional time, with a 180-day school year and a minimum of 10 hours per week for 35 weeks, although an extended public preschool program of more than 10 hours per week is encouraged;
- Personnel ratios;
- Teacher credentialing, which includes that teachers must hold the required Maine DOE Early Childhood 081 (B-5) endorsement; and
- Additional requirements, such as those related to nutrition, school facilities, family and community engagement, and parameters of an MOU with community partners if a partnership is utilized.

The Maine Department of Education is responsible for providing program approval and technical assistance related to public preschool program requirements.

As noted in the 2023 Measures of Growth Report, published by the Maine Economic Growth Council, the percentage of SAUs with at least one public prekindergarten classroom has risen drastically in the last two decades, from 24% in the early 2000's to 85% last year. This expansion is due in large part to the funding opportunities over the past few years.[5]

B. How Public Preschool is Funded

It is a local decision for SAUs in Maine to determine whether to develop a public preschool program, also referred to as a pre-k or 4-year old program. However, if a SAU does decide to pursue a program, it is funded through two key components: initial start-up funding, which – if available – is usually provided through state and federal grants, and ongoing funding provided

[5] https://www.mdf.org/wp-content/uploads/2023/11/2023_MOG_FullReport_FINAL.pdf

through the State's Essential Programs and Services (EPS) school funding formula and/or through local school budgets.

1. Start-up & Grant Funding

Recognizing the high-cost of starting a public preschool program, the Legislature, beginning with the 2015-2016 school year and for each subsequent school year, authorized the Commissioner of Education to provide start-up funding – if available – to SAUs to operate public preschool programs for children 4 years of age through grants provided from state, federal or private funds.[6] How much funding, and whether funding is available and/or allocated by the Commissioner for funding for start-ups beyond what SAUs receive through the school funding formula, varies from year to year. It is also important to note that start-up grant funding is distinct from the preliminary calculation of funding for the first year of preschool provided through the EPS formula. If grants are available and the Commissioner chooses to allocate funding for start-up costs beyond what a SAU receives through the formula, start-up funding may be available.

In addition to any state funds provided, Maine has also been awarded several federal Preschool Development Grants (PDGs) that have been critical in supporting the State's public preschool and early childhood system. The first grant, a Preschool Expansion Grant (PEG), was awarded to expand public pre-k programming beginning in the 2014-2015 school year and running through the 2018-2019 school year.

Administered by the Maine DOE, these grants were provided to 13 economically challenged SAUs to provide high-quality programming that included full-day programming, evidence-based curriculum and assessment, ongoing professional learning and coaching support, and onsite coordination of programming. The resulting strong child-outcomes included that:

- Classrooms were found to score in the mid to high ranges on indicators of classroom organization, instructional support, and emotional support;
- 75% of students who began the year at high risk moved to some or low risk by the end of the year; and
- 73% of students who began the year at some risk moved to low risk by the end of the school year.

In 2019, the Department of Education, in partnership with the Department of Health and Human Services, received a one-year PDG Birth through Five (PDG B-5) planning grant to conduct a needs assessment of its mixed-delivery system and create a strategic plan. An additional needs assessment was also conducted by the Maine Education and Policy Research Institute (MEPRI) in 2021. These needs assessments identified that some of the biggest barriers for the public pre-k and early care and learning programs include:

- A mismatch between families' need for full-day care options and the preponderance of half-day public pre-k options;

[6] 20-A MRSA §4271.

- Lack of transportation and physical space for children to attend public pre-k programs;
- Difficulty hiring and/or retaining qualified staff,
- Start-up and ongoing costs; and
- Finding partnerships.[7]

In addition, the 2019 PDG B-5 Needs Assessment noted that unintended consequences can occur for the early childhood system as a whole when public pre-k expands, particularly raising issues of pay parity between the school system and the child care system and workforce shortage issues. Furthermore, schools noted a need to build administrator background in early childhood and that educators and schools in general are not well-enough equipped to address or support families with comprehensive services, especially in regards to the behavioral and mental health needs of pre-k children.

In 2022, the Maine DOE received $10 million through the Maine Jobs and Recovery Plan to develop and administer a Pre-K Expansion Grant program. These grants have supported new program start-ups and expansion of current programs, with priority given to programs expanding from part-day/part-week to full day/full-week programming, expansions happening through partnerships with community providers, and programs at SAUs with higher percentages of economic need. A summary of the pre-k expansion grant rounds can be found in the chart below:

Round	# of SAUs	# of Students	# in Partnership	Amount of Funding
1	10	319	2	$2,422,743.89
2	16	533	10	$3,795,845.53
3	5	103	1	$835,580.45
Totals	**31**	**931**	**13**	**$7,054,169.87**

Of the 31 SAUs that received this grant funding, 28 are offering full-day/full-week programming through expansions.

In 2022 the State was also awarded a PDG B-5 Renewal Grant. The OCFS served as the lead agency on the grant, with projects implemented through strong partnerships between DHHS, DOE and the Governor's Office of Policy Innovation and the Future (GOPIF). The grant provided $8 million per year for three years, for a total of $24 million. The goal of the grant was to support the State to continue to build needed infrastructure and capacity to create a more coordinated, efficient, and high-quality mixed-delivery system for children ages birth to five and their families and to ensure all children enter kindergarten prepared to succeed into the early elementary school grades. The PDG B-5 Renewal Grant will enable Maine to implement the roadmap created in the strategic plan developed through the original PDG B-5 grant. Grant funding began in 2023 and will run through 2026. In addition to funding a pre-k partnership

[7] State of Maine Needs Assessment: Vulnerable Children Birth to Age 5 and Their Families and Public Preschool Programs in Maine: Program Design, Capacity and Expansion Challenges (MEPRI) February 2020

specialist, this grant will also fund a Pre-K Advisory Team, made up of a diverse group of stakeholders that is representative of the State and of the mixed-delivery system that supports public pre-k. The group will meet monthly and is charged with studying public pre-k to help inform recommendations to support expansion. Sub-groups will focus on specific issues, including but not limited to: governance, funding, credentialing, and partnerships. The work of the Pre-K Advisory Team will inform design and implementation of a pilot to study partnership strategies in the Fall of 2024.

This grant is also funding the OCFS, DOE's early learning team, and key external stakeholders to work with the Center for Early Learning Equity to conduct a cost model for both child care and publicly funded preschool. The cost model will estimate the related costs associated with providing early childhood education and care at different levels of quality across program setting and geography, by assessing all the factors associated with delivering licensed services at different levels of quality (for example, by considering staffing ratios, compensation, rent, food, and other costs) and relies on input from providers, State agencies, and advocates. When paired with market rate surveys, this kind of cost modeling gives states a more accurate understanding of operating costs and current realities while providing them with key data to inform policy, budgeting and future decision-making.

Finally, the PDG funds are being used to support expanded professional development. The goal is to build off of the current professional development and professional learning provided to early childhood educators and early elementary school teachers by Maine Roads to Quality (Maine's Professional Development Network for early childhood educators), OCFS and the Early Learning Team at DOE to implement a variety of professional learning strategies, many of which will be structured to connect early childhood educators working in child care with those working in public schools. Currently, PDG funds are supporting the Maine Resilience Building Network (MRBN) to offer a variety of synchronous and in-person professional learning sessions focused on building early childhood practitioners' understanding of the impacts of adverse and positive childhood outcomes, trauma informed practices and resilience building strategies, and teams are working on professional learning to build coordinated understanding of language and literacy development across the birth-grade 3 span and strengthening inclusionary practices.

Other workforce initiatives supported by the PDG funds include providing sizable grants to support child care programs to take steps to improve the quality of their programs and move up the Quality Rating and Improvement System (QRIS) and align quality programming for TANF/ASPIRE's childcare subsidy program with the Child Care Subsidy Program, as funding will be used to pay the higher reimbursement rates for programs on the QRIS.

Another source of grant funding has been the Child Care Infrastructure Grants. These grants are directed to support family childcare programs and center-based child care facilities. As of October 1, 2023, OCFS has awarded 136 grants, totaling $8,607,400. So far:

- 59 of these grants have been or will be used to start up new Family Child Care Programs;
- 40 of these grants have been or will be used to start up new Center-based Child Care Facilities; and

- 37 of these grants have been or will be used to expand existing Center-based Child Care Facilities;

These grants are expected to create 3,068 slots. Over 2,200 of these slots have already been completed.

2. Ongoing funding

Once a public preschool program has been established, ongoing state funding for public pre-k programs is provided through the State's school funding formula, known as the Essential Programs and Services, or "EPS" formula. Essential programs and services are those educational resources that are necessary to ensure the opportunity for all students to meet the standards in the eight-content standard subject areas and goals of the system of learning results established pursuant to Maine Revised Statutes, Title 20-A, section 6209. Accordingly, the EPS formula provides the State with a mechanism for establishing the minimum sufficient funding level for achieving the Maine Learning Results[8] and an equitable way to distribute the funding responsibly between local communities and the State. While the EPS formula allocates funding for pre-k as described below, it is critical to note that the formula does not prescribe how funds should be spent; how funds are budgeted and spent on public education and how much to budget and spend on public education is a local decision.

Funding allocated for pre-kindergarten students are included in the EPS formula. A child must be 4-years-old by October 15th to attend a program receiving state subsidy and the program must meet the requirements set forth in Chapter 124. If a SAU operates an approved public preschool program – which requires a minimum of 10 hours per week for 35 weeks – the SAU will receive a basic count allocation for their 4-year-old and 5-year old pre-k students. This allocation remains the same regardless of how many hours (above the minimum) the SAU offers pre-k programming. In addition, allocations for pre-k students are included in the SAU's overall allocations and/or weighted counts for students identified as English learners, economically disadvantaged students, targeted amounts for student assessments and technology resources, and specific targeted amounts for pre-k programming.

For new or newly expanded public preschool programs, the preliminary calculation of allocations for the first year of the new program or expanded program is based on estimated public preschool program counts, estimated rates and weights based on statewide averages, and the preliminary calculation of total allocation (which must be replaced with actual student count data once students have been enrolled for the new school year).[9] This funding is distinct from any start-up *grant* funding, which is only provided if available.

These allocations are included in an SAU's total cost of education, which, after any other adjustments (such as those for isolated small schools, adult education, or equivalent instruction), is then divided into each SAU's state and local share. Because the total amount of state funding

[8] Maine Department of Education Rule Chapter 132: *Learning Results: Parameters for Essential Instruction* establishes the parameters for essential teaching and learning in grades pre-kindergarten through diploma across the eight content areas. High school, middle school, and elementary school programming in Maine's publicly supported schools must be aligned to the knowledge and skills described by this rule.
[9] 20-A MRSA §4271, sub-§3-A.

that a municipality receives is based on the calculation of that municipality's ability to pay towards the cost of that municipality's cost of education, the actual amount of state versus local funding for municipalities varies drastically. Accordingly, the impact of the funding provided through the EPS formula for each SAU will be felt differently in different communities.

However, a notable feature of the EPS funding formula as it pertains to public preschool allocations is that if, for example, a SAU currently serving 32 students in half-day programming (16 students in the morning and 16 students in the afternoon) wants to move to full day programming for all students, the funding formula does not adjust to provide additional funding to support the required 1:8 teacher-to-student ratio. In other words, in the half day model, a SAU with 32 students receives funding to support two educators (a teacher and an educational technician). However, in the full day model, a SAU needs four educators (one teacher and one educational technician in each of the two classrooms of 16 students), but does not receive additional funding through the formula to support the increased staffing requirements.

In fiscal year 2024, the total EPS calculation for the State was $2,545,271,871. Of that, the 55% state share as required by law[10] equaled $1,400,174,513; the local required contribution equaled $1,145,097,328. Of these amounts, the state allocation specific to pre-k allocations for FY 2024 was $34.0 million and $27.8 million for the local share. For a breakdown of the 4-year-old and pre-k funding for the 2023-24 funding year, see Appendix C.

C. Current Status of Public Preschool

With the increase in funding and initiatives over the last few of years, currently 85% of Maine SAUs offer public pre-k programming, with 51% of SAUs offering pre-k universally to their catchment area. Forty-two percent of the public pre-k programs operate 25 or more hours per week (which is considered as a proxy for what is called "full-day" or "full-week" programming). Additionally, 30% of SAUs are operating pre-k programming in partnership with a community partner, such as a Head Start or childcare program.

As programs expand, so too does access for pre-k students and working Maine families. The percentage of 4-year-olds enrolled in public pre-k rose from 33% in 2020-2021 to 41% in 2021-2022.[11] In the 2022-23 school year, 6,269 eligible 4-year-olds were enrolled in public pre-k programs. When using kindergarten enrollment numbers as a proxy for the number of eligible 4-year-olds, this amounts to 52% of all eligible 4-year-olds accessing public preschool.

Ultimately, there are a variety of factors that contribute to whether a SAU offers public pre-k programming, including the extent to which a SAU is able to enroll some or all of the interested students and how accessible the programming is for students and families in the community. As the commission met over the course of a month and a half they sought to focus on the barriers to expansion and to make recommendations to help move the State forward towards its goal of universal access by the 2026-2027 school year and offering Maine families the ability to choose from a variety of high-quality preschool programs based on their needs.

[10] 20-A MRSA §15671, sub-§1;
[11] 2023 Measures of Growth Report

III. Commission Process

Public Law 2023, chapter 477 became effective on October 25, 2023. The commission was authorized to hold four meetings, which were held on November 1, November 9, November 28, and December 13.

A. First Meeting: November 1, 2023

The first meeting of the commission was held on November 1, 2023. The meeting began with comprehensive commission member introductions, where members were asked to talk about their respective backgrounds, roles, and interests in public preschool and early care and education in the State, as well as what they think are the biggest challenges to expanding public preschool access and what they hoped to get out of the commission's work. Common themes that emerged included increase of equitable access for students, maintaining high-quality programming and ensuring appropriate settings, use of non-traditional settings and mixed-delivery partnerships, solutions for ongoing staffing challenges, and increased funding.

Legislative staff provided an overview of the enabling legislation (Public Law 2023, chapter 477 in Appendix A) covering the duties, process, and timeline for the commission's work, as well as the overarching goal established by the Legislature, to establish an equitable, mixed-delivery public preschool system that provides universal access for preschool-aged children and their families by the 2026-2027 school year.

The commission received two presentations at the first meeting. The first presentation was from Lee Anne Larsen, Director of Early Learning, Maine Department of Education (DOE) and task force member, on the current status of public preschool in Maine and an overview of ongoing efforts, programs, and strategies for increasing access to public preschool and early care and education in Maine. Much of the information included in Director Larsen's presentation is included in Section II of this report. Two issues that arose during Director Larsen's presentation, were questions around how the DOE's figure of 52% of eligible children in the State being enrolled in preschool was calculated, as well as questions about the persistent barrier of transportation.

Annie Colaluca, Pre-School Director, Bath Area Family YMCA provided the second presentation on the Bath Area YMCA and Regional School Unit (RSU) 1 CHOICES[12] public pre-k partnership. Considered one of the best public pre-k programs in the State, the CHOICES partnership was founded with the mission to provide all families with 4-year-old children living in the towns served by RSU 1 access to quality developmentally-appropriate preschool programs. The unique collaborative offers families choices between curricula and child care options that meet their needs and philosophy through a mixed-delivery model including the Bath YMCA enrichment program, RSU 1 elementary schools, [13] and Head Start. At the heart of the

[12] The acronym "CHOICES" stands for: Children Having Opportunities in Collaborative Early Settings
[13] RSU1 includes: The Dike-Newell School, Phippsburg Elementary School, and the Woolwich Central School

partnership is the Memorandum of Understanding (MOU), which outlines the terms of service, vision, goals, joint responsibilities and partnerships. A copy of this MOU, along with another sample MOU that the commission discussed, is included in Appendix D. To be eligible for the CHOICES program, the child must be a resident of the RSU 1 school district and must be 4 years of age on or before October 15 of the enrollment year. The enrollment process includes an open house, with the opportunity for parents to meet the partners and ask questions, an application process open for a two-week period in May, and a lottery handled by a third party. Families and partners are informed of the results by June.

Ms. Colaluca identified for the commission four critical success factors for the program:

1) Choice: program options that meet families' needs and philosophies;
2) Communication: a streamlined process for families to learn about and enroll in the program;
3) Collaboration: partners at the table monthly to discuss programmatic logistics, which ensures continuity and consistency;[14] and
4) Coordination: having a single point person to assist and communicate with partner agencies and the school district to ensure alignment.

Ms. Colaluca also identified some of the challenges that still exist even once a successful program gets off the ground. These challenges include issues around equity and ensuring there are enough programs offering full-time care for working families; transportation, especially in regard to the different safety standards for 4-year-olds; partnerships; ensuring developmentally appropriate practices; supporting children with challenging behaviors, and pay parity – as staff in partnership locations are not being offered similar compensation and benefits as those employed by the school districts.

Nevertheless, the benefits of successful partnerships are evident in the CHOICES model. Such benefits include the continuity of care for a child throughout their school day and the early years; having childcare available for families during school vacation weeks and holidays; support for childcare partners with professional development and continued opportunities for education and training; financial benefits for working families who have reduced parent fees for full time care when their children attend through a pre-k partnership; flexibility for childcare programs to honor their unique philosophies and meet community needs simultaneously, opportunities for collaboration and support among childcare providers to strengthen relationships, and the early identification of students who qualify for additional support services.

However, continuing and maintaining a successful partnership also takes work, and Ms. Colaluca noted the importance of considering opportunities to include additional partnerships, such as family childcare providers, the need for continued meetings and ongoing communication with superintendents, the school board, and community members, and an annual report to keep the community informed of the success of the program that includes data that reflects students' growth.

[14] This collaboration includes an Early Childhood Advisory Council, with representative partners involved in the program, including the RSU1 superintendent, a principal, CHOICES coordinator, kindergarten teacher, partner agencies, Child Development Services, a school nurse, and a community representative.

B. Second Meeting: November 9, 2023

The second meeting of the commission was held on November 9, 2023. The first half of the meeting focused on presentations regarding the financing of public preschool programs and early care and education.

Ana Hicks, Children's Cabinet Coordinator, Governor's Office of Policy Innovation and the Future (GOPIF) provided an update on the work of the Children's Cabinet and their plans to ensure all Maine children enter kindergarten prepared to succeed. To accomplish this, the Children's Cabinet focuses on three key components:

1) Access: Increasing access to affordable early care and education and preventative and early intervention services for young children and their families;
2) Quality: Raising the quality of the State's early care and education system and supporting families to access quality programming; and
3) Workforce: Recruiting, preparing, and retaining a diverse early childhood workforce.

The ongoing projects highlighted include work funded through the federal Preschool Development Grant (PDG) funds and grants funded through the federal Maine Jobs and Recovery Program, which are both discussed in more detail in Section II of this report. When asked by a commission member about how the Legislature could support the work of the Children's Cabinet as it pertains to expansion of preschool, Ms. Hicks responded that it is funding that would make the biggest impact on their work. She further noted that the Children's Cabinet focuses much of its work around the structuring of partnerships, but funding is ultimately under the purview of the Legislature.

Paula Gravelle, Director of School Finance, Maine Department of Education provided an overview of how 4-year-old and pre-kindergarten funding allocations are incorporated into the Essential Programs and Services (EPS) school funding formula. Director Gravelle outlined the statutory requirements governing how funding is allocated for pre-kindergarten students through key operating, cost-driven components. These components include student demographics, an EPS per-pupil rate for each individual SAU, weighted amounts for specialized student populations (such as English language learners and economically disadvantaged students), and additional targeted amounts for SAUs who meet specified eligibility criteria. Director Gravelle also explained how this funding fits into the overall funding "pie" of the total cost of public education in the State. Director Gravelle also reviewed the phase-in procedures for newly expanded public preschool programs. However, throughout the overview, Director Gravelle emphasized that the EPS formula is not a prescription for how funds should be spent at the local level

Following presentations, and in recognition of the differences among public preschool programs throughout the State, the commission invited Superintendent Jonathan Moody, MSAD 54 and Superintendent Howard Tuttle, RSU 12, to join the discussion and offer their respective

experiences and perspectives. Both superintendents noted how critical expansion grants were in expanding their programs and having partnerships and transportation for children. Superintendent Moody also noted the importance in recognizing that pre-k involves more staff and that whatever funding model is utilized should not incentivize doing less in terms of public preschool offerings, such as only offering half-day preschool rather than full-day.

With the ongoing work of GOPIF and the Maine Children's Cabinet initiatives, the commission sought suggestions on how to ensure that the commission's work not duplicate efforts that are already underway. The commission also discussed the difficulty of determining what "access" and what percentage of access truly mean when it is unknown how many public preschool "seats" are needed to ensure that all families who want to access public preschool in the State are able to do so. Similarly, challenges may also arise when some 3-year-olds transition out of a 0-3 child care setting but experience a gap in services before they turn 4 and are preschool eligible.

Another issue that was raised is that the EPS formula does not differentiate between part-time (either half-day or only a couple of days a week) programming and full-time programming. Accordingly, there may be a financial disincentive for a SAU to provide full-time programming if the SAU is not receiving additional funding for providing the additional programming. And, the question was raised as to whether the funding provided through the EPS formula is truly capturing what is "essential" for funding schools today.

Additional impediments to expanding public preschool programs raised by commission members included, but were not limited to: credentialing; misalignment of DHHS and DOE fingerprinting requirements and systems; low wages and disparity in pay between child care staff and school staff; how pupil counts might work in a mixed-delivery system where child care may be out of a student's resident school district or if a preschool-aged child may need occasional childcare outside of the school setting; child care facility ratios; space limitations; wraparound services; staffing; special education and CDS; and transportation.

However, many commission members also touched on the successes of programs, including the benefit of robust start-up funding, quality programming, and successful partnerships, including coordinating with family childcare centers and Head Start.

C. Third Meeting: November 28, 2023

At the commission's third meeting, members engaged in a robust discussion of potential recommendations based on information gleaned from previous meetings.

The first matter of discussion was the relationship of the education funding formula with public preschool and specifically how the funding formula could be changed to incorporate public preschool and encourage (but not require) SAUs to explore a full-day preschool model. Commission members concluded that state education funding formula would be best suited to support the ongoing costs of public preschool programming but there remains the barrier of significant upfront costs to SAUs such as transportation and infrastructure costs.

The discussion then moved to the issue of staffing ratios and how this may hinder a childcare provider from filling all of their spots if a 4-year-old child is also enrolled in a public preschool for part of the day. A general recommendation that arose from this discussion reflected the need for increased flexibility with regard to ratios and how school-aged children are counted in childcare settings.

The commission sought to determine where credentialing may create barriers to the implementation or expansion of public preschool programming. Members explored the different general education certifications currently available in the State and identified that the K-6 certification could be reworked to extend certification to allow those educators to teach preschool as well, either through expanding the certification into pre-K-6 or administering a waiver to K-8 certified educators who have taught kindergarten for a certain number of years. This discussion also touched on existing childcare provider staff who may have enough experience to teach preschool but lack a certain credential such as a Bachelor's degree, which then raised the question of how to determine which providers could meet that threshold. From this discussion, the commission came to a potential recommendation for legislation that would direct the Maine Department of Education to review all credentialing and determine how to align credentialing to address gaps in early childhood education roles, or seek a pathway to an alternative certification.

On the topic of fingerprinting and background checks, the commission recommended support for an upcoming bill on this issue, which is anticipated to be introduced to the 131st Legislature, Second Regular Session by Senator Trey Stewart.

The commission then moved on to the topic of pay parity among schools, Head Start Centers, and childcare providers. The commission considered the idea that braiding and blending funding – which involves combining two or more sources of funding to support a program or activity either by tracking the funding sources separately or comingling them, respectively - may help achieve pay parity. It was suggested that this may not be the case without specific direction or requirement – the commission resolved that this could be a question to ask the presenters from Colorado that were speaking to the commission later on in the meeting.

The commission also began a discussion on public preschool partnership coordination and outreach and discussed a potential recommendation to establish a position within the Department of Education that would specifically handle coordination and outreach to districts and community partners, as well as determine the needs and current practices of districts. The commission learned that the Department of Education currently has a similar position in place, but it is federally grant-funded and therefore would be dissolved upon the end of that funding stream. One commission member detailed their school district's partnership with the Maine Association for the Education of Young Children which has taken on much of the work of coordinating with local community partners. It was also noted that, whether with MaineAEYC or the Department of Education, some level of ongoing support is needed as programs come online and grow. The commission suggested a potential recommendation to transition the current coordinator position from limited period to a permanent position to ensure ongoing support for districts pursuing universal public preschool. It was later discussed whether it would be more advantageous to instead have a number of regional coordinators rather than one or two

at the state level, or whether regional coordinators could be available to districts that feel they need them.

At the third meeting the commission also received a presentation from representatives of the Colorado Department of Early Childhood: Dr. Lisa Roy, Executive Director, and Dawn Odean, Universal Preschool Program Director and Ian McKenzie, Public Information Officer.

Colorado officially launched its universal public preschool program for the 2023-2024 school year. Starting this year, families in Colorado can receive at least 15 hours per week of free, voluntary preschool for 4-year-olds, although providers may choose to only provide 10 hours.[15] To make this possible, in November 2020, the Colorado voters passed Proposition EE, which created a preschool program cash fund and required enacting legislation in the 2021 legislative session. Proposition EE, a ballot question, asked voters whether state taxes shall be "increased by $294,000,000 annually by imposing a tax on nicotine liquids used in e-cigarettes and other vaping products that is equal to the total state tax on tobacco when fully phased in" and use those funds, in part, to "enhance the voluntary Colorado preschool program and make it widely available for free." (Appendix E).

On June 23, 2021, the Governor signed HB 21-1304, which established stakeholder and agency working groups and called for the creation of two reports: A Department of Early Childhood Transition Plan and recommendations for universal preschool. The following year, legislation aligned with the two reports was passed, establishing the responsibilities of the Colorado Department of Early Childhood (CDEC) and its Executive Director, moved early childhood programs to the new department, and created the Colorado Universal Preschool Program. On July 1, 2022, the new CDEC officially launched.

As Dr. Roy noted in her presentation, prior to the new structure, the vast array of programs that served young children and their families were administered across various agencies. The new CDEC instead brought in all programs and services administered by the Colorado Department of Human Services' Office of Early Childhood, as well as the Colorado Preschool Program/Early Childhood At-Risk Enhancement (ECARE) and all services administered by the Early Childhood Workforce Development Team, both of which were housed within the Colorado Department of Education. Consolidating these programs and services ensured a centralized and more stream-lined structure with a singular vision for service.[16] As the commission heard at this meeting, the CDEC identifies their vision as "all Colorado children, families, and early childhood professionals are valued, healthy, and thriving." And the mission of the CDEC is to "ensure the delivery of an inclusive, community-centered, data-driven, high quality and equitable early childhood system that supports the care, education, and well-being of all Colorado's young children, their caregivers, and early childhood professionals in all settings."

Dr. Roy also reviewed the goals of the newly-established CDEC, including equitable access, recruiting, retaining and adequately compensating the early childhood workforce, and

[15] Some eligible 3-year-olds may also receive 10 free hours per week; some 4-year-olds with additional qualifying factors may qualify for additional hours of free preschool.
[16] One program excluded from the new structure is preschool special education, which remains housed under the purview of Colorado's Department of Education.

strengthening families by giving caretakers the necessary opportunities, relationships, network, and supports to raise their children successfully. To accomplish these goals, Dr. Roy noted the importance of meeting the evolving early childhood needs to sustain the system, maximizing funding, utilizing data-informed decision-making, and committing to workplace excellence.

As the CDEC develops and evolves, the commission heard that they are focused on four key areas: childcare and preschool, child health and wellbeing, supporting the early childhood workforce, and improving quality environments in all settings. Dr. Roy noted that they are working on different tools to be able to increase compensation for everyone.

One of the most important components of Colorado's system is the focus on mixed-delivery, which brings together a variety of provider types and program settings, but public and private, to serve children. In their mixed-delivery system, any program is eligible to participate so long as they are licensed and meet certain requirements. This includes faith-based early learning programs, elementary schools (including charter schools), family child care homes, for-profit and nonprofit center-based child care programs, and stand-alone preschools.

The system works through an application and match process. Interested programs sign up stating the number of children they have the capacity to serve. Interested families complete a simple application and rank their preference of up to 5 participating programs. The system generates matches based on families' rankings and program availability, and rather than operating on a first-come, first-served process. The match program also includes parameters to help keep families and siblings together where possible. Today, there are just under 2,000 providers participating. Of those, about 48% are community-based programs, 40% are school-based programs, and 12% are family-care providers.

As the CDEC looks to the future, the commission heard that they are focusing on quality standards, including on issues related to eligibility, instructional practice, healthy development, family and community engagement, and teacher quality/workforce. With regard to workforce, the CDEC noted the demographics of the early childhood workforce and some of the efforts to recruit and retain a quality workforce. Recent initiatives include stabilization grants aimed at the child care sector, grants aimed at providing free early childhood education coursework, T.E.A.C.H scholarships designed to provide funding to allow recipients to earn early childhood credentials towards Bachelor's degrees, and many other workforce strategies.

Following the presentation, commission members asked a variety of questions about Colorado's model, the benefits, and the challenges they've encountered. Of particular interest to the commission was that Colorado's special education oversight for preschool-aged children remained with the Department of Education. Dr. Roy and Ms. Odean noted that there have been challenges with ensuring that families are matched with their necessary IEP resources. Ultimately, they noted that Colorado defers to the local level in many ways, and the local districts have purview of local policy, which varies greatly from district-to-district.

Another question that arose was on the number of hours offered. When first launched, the UPK intended to allow for 30 state-funded hours a week for children with qualifying factors, but the level of poverty had been underestimated and there was not sufficient funding to provide that

level of state-funded preschool. Another issue that was identified and addressed early on had to do with provider rates. Initially, if a provider charged less than the standard rate, families would get a credit. However, many providers noted that they based their rates on what families could afford, and that this penalized them for doing so. Accordingly, revisions were made to the rate formula. The commission also learned that the funding stream is provided directly to providers through a vendor, with pay based on enrollment.

Mr. McKenzie spoke to the commission briefly about the outreach to families, especially disadvantaged families, to ensure that those who want to access the program know how to do so. Mr. McKenzie noted the importance of partnering with a marketing organization to assist with that community outreach, connect with community non-profits and other groups to help insure the necessary information is conveyed to communities. He noted that building a communication strategy around outreach to families was crucial, as was ensuring that the application was simple and easy to fill out.

As the presentation concluded, the Colorado team also touched on the importance of vetting providers for quality and credentialing. Colorado was one of the first states to institute quality ratings and incorporated that into the department. Waivers are also available in certain situations. They noted that paying the same rate per child has raised the quality of all settings and that, as the CDEC gets into its first year they are working support professional development at the department level. They noted the importance of avoiding additional burdens and focusing on supporting providers in raising the bar with child outcomes in mind.

D. Fourth Meeting: December 13, 2023

The commission met for a fourth and final time on Wednesday, December 13th to review its draft report and take final votes on findings and recommendations. As staff provided an overview of the draft report, commission members provided feedback, clarifications, and additional information to include in the final report.

The main focus of the fourth meeting was discussion of the draft recommendations and any revisions necessary to fully capture the scope and intent of each recommendation. In particular, the commission discussion focused on the potential models of statewide and/or regional positions necessary to facilitate coordination and outreach to increase public preschool partnerships as captured in Recommendation #3. After weighing these different models, the commission envisions a single statewide coordinator and various regional coordinators. Although under the direction of a statewide professional, the regional coordinators would still maintain that important familiarity with the region's schools, culture, and needs while still having a direct line of communication with the State for consultation when necessary. The commission also revised Recommendation #4, recognizing that the issues of licensing and regulation alignment is broader than just childcare staffing ratios.

At the conclusion of the meeting, the commission decided to vote on the full report as a whole, including each of the four recommendations included in Section IV. With the exception of those abstaining or absent, the commission voted unanimously in support of this report and the recommendations to the Legislature it contains.

IV. Commission Findings and Recommendations

A. Overview & Context

Although the commission would have liked additional time to fully develop a plan to expand public preschool programming as required by its authorizing legislation, the commission focused the limited time that the commission did have on exploring options to provide full-day preschool and identifying pathways for publicly funded early care and education programs, and identifying the barriers that will need to be overcome to implement universal preschool programming. The commission is mindful that a lot work is already being done at the State level by the Department of Education, the Department of Health and Human Services, and the Children's Cabinet Early Childhood Advisory Council. These efforts are in addition to the great work being done at the local level by many of the school administrative units and community partners throughout the State.

As the commission heard over the course of their four meetings, the Department of Education and the Children's Cabinet Early Childhood Advisory Council are committed to long-term strategies to support expansion of public pre-k in Maine. In addition to the initiatives funded through the PDG B-5 Renewal Grant discussed above, long-term strategies include:

- Exploring refinements to the pre-k funding formula, DOE's Chapter 124 preschool approval rules, and the MELDs to increase pre-k "dosing" and programming quality;
- Expanding DOE staffing to support pre-k expansion efforts related to technical assistance and continuous improvement;
- Securing resources to provide professional learning and coaching support for public pre-k programs,
- Tracking public pre-k expansion efforts towards reaching the goal of all Maine 4-year-olds having access to quality pre-k, and
- Exploring methods for determining data-based impact on student learning.

It is with this background in mind that the commission began developing its own recommendations to support the ongoing work towards the goal of establishing an equitable, mixed-delivery public preschool system that provides universal access for preschool-aged children and their families by the 2026-2027 school year. In developing these recommendations, the commission emphasizes that all stakeholders – from government agencies to school districts, child care programs, and the families and children they serve – must collaborate and work together to find solutions to overcome barriers. Each community in Maine is different and will require different resources to establish and maintain successful programs.

As identified in the authorizing legislation, the goal is to provide universal access to public preschool. As the commission learned, currently 52% of 4-year-olds were enrolled in public pre-k when kindergarten enrollment is used as a proxy. However, some commission members questioned whether kindergarten enrollment is an appropriate analogue for calculating access to pre-k. Barriers to public preschool such as lack of transportation, limited seats, and lack of full-day programming and/or wrap-around care make public preschool, even if offered by a SAU,

inaccessible to many working families. Simply increasing the number or hours of public preschool programs is not sufficient to address the barriers to access. As the State works towards universal access for public preschool, the State should be mindful of what 100% access should look like and how to ensure that an equitable, mixed-delivery public preschool system meets the needs of the State, communities, and the families and students who choose to utilize it.

Accordingly, much of the commission's work was devoted to identifying these barriers that obstruct Maine's pathway to universal preschool and developing ideas to help preschool providers navigate around these hurdles, while avoiding duplicating the work that is already being done. The culmination of this work is four interrelated recommendations that target issues of funding, the reduction of barriers, and assistance for fostering partnerships. Of course, these recommendations do not constitute the entirety of the necessary work to achieve the goal of high-quality universal preschool in Maine. Nevertheless, the commission believes that the implementation of the following recommendations will spur some of the necessary collaboration and provide more Maine families with access to a high-quality preschool program.

With the exception of two members abstaining and two members who were absent for the vote and did not subsequently record a vote, commission members unanimously voted to endorse this report and make the following recommendations.[17]

B. Commission Recommendations

❖ **Recommendation 1: Provide incentives and increase funding – both for ongoing costs and start-up costs – for public preschool programs.**

The first recommendation of the commission is for the Legislature, partnering community providers and organizations, and the Maine Department of Education to facilitate and implement financial incentives that encourage the inception or expansion of public preschool offerings in local communities. The commission discussed three general ways these incentives should take shape – funding opportunities to address upfront costs for new and expanding programs, revisions to the school funding formula to support ongoing funding, and the braiding and blending of funding streams with partnering organizations and providers.

From its discussions and after hearing from school administrators, the commission recognizes that the EPS funding formula may not sufficiently address the cost of public preschool programming. Specifically, the EPS funding formula may actually disincentivize schools from implementing full-day public preschool, despite language in the Department of Education's rule chapter 124 that "encourages SAUs to schedule public preschool for more than ten hours per week to improve child outcomes and to reduce the risk of later school failure." (Appendix F). The EPS formula provides funding without regard to half-day or full-day programming. In other

[17] Dr. Todd Landry, who served as the representative from the Department of Health and Human Services resigned from his position prior to the commission's final vote and was not replaced; Lee Anne Larsen, serving as the representative from the Department of Education, and Erin Frazier, serving as the representative from the Child Development Services System, both abstained from the final vote; Joe Whitmore, representing a parent of a child who is under 5 year of age who has used state services and Jordyn Rossignol, representing center-based child care services were both absent for the final vote and did not subsequently record a vote.

words, the EPS funding formula does not supplement preschool funding if the school chooses to offer more than the minimum-required preschool hours including full-day preschool, which requires additional space and staffing unless the school ultimately decreases the number of available seats for preschool students. Thus, the commission recommends that the EPS funding formula be revised to truly incentivize schools to offer full-day preschool by appropriately increasing a school's preschool funding to meet the needs of full-day programming without a loss in overall capacity. The commission notes that this change would not necessarily preclude a school from only offering half-day preschool if the school determines that is best for them – this revision to the EPS formula would simply ease the burden on schools to come up with additional funding to expand their programming.

However, changes to the EPS funding formula would only ease the burden of *ongoing costs* and would not address the significant *upfront costs* that a school may be faced with when starting or expanding a public preschool program. These may include infrastructure costs (e.g. construction of a new classroom or outfitting an existing classroom with age-appropriate furnishings) and transportation-related costs (e.g. additional buses, outfitting existing buses with harnesses to transport preschool-aged students, or additional staff to be present on buses). To address this significant barrier, the commission recommends increasing – to the extent possible – grant-based funding opportunities or expanding existing opportunities that specifically target these upfront needs. Moreover, as previously noted, the Commissioner of Education may allocate additional funding to SAUs for these upfront costs if such funding is available. The commission strongly emphasizes that, in order to meet the State's goal of 100% access to public preschool by the 2026-2027 school year, the Legislature needs to appropriate funds and allocate the resources necessary to achieve this goal.

The commission acknowledges that schools in the State will have varying degrees of upfront costs depending on the current status of their preschool offerings and their existing infrastructure; the expansion of grant-based funding is a more appropriate avenue for ensuring that funding is allotted on an as-needed basis. As the commission heard, this initial influx of funding is especially important for costs such as equipping school buses with the appropriate harnesses to allow for transportation of preschool-aged children and adapting physical spaces to be age-appropriate.

Finally, the commission recommends that the various preschool providers in the State (schools, community childcare providers, Head Start) collaborate to blend and braid funding streams in order to better align programming and achieve a full-day program. The opportunity to capitalize on existing resources – rather than having a sole provider take on a public preschool program and fill their own gaps – may incentivize SAUs and partnering providers to come together and jointly expand their programming. On this topic, the commission discussed the difficulties around the different requirements and capacities for different providers – for example, the Maine Department of Education's rule chapter 124 requires that ten hours of preschool are offered while Head Start requires six hours a day for five days a week (although there is flexibility in those Head Start requirements based on community need).[18] There is opportunity for these

[18] Potential changes to the Head Start performance standards are in development and are open to public comment at the time of the writing of this report. If implemented, these changes would place more emphasis on community partnerships, among other things. For further information, see:

providers to collaborate with the resources they each have available to be able to jointly offer a full-day preschool program. In order to do this, however, the Department of Education, Head Start, and community partners would also need to collaborate on revisiting each entity's preschool standards and ensure those standards are aligned across the various providers, from length of the preschool day to licensing and inspection. Standards also need to be flexible to local community needs. This is further detailed in the commission's recommendation #4, below. The collaboration around these resources may extend beyond alignment and include the blending and braiding of funding for staffing, classroom supplies, and meal resources as well to achieve the full-day programming goal.

❖ **Recommendation 2: Increase flexibility in early childhood education credentialing.**

Over the course of their work, the Commission identified educator credentialing as a barrier to the expansion of public preschool in the State and believes that additional flexibility in credentialing may ease the some of the effects felt from educator workforce shortages. The commission discussed several possible avenues to achieve more flexibility and would simultaneously like to express and encourage support for some of the ongoing work on this issue in addition to the possibility of legislation to expand on that work.

Currently, the State Board of Education Rule Chapter 115, Part II: Requirements for Specific Certificates and Endorsements governs early education teacher credentials. As required under the Maine DOE rule chapter 124, public preschool teachers must hold the Endorsement 081: Early Childhood Teacher, which allows the certificate holder to teach students birth through kindergarten (also referred to as the Maine DOE Early Childhood 081 (B-5) endorsement). The other elementary endorsements available for early childhood educators in the State include:

- Endorsement 029: Early Elementary Teacher, which allows the certificate holder to teach students pre-kindergarten through grade 3 (Prek-3);
- Endorsement 020: Elementary Teacher, which allows the certificate holder to teach students kindergarten through grade 6 (K-6); and
- Endorsement 282: Teacher of Children with Disabilities, which is divided by age ranges including a birth to school age 5 (B-5) and a kindergarten through grade 8 (K-8).[19]

Commission members noted that the varying grade spans create a barrier for SAUs in creating or expanding programs as, for example, a currently certified kindergarten teacher is not certified to teach preschool instead. One pathway to afford more flexibility may be to reconfigure grade-level breakdowns for each of these certification endorsements. A recommendation that arose from a discussion around this was the possibility of extending the 020 endorsement and the K-8 282 endorsement to include preschool on the basis that kindergarten students and preschool students are typically only a year apart in age. This would allow greater flexibility for SAUs to staff preschool classrooms and decrease the additional burdens on teachers to obtain additional endorsements.

https://www.federalregister.gov/documents/2023/11/20/2023-25038/supporting-the-head-start-workforce-and-consistent-quality-programming

[19] See Appendix I for the specific requirements and details of each of these endorsements

An alternate avenue that arose in discussion was the establishment of a pathway to an alternate certification for early childhood professionals (e.g. childcare provider staff) that have a wealth of experience but who may not hold a Bachelor's degree, disqualifying them from traditional certification. Some members noted that determining eligibility for this certification may be challenging, but acknowledged the potential for an untapped pool of resources in the childcare industry. Another perspective from commission members suggested that a waiver become available for kindergarten-certified educators, granting them the ability to teach preschool if that educators has taught kindergarten for a certain number of school years.

With regard to any potential changes to educator credentialing, however, the commission emphasizes that Maine's preschool students must be taught by the most qualified educators with the best appropriate training for that age group. Although the commission recommends further exploring flexibility in this area, such exploration must include careful consideration of both the needs of expanding the educator pool, while not reducing professional standards. The commission encourages following the guidance of education and early childhood experts on determining, for example, whether a kindergarten educator is sufficiently prepared to teach preschool at the highest standard for Maine's students.

Accordingly, the commission expresses and encourages support for the ongoing work of the Pre-K Advisory Team, which has been formed through the funding of the Preschool Development Grant and which has already begun to explore this critical issue. To expand on the tasks of the Advisory Team, some members of the commission would also put their support behind legislation directing the State Board of Education and relevant stakeholders to study the above issues around early childhood educator credentialing and the feasibility of reworking existing credentialing and/or of establishing an alternate preschool educator certification for childcare professionals.

- **Recommendation 3: Facilitate coordination and outreach to increase public preschool partnerships through the use of a statewide coordinator and regional coordinators.**

The commission reiterates the need for and the importance of partnerships in order to achieve the goal of universal preschool in Maine. Where SAUs may have gaps in resources, collaboration with a local childcare provider or other organization can fill these gaps and meet the goal of high-quality preschool programming for communities and SAUs that may feel they are unable to expand or establish a preschool program. These partnerships can also help to preserve family choice, allowing parents to choose what is best for themselves and their children in terms of preschool environment and the convenience of the location. Moreover, encouraging partnerships also facilitates the commission's earlier recommendation regarding the blending and braiding of funding in order to achieve a high-quality program. During the commission's third meeting, members also heard about and discussed examples of successful MOUs with various organizations for preschool programs in the State, and ultimately believe that maintaining a long-term MOU and fostering partnerships is a potential way to address ongoing needs that arise as programs expand. (Appendix D).

A recurring acknowledgement of the commission throughout their meetings was the highly variable status of current public preschool offerings in the State – some school administrative

units may already have a comprehensive preschool program and not need much external support while others may have a dearth of resources and no existing preschool offering. This aspect of the current preschool landscape informed the commission's recommendation to facilitate outreach and assistance to SAUs related to coordinating partnerships between preschool providers in order for the State to meet its goal of universal access to public preschool by the 2026-2027 school year.

First, the commission expresses and encourages continued support for the existing position within the Maine Department of Education that serves as a statewide resource for preschool-related outreach and coordination. The commission sees this as a vital point of coordination for schools looking to start or expand their public preschool offerings. However, because this is a federally-funded grant position and therefore contingent upon the availability of those funds, members of the commission recommend reclassifying this position as permanent and support making an appropriate allocation of funding for this position upon the termination of the federal grant funding if the position is still needed upon the termination of the federal funding. The continuation of this coordinator position reflects the ongoing and varied needs of SAUs and childcare partners in the State to foster those partnerships and expand their mixed-delivery preschool programming.

However, a single, statewide coordinator position is unlikely to provide sufficient local coordination and is unlikely to know the needs and available resources in every local community. Thus, given the varied needs around the State – as well as the different dynamics and distinct cultures of each region – the commission recommends the creation of several regional coordinator positions as well. If realized, these positions could be housed within the Maine Department of Education and take on similar responsibilities as the statewide coordinator, except that the regional coordinators would only work with schools and potential partners in a particular region of the State. This regionalized approach will consequently allow the regional coordinator to gain a more intimate familiarity with local organizations and partners as well as with the overall landscape and needs of the local SAUs, allowing DOE to more efficiently allocate and direct targeted resources to address the various needs of SAUs. Regional coordinators could also work directly with the statewide coordinator to access resources at the state-level that the local community might not otherwise be aware of. One example of coordination that could be especially helpful is navigating school construction projects, as a critical step to starting or expanding a public preschool program is often constructing or renovating age-appropriate facilities – having regional coordinators help local communities determine their respective need will also necessarily assist the State in directing targeted grant funds where they are needed most.

While the commission does not make a specific recommendation as to how many regional coordinators would be necessary and how the boundaries of each region would be determined, the commission notes that many regional entities already exist and that the State could take advantage of these existing regional structures.[20] As such, the commission encourages flexibility in this regard and encourages appropriate funding for these positions.

[20] Examples given include, but are not limited to: the 9 superintendent regions; the regional structure of the Child Development Services System (CDS); counties; and/or public health districts

The commission's focus for these coordinator positions is largely to assist the State in moving toward the goal of 100% public preschool access. The commission recognizes that some regions may achieve this before others and that the level of need for ongoing support is difficult to determine at this time. Accordingly, it will likely be appropriate to reevaluate the coordinator positions to determine the necessary level of ongoing support going forward once the 100% goal is realized.

- **Recommendation 4: Direct the Department of Health and Human Services, in collaboration with the Department of Education and stakeholders, to study the alignment of standards and rules for early childhood educators and providers to reduce barriers.**

A significant and complex barrier to the expansion of preschool is the misalignment of standards and rules for each type of (potential) preschool provider. Adding to this complexity is the fact that each type of provider is under the purview of a different agency – childcare providers are regulated by DHHS, preschool programs in public schools are regulated by DOE, and Head Start is federally regulated. The commission repeatedly heard how the differences in each entity's standards for their respective preschool providers can hinder partnerships and ultimately reduce a preschool program's capacity and ability to meet the needs of their communities. With these challenges in mind, the commission recommends directing the Department of Health and Human Services to collaborate with the Department of Education, including the DOE's Head Start Collaboration Office, and other relevant stakeholders, to review each entity's standards and rules and propose changes to better align standards and rules across the all entities.

While this recommendation would initiate a broad look at all misaligned standards and rules, the commission would like to highlight a particular issue that came to its attention and recommend that scrutiny is specifically applied to this problem. The issue arises in the staff-to-child ratios established in Department of Health and Human Services rules for childcare providers. (Appendix G, H). The issue arises when a preschool-enrolled child is also placed with a childcare provider outside of preschool hours – the childcare provider must classify that child as a full-day participant despite only needing care for part of the day. As a result, the childcare provider is in the position of either needing to charge a full-day rate for their care even if the child is not there for the full-day, or charging for a half-day and absorbing the cost, which imposes a financial burden since they cannot fill that spot with another child. Neither option is conducive to a successful childcare model. These constraints can impact the availability of access to childcare if a provider is unable to offer care to an additional child for the duration of preschool hours, and impact the provider's ability to serve all of their clients during instances of school closures.

While the commission is not prepared at this time to recommend exactly which changes need to occur – or whether changes should be accomplished through statutory, regulatory, or other framework – the commission does recognize that this is a barrier to increasing availability of public preschool and early care and education and that DHHS and DOE should examine this issue further. Ultimately, reducing barriers related to alignment of standards and rules will encourage and foster partnerships without imposing financial burdens on those who want to participate in an equitable, mixed-delivery system that meets the communities' needs.

❖ **Additional issues; further research**

Throughout its work, the commission came upon a number of issues that the commission is unable to make concrete recommendations on, as these issues require either further research and/or more dedicated time to reach a firm conclusion. Despite this, the commission believes the following issues warrant consideration and offer them to the Legislature for further examination and discussion:

- **Fingerprinting and background checks:** The commission supports a solution to the issue of the misalignment between Department of Education and Department of Health and Human Services fingerprinting and background check processes for educators and childcare providers. This misalignment hinders partnerships and staffing solutions, and encourages support of Senator Stewart's bill that seeks to address this issue in the Second Regular Session of the 131st Legislature.

- **Special education/Child Development Services (CDS):** The commission repeatedly encountered issues surrounding the delivery of early childhood special education and how it may fit into the model of a mixed-delivery public preschool program, especially as it pertains to the transition from CDS in preschool to special education in kindergarten and ensuring that students and families do not encounter gaps in services. It is clear to the commission that early childhood special education and CDS in the context of mixed-delivery public preschool probably warrants its own dedicated study and research. Given the complexity of this issue, the commission did not have time to give it the attention that it deserves. The commission emphasizes and encourages that this issue not be neglected as any expansion to universal access for public preschool must include those children who are also receiving special education services.

- **Alternate funding mechanisms:** As identified earlier in this report, the current funding model for public preschool in this State flows through SAUs. During a presentation from the Colorado Department of Early Childhood, the Commission heard about a funding model in which the state (in this case Colorado) pays partnering providers directly at a pre-determined per-pupil rate for their participation as a partner in public preschool programming. Some commission members noted that this framework mirrors the way Maine allocates funding to schools that serve towns without schools, however, some members expressed concerns that this model would ultimately redirect funding away from schools. The commission feels this model and its feasibility in Maine – as well as the details and feasibility of other alternative funding models – should be explored further as the State moves towards universal access to public preschool, but also emphasizes the need to respect local control when exploring such alternate funding mechanisms.

- **Pay parity:** Much like CDS, the commission feels that determining how to ensure pay parity across different partnering preschool providers is a significant undertaking

and is beyond the scope of this commission's duties as described in the enabling public law. The commission understands that this issue appears in other states' universal preschool programs and the issue of pay parity could warrant its own discreet study and research. Revision and better alignment of credential and licensure requirements between schools and child care programs may impact the pay gap. An additional area of potential is the recent implementation by OCFS of monthly stipends for early childhood educators. These stipends were initially funded through initially ARPA Child Care Stabilization Grants, but were continued with state general funds in October 2022. Ultimately, the commission recognizes the need to support all professionals involved in preschool and early care and learning support initiatives to increase pay – and the equity in pay – across all providers.

- **Determining needs, gaps, and resources:** As mentioned, the commission acknowledges the varying level of needs among providers in Maine. The implementation of each of the commission's recommendations could benefit from more detailed knowledge of the current landscape of public preschool in Maine, including specifically identifying high-need districts and low-need districts. Additionally, the Commission identified two initiatives that could potentially be major partners in the expansion of preschool – First4ME and Help ME Grow – but utilizing these initiatives to their fullest potential and determining their capacity will ultimately depend on the level of support needed across the State.

- **School construction:** The commission discussed that changes to school construction requirements may be an effective avenue to the goal of 100% access to public preschool in Maine. With physical space limitations often cited as a barrier to expanding or starting public preschool programs, the commission noted that many newly-constructed schools that plan to house kindergarten also incorporate plans for a preschool classroom(s) in their construction plans. It was also discussed that this may be something that a statewide and regional coordinators (as discussed in recommendation 3) could assist with. However, given the complexities around school construction funding and requirements, the commission felt that this requires more discussion and research with input from the State Board of Education.

The work of expanding public preschool in Maine is multi-faceted and will require collaboration among a diverse group of entities (including but not limited to government agencies, SAUs and school professionals, childcare providers and community organizations) and evolving policy and legislative work in order to deliver uniformly high-quality programming throughout the State. The commission recognizes that the work is not yet complete but believes that the implementation of the above recommendations will spur some of the necessary collaboration and provide more Maine families with access to a high-quality preschool program.

A final recommendation from the commission – and perhaps the most salient one – is somewhat symbolic: setting and enforcing a goal with a firm deadline for universal access to public preschool in Maine and adequately communicating this goal to SAUs and providers will encourage SAUs to more closely assess their needs and shed light on where the most support is needed. A goal and deadline acting as an inherent incentive can empower local entities – SAUs,

childcare providers, and community organizations – to take the steps they are able to take on their own in developing their own programs at the local level. Public Law 2023, chapter 477 sets the goal of establishing an equitable, mixed-delivery public preschool system that provides universal access for preschool-aged children and their families in accordance with the following timeline: 60% by the 2024- 2025 school year; 80% by the 2025-2026 school year; and 100% by the 2026-2027 school year. The commission is excited to see the progress so far and looks forward to engaging in the work necessary to meet this ambitious goal.

IV. Conclusion

The commission's work and publication of its report comes at a time of great energy and movement towards expanding public preschool and early care and education in the State and nationwide. As noted throughout its work, there are many stakeholders engaged in this working, including but not limited to the Maine Department of Education, Maine Children's Cabinet, Early Advisory Team, and local schools, communities, childcare providers, and families.

However, this work cannot move forward without continued effort by all of those involved. The commission hopes that this report can be leveraged to augment the incredible ongoing work already being done to help meet the State's goal of universal public preschool through an equitable, mixed-delivery system. It is through the development of this crucial mixed-delivery system that is flexible and can adapt to the diverse local needs of the State, that public preschool can best meet the needs of schools, early care and education providers, local communities, and most importantly, the students and their families.

Finally, the commission would like to thank all of its members and presenters for generously offering their time, expertise, and advice on the complicated issues involved in supporting expansion of public preschool and early care and education. Their knowledge and perspectives were invaluable in honing the focus of the commission's work and in the development of the commission's findings and recommendations. In particular, the commission would like to thank and support the ongoing work of the Maine Children's Cabinet, the Pre-K Advisory Team, DOE, DHHS, Head Start, family child care providers, schools, and everyone else who is so vital in providing quality, equitable early care and education for Maine's children.

APPENDIX A

Authorizing Legislation: Public Law 2023, chapter 477

APPROVED
JULY 27, 2023
BY GOVERNOR

CHAPTER
477
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

S.P. 724 - L.D. 1799

An Act to Expand Maine's High-quality Early Learning and Care for Children by Increasing Public Preschool Opportunities in Communities

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

Sec. 1. 20-A MRSA §4272 is enacted to read:

§4272. Expansion of public preschool programs report

The commissioner shall report annually by February 15th to the joint standing committee of the Legislature having jurisdiction over education matters on the department's initiatives, incentives and progress to expand public preschool programs.

Sec. 2. 20-A MRSA §4501, first ¶, as amended by PL 2019, c. 343, Pt. UUUU, §1, is further amended to read:

In accordance with the policy expressed in section 2, every school administrative unit shall raise annually sufficient funds to maintain or support elementary and secondary schools to provide free education for its resident students at all grade levels. These schools shall meet the requirements of basic school approval. To the extent the State provides adequate start-up funding, a school administrative unit may offer an opportunity for every child 4 years of age residing in the school administrative unit to attend a public preschool program, or a program affiliated with the school administrative unit, meeting the requirements of basic school approval. It is the goal of the State to ~~provide adequate start-up funding to ensure that public preschool programs for children 4 years of age are offered by all school administrative units by the 2023-2024 school year~~ establish an equitable, mixed-delivery public preschool system that provides universal access for preschool-aged children and their families in accordance with the following timeline: 60% by the 2024-2025 school year; 80% by the 2025-2026 school year; and 100% by the 2026-2027 school year.

Sec. 3. Commission established. The Commission to Study Expansion of Public Preschool and Early Care and Education, referred to in this section as "the commission," is established.

1. Notwithstanding Joint Rule 353, the commission consists of 15 members appointed as follows:

A. Two members of the Senate appointed by the President of the Senate, including a member from each of the 2 parties holding the largest number of seats in the Legislature;

B. Two members of the House of Representatives appointed by the Speaker of the House, including a member from each of the 2 parties holding the largest number of seats in the Legislature;

C. One representative from the Department of Health and Human Services involved in the provision of services for children and families of children under 5 years of age selected by the Commissioner of Health and Human Services;

D. One representative from the Department of Education involved in the provision of services for children and families of children under 5 years of age selected by the Commissioner of Education;

E. One representative of the public school system nominated by the Maine School Management Association and appointed by the President of the Senate;

F. Two parents of children who are under 5 years of age who have used state services for their children, one appointed by the President of the Senate and one appointed by the Speaker of the House;

G. One representative of family child care services appointed by the President of the Senate;

H. One representative of a Head Start program appointed by the President of the Senate;

I. One representative of center-based child care services appointed by the Speaker of the House;

J. One representative of public preschool teachers appointed by the Speaker of the House;

K. One member with expertise in school funding nominated by the Commissioner of Education and appointed by the Speaker of the House; and

L. One representative from the Child Development Services System selected by the Commissioner of Education.

2. The first-named Senate member is the Senate chair, and the first-named House of Representatives member is the House chair of the commission.

3. All appointments must be made no later than 30 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this Act a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

4. The commission shall explore options to provide full-day preschool and pathways for publicly funded early care and education programs. The commission shall establish a plan that must address the following:

A. How to offer publicly funded preschool in all types of programs and classrooms where 4-year-olds are enrolled, including, but not limited to, school administrative

units and licensed child care programs such as Head Start programs, child care centers and family child care programs;

B. Partnerships between school administrative units and child care programs that meet or could be supported to meet the public preschool basic approval standards under Department of Education rule Chapter 124: Basic Approval Standards: Public Preschool Programs; and

C. Ways to design a funding formula that can achieve the goal of 100% access to preschool programming by 2026. The commission shall establish a timeline, an implementation plan and incentives to expand publicly funded preschool programming to 30 hours per week or the length of the local school day at a school administrative unit with the goal of establishing an equitable, mixed-delivery public preschool system that provides universal access for preschool-aged children and their families as follows: 60% by the 2024-2025 school year; 80% by the 2025-2026 school year; and 100% by the 2026-2027 school year.

5. The commission may also study and make recommendations on aligning programs and blending and braiding funding in early care and education systems. The commission may make recommendations on the following:

A. Improving the opportunities for children under 5 years of age by ensuring the availability and coordination of early childhood programs and services through the State with a focus on child development, education and supporting the needs of working families;

B. Prioritizing the interests and input of children, parents, providers and the community in designing and delivering early childhood programs and services and the equitable delivery of resources and supports for early childhood education;

C. Determining whether integrating early care and education systems with a central state access point and a regional hub structure could serve as part of a funding structure;

D. Examining how various funding streams can be blended and braided to provide more efficient service delivery for families and providers; and

E. Ensuring that data about programs and early care and early childhood education systems are available to the public and are shared, coordinated and used by the State to improve policies and outcomes for children and families.

6. The Legislative Council shall provide necessary staffing services to the commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

7. No later than December 6, 2023, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Education and Cultural Affairs and the Joint Standing Committee on Health and Human Services. The Joint Standing Committee on Education and Cultural Affairs may report out a bill based on the recommendations to the Second Regular Session of the 131st Legislature.

Sec. 4. Department of Education responsibilities. The Department of Education, referred to in this section as "the department," shall inform the Joint Standing Committee on Education and Cultural Affairs and the Commission to Study Expansion of

Public Preschool and Early Care and Education on progress relating to the expansion of public preschools, and the department shall:

1. Develop a plan to align the credentials and training earned through the Maine Roads to Quality Professional Development Network with those earned through the Department of Education early childhood education certification. The department, through a professional development and certification stakeholder working group, shall develop a plan that includes the following components:

A. The development of a competency-based credential that recognizes experience, cumulative elective training hours and a demonstration of knowledge and skills in early childhood teaching practices;

B. Reciprocity for credit for or training hours toward certification from other states and countries;

C. A Maine Roads to Quality Professional Development Network career lattice to align with department educator credentials and that considers credentials obtained in the absence of college course work of the same content;

D. Eligibility of family child care providers who hold and maintain national accreditation standards accepted by the Department of Health and Human Services, Office of Child and Family Services as publicly funded preschool locations; and

E. Collaborating with local adult education providers, apprenticeship sponsors, career and technical education programs, the Maine Community College System and the University of Maine System to create articulation agreements between these entities for the transfer of credits for course work related to early childhood education and to facilitate enrollment in courses that lead to the awarding of a postsecondary degree by an accredited institution of higher education; and

2. Report to the Commission to Study Expansion of Public Preschool and Early Care and Education and the Joint Standing Committee on Education and Cultural Affairs on progress relating to public preschool expansion, including establishing state and community partnerships for a mixed delivery of child care and early childhood education programs and services through community and school-based providers by November 15, 2023.

APPENDIX B

Commission Membership list: Commission to Study Expansion of Public Preschool and Early Care and Education

The Commission to Study Expansion of Public Preschool and Early Care and Education

An Act to Expand Maine's High-quality Early Learning and Care for Children by Increasing Public Preschool Opportunities in Communities (LD 1799)

Membership List

Name	Representation
Senator Eloise Vitelli, Chair	Member of the Senate
Senator Jim Libby	Member of the Senate
Representative Tavis Hasenfus, Chair	Member of the House of Representatives
Representative Amanda Collamore	Member of the House of Representatives
Dr. Todd Landry	One representative from the Department of Health and Human Services involved in the provision of services for children and families of children under 5 years of age
Lee Anne Larsen	One representative from the Department of Education involved in the provision of services for children and families of children under 5 years of age
Christine Frost-Bertinet	One representative of the public school system
Melissa Harding	One parent of a child who is under 5 years of age who has used state services for their children
Joe Whitmore	One parent of a child who is under 5 years of age who has used state services for their children
Chrissie Davis	One representative of family child care services
Sue Powers	One representative of a Head Start program
Jordyn Rossignol	One representative of center-based child care services
Carla Kelly	One representative of public preschool teachers
Heather Manchester	One member with expertise in school funding
Erin Frazier	One representative from the Child Development Services System

APPENDIX C

Four-Year-Old and Pre-K Funding Breakdown

Four Year Old and PreKindergarten Funding

2023-24 Funding Year **Preliminary Data as of 5/16/2023** *Includes estimated counts*

Essential Programs & Services Allocation

	4 year old & PreK count		Estimate Counts
Title 20-A, §15674 (3)	6,572.0	10/1/2022	466.0

* In Maine, Pre-kindergarten includes 4-year-olds public preschool and 5-year-old public pre-kindergarten.

Basic Allocation -- Essential Programs & Services Funding for 4 year old and PreK students

Basic Count Allocation*

Allocation for 4 year olds and PreK students - ED 279 Section 2B.1	$50,632,590	Combined State & Local Allocations
Title 20-A, §15683	55%	times State share percentage
	$27,867,454	Estimated State Share of "Allocation"
	$22,765,136	Estimated Local Share of "Allocation"

Weighted Allocation -- Essential Programs & Services Funding for 4 year old and PreK students

Weighted Count Disadvantaged Allocation*

Allocation for 4 year olds and PreK students - ED 279 Section 2C.1	$3,186,922	Combined State & Local Allocations
Title 20-A, §15675 (2)	55%	times State share percentage
	$1,754,036	Estimated State Share of "Allocation"
	$1,432,886	Estimated Local Share of "Allocation"

Weighted Count English Learners Allocation*

Allocation for 4 year olds and PreK students - ED 279 Section 2C.4	$843,451	Combined State & Local Allocations
Title 20-A, §15675 (3)	55%	times State share percentage
	$464,223	Estimated State Share of "Allocation"
	$379,227	Estimated Local Share of "Allocation"

**** Caution these are funding allocations and do NOT represent actual expenditures. There is no requirement that these funds be expended on 4 year old or PreKindergarten students -- local units determine how these funds will be expended through there local budget process.***

Targeted Funds Allocation for 4 year old and PreK students

Targeted Funds Student Assessment Allocation**

Allocation for 4 year old and PreK students- ED 279 Section 2D.1	$354,888	Combined State & Local Allocations
Title 20-A, §15681 (1.C)	55%	times State share percentage
	$195,325	Estimated State Share of "Allocation"
	$159,563	Estimated Local Share of "Allocation"

Targeted Funds Technology Resources Allocation**

Allocation for 4 year old and PreK students- ED 279 Section 2D.4	$775,496	Combined State & Local Allocations
Title 20-A, §15681 (3)	55%	times State share percentage
	$426,822	Estimated State Share of "Allocation"
	$348,674	Estimated Local Share of "Allocation"

Targeted Funds 4 year old and PreK Pupils Allocation**

Allocation for 4 year old and PreK students- ED 279 Section 2D.7	$5,063,259	Combined State & Local Allocations
Title 20-A, §15675 (3)	55%	times State share percentage
	$2,786,745	Estimated State Share of "Allocation"
	$2,276,514	Estimated Local Share of "Allocation"

Targeted Funds 4 year old and PreK Disadvantaged Allocation**

Allocation for 4 year old and PreK students- ED 279 Section 2D.9	$1,062,307	Combined State & Local Allocations
Title 20-A, §15675 (2.B)	55%	times State share percentage
	$584,679	Estimated State Share of "Allocation"
	$477,629	Estimated Local Share of "Allocation"

***** Note: these are funding allocations and do NOT represent actual expenditures. School units are required to expend Kindergarten through Grade 2 funding on early childhood programs for students age 4 through 9 in accordance with Title 20-A MRSA Section 15675 (3).***

Total Allocation for 4 year old and PreK students

Total Allocation for 4 year old and PreK students	$61,918,913	Combined State & Local Allocations
	55.0%	times State share percentage
	$34,079,285	Estimated State Share of "Allocation"
	$27,839,628	Estimated Local Share of "Allocation"

Estimated State Share Calculation

State share percentage	Total	State	Preliminary ED 279 as of 5/05/2023
55%	$2,543,987,734	$1,400,174,513	*ED 279 - Section 5A Adjusted*

APPENDIX D

Samples of Memoranda of Understanding (MOU)
for Public Preschool Partnerships

Memorandum of Understanding

RSU1: Woolwich Central School, Dike Newell School, Phippsburg Elementary School
Community Partner: Bath YMCA

Bath YMCA and RSU1 recognize and value quality comprehensive early care and education services for young children. In the interest of ensuring that young children receive quality services that prepare them and their families for public school, the parties enter into this collaborative agreement known as **C.H.O.I.C.E.S.**, *Children Having Opportunities in Collaborative Early Settings.*

The **C.H.O.I.C.E.S** vision is: *To empower parents, as the true experts of their own child's and family's needs, through choices of community preschool programs that meet the RSU1 standards. These early collaborative partnerships will strengthen families, allow a seamless transition from preschool to kindergarten, and honor and embrace the whole child.*

The **C.H.O.I.C.E.S** mission is: *To provide all families with 4-year-old children living in the towns served by RSU1 access to quality, developmentally appropriate preschool programs.*

C.H.O.I.C.E.S. goals are:

- To provide developmentally appropriate learning experiences for all learners in the program that will develop, enhance and enrich their understanding of themselves and the world around them by integrating the Maine's Early Learning and Development Standards and the NAEYC Accreditation Criteria through the use of the Creative Curriculum or Tools of the Mind Curriculum.
- To facilitate positive transitions for both children and their families into the public school setting, and to minimize transitions for children and families between preschool, childcare, and special services.
- To recognize the importance of parents/guardians in their child's educational process and to enable them to participate as fully as possible through participation on the CHOICES Advisory Board, family conferences, and kindergarten transition activities.

This agreement is for the period of **September 1, 2022 through June 30, 2023** for the purpose of jointly providing early care and educational services. Direct services provided by partners will commence on **September 12, 2022 (with screening & appointments 9/6-9)** and continue on a five morning/week schedule for 35 weeks. This MOU will be reviewed and updated annually and is a working document that is subject to change when necessary. All parties will meet and be informed of any changes. Parties agree to abide by the terms and conditions set out in this MOU and the attached provisions, which are included.

JOINT RESPONSIBILITY AND GENERAL PROVISIONS (or as Partners we will…)

Woolwich Central School, Dike Newell School, Phippsburg Elementary School, Bath YMCA

1. All program activities will occur in inclusive settings. The program will focus on all areas of the child's development: social, emotional, language, cognitive, and physical.
2. Creative Curriculum or Tools of the Mind Curriculum will be the basis for the developmental program.
3. Assessments will be completed three times per year utilizing the Children's Progress Academic Assessment (CPAA).
4. Parent/teacher conferences will be offered at least two times per year.
5. Within 30 school days of enrollment, program partners will conduct developmental screenings and appropriate referrals to Child Development Services will be made.
6. Teaching staff will participate jointly in Early Childhood Team meetings.

7. Families will be encouraged to participate in Kindergarten transition activities.
8. Each site will enter student absences daily into the Infinite Campus system as required by RSU1.
9. Maintenance of records, access to records and storage of records will be supervised by the director at each site during the school year.
10. At the end of each school year, all **C.H.O.I.C.E.S.** records will be transferred to RSU1.
11. A representative from each community partnership will participate in monthly meetings of the Early Childhood Advisory Council.
12. Each site will utilize its own application packet once the student is enrolled in **C.H.O.I.C.E.S.**
13. Professional development opportunities will be promoted and shared among program partners.
14. Each community program will maintain Step 4 on the Quality Rating System and maintain Child Care Licensing in good standing.
15. Each **C.H.O.I.C.E.S.** program will employ teaching staff who hold a 081 Teaching Certificate and teaching assistants with an Educational Technician II qualification.
16. The ratio of qualified staff to children will be 1:8 with a maximum class size of 16.
17. Each community partner will provide representation at the annual **C.H.O.I.C.E.S.** Family Information Meeting.

RSU1

1. Provide a program coordinator to monitor each RSU1 student's progress, consult with the preschool provider, and maintain contact with other agencies to ensure integration of programming to meet individual student needs.
2. Maintain and store documentation related to student attendance, participation, developmental progress, as well as parent contact and other agency consultations.
3. Provide vision and hearing screenings of CHOICES students at all partner sites as well as school based sites.
4. Seek out students on an annual basis to be enrolled in **C.H.O.I.C.E.S.** with a public preschool enrollment form.
5. Advertise and conduct an annual Family Information meeting to assist families in selecting the **C.H.O.I.C.E.S.** site that best meets their family's needs.
6. Negotiate fiscal contracts annually with each community partner.

AUTHORIZED SIGNATURES **DATE**

Regional School Unit 1 _____ 08/22/22

Bath YMCA _____ 9/25/23

Regional School Unit 1
34 Wing Farm Parkway, Bath, ME 04530
Telephone: (207) 443-6601

CONTRACTUAL AGREEMENT

This agreement is made between Regional School Unit 1 hereinafter referred to as the Administrative Unit and Bath Area YMCA, hereinafter referred to as the Agency.

The Agency agrees to provide the following professional services as recommended by the C.H.O.I.C.E.S. Program: *Children Having Opportunities in Collaborative Early Settings* and maintain NAEYC certification.

These services will be provided at the following site: 303 Centre Street, Bath, Maine.

The frequency of services shall be 5 mornings per week, 35 weeks per year. The weeks shall follow the public school calendar and does not include vacation weeks. The provision of professional services will commence on **September 12, 2022**, and will continue through **June 9, 2023**. Services will end if the CHOICES Program terminates a student upon a 2-week notice. The agency will be responsible for recording daily student attendance in the Regional School Unit 1 Infinite Campus database.

In consideration of the aforementioned services provided, the Administrative Unit agrees to pay the Agency in accordance with the following schedule:

The **unit cost** contracted is $ 150.00 per week for up to 16 students. If parents are interested in additional services provided by the agency, parents will be responsible for additional costs.

The Agency shall utilize wherever possible third party payment for the services provided.

The Agency will forward monthly statements to the Administrative Unit. Under no circumstances may parents be charged for the costs of services performed under this contract. Charges shall be based upon the actual enrollment per student. Payment by the Administrative Unit will only be made upon the receipt of the statements.

The Agency agrees to abide by the applicable State and Federal Laws and Regulations, including the protection of information regarding all students served under the terms of this agreement.

The Agency agrees to comply with all applicable State and Federal licensing, certification and/or accrediting standards established by the Maine Department of Educational and Cultural Services and/or other local, state or federal agencies or departments.

The Agency agrees to notify the Administrative Unit of any change in the site certification as required for the above professional services.

The Agency agrees to hold the Administrative Unit harmless for claims made by third parties arising out of any act or failure to act on the part of the Agency, including, but not limited to, claims based on theories or tort or contract liability or any other theory of legal liability.

This agreement covers all students approved by the Administrative Unit for these services.

The Agency shall maintain all books, documents, payrolls, papers, accounting records, and other evidence pertaining to costs incurred under this agreement. The Agency shall make such materials available at their office at all reasonable times during the period of this agreement and for three (3) years from the date of the expiration of this agreement for inspection by the Administrative Unit, the Maine Department of Education Cultural Services, or any authorized representative of the State of Maine, and copies thereof shall be furnished, upon request.

This document contains the entire agreement of both parties, and neither party shall be bound by any statement or representation not contained herein or attached hereto.

This agreement may be canceled by either party upon 30 days written notice.

IN WITNESS WHEREOF, the Administrative Unit and Agency, by their representatives duly authorized, have executed this agreement in duplicate.

BY: _____	BY: _____
Authorized Signature	Authorized Signature
Dr. Patrick M. Manuel, Superintendent	Rob Gray, CEO
Type Name and Title	Type Name and Title
Regional School Unit 1	Bath Area Family YMCA
Administrative Unit	Administrative Unit
34 Wing Farm Parkway, Bath, ME 04530	303 Centre St., Bath, ME 04530
Address	Address
443-6601	443-4112
Phone Number	Phone Number
08/22/22	9/28/23
Date	Date

MOU Between RSU 14 and A Child's World

Purpose: To improve availability and the quality of early childhood education for district area children and their families.

This collaborative agreement represents a partnership between RSU 14 and A Child's World, who recognize and value a community approach to comprehensive early care and education services for young children.

We agree that this collaboration will enhance our ability to recognize the value of our individual expertise, and more importantly, our combined value when we can work productively, combining our thinking, talents and financial resources toward the common goal of creating quality early childhood programming.

To support early learning for four year-old children, their families, and our community, A Child's World will offer publicly-funded Pre-K for 11 children, 6.75 hours per day (M-T-TR-F), 3.5 hours on Wednesdays, 5 days per week, during the 2023/2024 school year, from August 31, 2023 to June 7, 2024 based on the RSU 14 school calendar. The program will serve children who are four years old (before October 15, 2023).

This MOU will be reviewed and updated annually and is a working document that is subject to change when necessary. All parties will meet and be part of making decisions around any changes. Parties agree to abide by the terms and conditions set out in the MOU.

Shared goals:

- To provide developmentally appropriate, inclusive learning experiences for all learners in the program that will develop, enhance and enrich their understanding of themselves and the world around them.
- To facilitate positive transitions for both children and their families from early care and education into elementary school, and to minimize transitions for children and families between special services, child care, and elementary school.
- To recognize the importance of parents/guardians in their child's development and educational process and to improve our school, program, classroom, and community engagement with families.

Joint Responsibility and General Provisions:

1. All program activities will occur in an inclusive setting.

2. The programming, routines, and learning environment will focus on all areas of the child's development: social-emotional, early language and literacy, physical development and health, math, science, social studies, art, and music. Programs and classrooms will integrate and align the Maine Early Learning Guidelines within their curriculums.

3. A Child's World leadership and RSU 14 leadership will coordinate joint staff meetings, professional learning, and planning as deemed appropriate and beneficial.

4. A Child's World will enroll up to 11 4-year-olds for the 2023-2024 Pre-K class. If a space becomes available at any point during the school year then the child care program will notify the district so that the next family on the RSU 14 Lottery Waitlist can be offered the space.

5. The ratio of staff to children will be 1:8 with a maximum preschool class size of 16.

6. Within 30 school days of enrollment Pre-K staff will conduct developmental screening using the DIAL-IV and when appropriate referrals to Child Development Services will be made with parental input. Pre-0K staff will use their knowledge of separating differences from disability.

7. Assessment will be completed 2-3 times per year. Results will be shared amongst collaborative partners.

8. Documentation related to student attendance, participation, developmental progress, as well as parent contact and other agency consultation will be shared between RSU 14 and A Child's World.

9. Parent/teacher conferences will be offered 2 times per year.

10. A Child's World and RSU 14 will plan Pre-K and K transition activities and families will be encouraged to participate.

11. A Child's World will maintain child care licensing, be enrolled in Maine's child care Quality Improvement Rating System, meet Chapter 124 requirements, and will have teachers as staff enrolled in Maine's career lattice registry.

12. If the program is not at a QRIS Step 3 or 4 (Star 4 or 5), and does not yet have 029 or 081 certified teachers, the program and district leadership will develop a financially supported quality improvement plan.

This agreement covers all students approved by the Administrative Unit for these services. The parties shall maintain all books, documents, payrolls, papers, accounting records, and other evidence pertaining to costs incurred under this agreement. The parties shall make such materials available at their office at all reasonable times during the period of this agreement and for three (3) years from the date of the expiration of this agreement for inspection by RSU 14, the Maine Department of Education Cultural Services, or any authorized representative of the State of Maine, and copies thereof shall be furnished, upon request.

The Parties agree to comply with all applicable State and Federal licensing, certification, rules, and standards established by the Maine Department of Education, Maine Department of Health and Human Services and/or other local state and federal agencies and departments.

In addition the parties agree to abide by all applicable State and Federal laws and regulations, including the protection of information regarding students served under the terms of this collaborative agreement.

Expenses covered by this agreement:

Based on the number of students, A Child's World will receive $8,641.00 per student (not to exceed 11 students), which is based on the district's per pupil funding formula.

A Child's World will forward monthly invoices to the RSU 14. Under no circumstances may parents be charged for the costs of services performed under this contract. Payment by RSU 14 will only be made upon the receipt of the statements.

This document contains the entire agreement of both parties, and neither party shall be bound by any statement or representation not contained herein or attached hereto.

This agreement may be canceled by either party upon 30 days written notice. IN WITNESS WHEREOF, RSU 14 and A Child's World, by their representatives duly authorized, have executed this agreement.

Signatures:

_____	_____
A Child's World (Director/Owner)	Date
_____	_____
A Child's World (Director/Owner)	Date
_____	_____
RSU 14 Superintendent of Schools	Date

APPENDIX E

Colorado Proposition EE

Proposition EE
Taxes on Nicotine Products

Question:

SHALL STATE TAXES BE INCREASED BY $294,000,000 ANNUALLY BY IMPOSING A TAX ON NICOTINE LIQUIDS USED IN E-CIGARETTES AND OTHER VAPING PRODUCTS THAT IS EQUAL TO THE TOTAL STATE TAX ON TOBACCO PRODUCTS WHEN FULLY PHASED IN, INCREMENTALLY INCREASING THE TOBACCO PRODUCTS TAX BY UP TO 22% OF THE MANUFACTURER'S LIST PRICE, INCREMENTALLY INCREASING THE CIGARETTE TAX BY UP TO 9 CENTS PER CIGARETTE, EXPANDING THE EXISTING CIGARETTE AND TOBACCO TAXES TO APPLY TO SALES TO CONSUMERS FROM OUTSIDE OF THE STATE, ESTABLISHING A MINIMUM TAX FOR MOIST SNUFF TOBACCO PRODUCTS, CREATING AN INVENTORY TAX THAT APPLIES FOR FUTURE CIGARETTE TAX INCREASES, AND INITIALLY USING THE TAX REVENUE PRIMARILY FOR PUBLIC SCHOOL FUNDING TO HELP OFFSET REVENUE THAT HAS BEEN LOST AS A RESULT OF THE ECONOMIC IMPACTS RELATED TO COVID-19 AND THEN FOR PROGRAMS THAT REDUCE THE USE OF TOBACCO AND NICOTINE PRODUCTS, ENHANCE THE VOLUNTARY COLORADO PRESCHOOL PROGRAM AND MAKE IT WIDELY AVAILABLE FOR FREE, AND MAINTAIN THE FUNDING FOR PROGRAMS THAT CURRENTLY RECEIVE REVENUE FROM TOBACCO TAXES, WITH THE STATE KEEPING AND SPENDING ALL OF THE NEW TAX REVENUE AS A VOTER-APPROVED REVENUE CHANGE?

APPENDIX F

Maine DOE Rule Chapter 124, Basic Approval Standards for Public Preschool Programs

05-071 DEPARTMENT OF EDUCATION

Chapter 124: BASIC APPROVAL STANDARDS: PUBLIC PRESCHOOL PROGRAMS

SUMMARY: This rule establishes school approval standards governing the school administrative units which are implementing public preschool programs and adopts procedures for ascertaining compliance with all applicable legal requirements, as authorized by Title 20-A, *Maine Revised Statutes*, Chapters 203 and 206. By July 1, 2017, all preschool programs must comply with the program standards contained in this rule. Any new public preschool programs implemented for the 2015-2016 school year must be approved prior to opening.

Section 1. GENERAL OBJECTIVES

1.01 This rule establishes the substantive school approval standards pertaining to school administrative units which operate a public preschool program. Its intent is to provide a framework for planning and growth with local flexibility as influenced by local conditions. This rule establishes procedures for comprehensive reviews of school administrative units which operate a public preschool program by which the Commissioner will determine compliance with applicable standards and methods of enforcement for ensuring compliance.

1.02 School administrative units may operate a public preschool program or provide for children to participate in such programs in accordance with 20-A §4271 and shall meet all school approval requirements of Title 20-A, *Maine Revised Statutes* (20-A MRSA), other statutes, and rules applicable to the operation of public preschool programs, and the requirements of this rule.

Section 2. DEFINITIONS

2.01 **Administrator**: “Administrator” means any person certified by the Commissioner as an administrator and employed by a school administrative unit in an administrative capacity.

2.02 **Assessment**: “Assessment” means an educational instrument or activity designed to gather information on a child’s knowledge and skill to make instructional decisions.

2.03 **Commissioner**: "Commissioner" means the Commissioner of the Maine Department of Education or a designee.

2.04 **Curriculum**: “Curriculum” means the school administrative unit’s written document that includes the learning expectations for all children for all domains of development as indicated in the Early Learning and Development Standards. The curriculum shall reflect continuous, sequential and specific instruction aligned with the ELDS.

2.05 **Department**: "Department" means the Maine Department of Education.

2.07 **Early Learning and Development Standards (ELDS)**: “Early Learning and Development Standards” means what should children know and be able to do at kindergarten entry.

2.08 **Elementary school**: "Elementary school" means that portion of a school that provides instruction in any combination of grades pre-kindergarten through grade 8.

2.09 **Essential Programs and Services**: “Essential Programs and Services” means those programs and services, as defined by the State Board of Education or adopted by the Legislature, that a school administrative unit offers for each student to have the opportunity to meet the content standards of the system of Early Learning and Development Standards/Learning Results.

2.10 **Instructional day**: "Instructional day" means a school day during which both students and teachers are present, either in a school or in another setting.

2.11 **Instructional time**: "Instructional time" means that portion of a school day devoted to the teaching-learning process, but not including extra-curricular activities, or recess. Time spent on organized field trips related to school studies may be considered instructional time, but the instructional time counted for extended field trips shall not exceed a normal school day for each day of the field trip.

2.12 **Kindergarten**: "Kindergarten" means a one or two-year instructional program aligned with the system of Learning Results, immediately prior to grade one.

2.13 **Parent**: “Parent” means the parent or legal guardian of a student.

2.14 **Provisional Approval**: "Provisional Approval" means an approval for a specified period of time during which a school administrative unit must take corrective action to the public preschool program to comply with this rule.

2.15 **Public Preschool Program**: “Public Preschool Program” means a program offered by a public school that provides instruction of children who are four years of age by October 15th.

2.16 **School**: "School" means an individual attendance center within a school administrative unit including any combination of grades pre-kindergarten through 12. In this rule, an educational program located in or operated by a juvenile correctional facility, an educational program located in the unorganized territories and operated by the Department of Education, the Maine School of Science and Mathematics, and the Maine Educational Center for the Deaf and Hard of Hearing shall be considered schools.

2.17 **School administrative unit**: "School administrative unit" means the state-approved unit of school administration and includes a municipal school unit, school administrative district, community school district, regional school unit or any other municipal or quasi-municipal corporation responsible for operating or constructing public schools, except that it does not include a career and technical education region. Beginning July 1, 2009, “school administrative unit” means the state-approved unit of school administration and includes only the following:

A. A municipal school unit;

B. A regional school unit formed pursuant to chapter 103-A;

C. An alternative organizational structure as approved by the commissioner and approved by the voters;

D. A school administrative district that does not provide public education for the entire span of kindergarten to grade 12 that has not reorganized as a regional school unit pursuant to chapter 103-A;

E. A community school district that has not reorganized as a regional school unit pursuant to chapter 103-A;

F. A municipal or quasi-municipal district responsible for operating public schools that has not reorganized as a regional school unit pursuant to chapter 103-A;

G. A municipal school unit, school administrative district, community school district, regional school unit or any other quasi-municipal district responsible for operating public schools that forms a part of an alternative organizational structure approved by the commissioner; and

H. A public charter school authorized under chapter 112 by an entity other than a local school board.

2.18 **School calendar**: "School calendar" means the schedule of school days adopted in advance of the school year by the school board.

2.19 **School day**: "School day" means a day in which school is in operation as an instructional day and/or a teacher in-service day.

2.20 **School personnel**: “School personnel” means individuals employed by a school administrative unit or under contract with the unit to provide services to the children enrolled in the schools of the unit.

2.21 **School year**: “School year" means the total number of school days in a year as established by the school administrative unit.

2.22 **Screening**. “Screening: means utilizing a standard or norm-referenced screening tool designed and validated to identify a child’s level of performance overall in developmental areas (i.e., cognition, fine motor, gross motor, communication, self-help/adaptive, and gross motor skills). The screening is a brief check (10-15 minutes) of the child’s development and is not diagnostic or confirming in content.

2.23 **Student records**: "Student records” means those records that are directly related to a student and are maintained by a school or a party acting for the school.

2.24 **Teacher**: "Teacher" means any person who is regularly employed for the instruction of students in a school and who is certified by the Commissioner for this position.

2.25 **Teacher in-service day**: "Teacher in-service day" means a school day during which a majority of teachers and professional staff report for work, but students are not present for instruction. These days may include days devoted to in-service educational programs, administrative meetings, parent-teacher conferences, record-keeping duties, curriculum preparation, and other similar activities related to the operation of school programs, and may take place in a school in the school administrative unit.

Section 3. CLASS SIZE

3.01 Maximum class size: 16 children

Section 4. CURRICULUM AND COMPREHENSIVE ASSESSMENT SYSTEM

4.01 Each school administrative unit shall have an evidence-based written curriculum aligned with the Early Learning and Development Standards. The school administrative unit shall inform parents and students of the curriculum, instructional expectations, and assessment system.

4.02 Public preschool programs must demonstrate curriculum practice that aligns with the Maine Early Learning and Development Standards and is appropriate for the age and developmental level of the students. Teachers must organize space and select materials in all content and developmental areas to stimulate exploration, experimentation, discovery and conceptual learning.

A. A variety of activity areas are offered every session including, but not limited to: block building, dramatic play, writing, art, music, science, math, literacy, sand/water play, manipulatives, gross motor activities and mealtime routines , which allows teachers to eat with children.

B. Equipment, materials and furnishings are available and are accessible to all children, including children with disabilities.

C. A daily schedule is posted that includes:

(1) Opportunities for individual, small group and whole group activities. The amount of time spent in large group, teacher-directed activity is limited to short periods of time – 10-20 minutes depending on the time of the year.

(2) Opportunities for physical movement, fresh air and access to drinking water are provided to the children.

(3) Opportunity for rest in a full-day program (more than 5 hours) is provided for the children. Cots or mats are provided for each child.

(4) The schedule and program activities minimize the transitions that children make from one classroom space to another, including school “specials” especially during the first half of the school year. Most special

supports or therapies are provided in-class to minimize transitions for children with disabilities.

(5) Program development and services to any and all English learners are overseen by an English as a Second Language-endorsed teacher.

4.03 **Screening and Assessment**

A. **Screening**

(1) All children must be screened using a valid and reliable research-based tool within the first 30 days of the school year (or prior to school entry) which includes: early language and literacy/numeracy/cognitive; gross and fine motor; personal/social; social/emotional development- to identify those who may be in need of additional assessment or to determine eligibility for special education services unless the child has an existing Individualized Education Program-IEP). All children must receive a hearing, vision, and health screening upon entry to the public preschool program. The health screening must include information pertaining to oral health and lead poisoning awareness. If hearing, vision, and health screening has been done in the public preschool, the screenings do not have to be redone in kindergarten, unless there is a concern.

(2) Each preschool program shall develop a written Child Find referral policy consistent with the State of Maine Unified Special Education Rules 05-071 Chapter 101 Section IV. 2(D)(E).

(3) Administration of a home language survey is undertaken to identify possible English learners.

B. **Assessment**

Programs provide periodic and ongoing research based assessment of children's learning and development that:

(1) Documents each child's interests, needs and progress to help plan instruction, relying mostly on demonstrated performance of authentic activities.

(2) Includes: children's work samples, observations, anecdotal notes, checklists and inventories, parent conference notes, photographs, video, health screening reports and referral records for support services.

(3) Communicates with families regularly to ensure connection between home and school, including providing interpreters and translators, as needed.

(4) Aligns with the Early Learning and Development Standards and are used to inform curriculum and instruction.

(5) Is informed by family culture, experiences, children's abilities and disabilities, and home language.

(6) Is used in settings familiar to the children.

(7) Informs activities to support planning for individual children.

4.04 **Child Development Reporting**

Parents shall have the opportunity to meet individually with their child's teacher about their child's development at least twice during each school year using the research based assessment (providing interpreters and translators as needed).

Section 5. INSTRUCTIONAL TIME

5.01 **School Year**

A school administrative unit shall make provision for the maintenance of all its schools for at least 180 school days. At least 175 school days shall be used for instruction. In meeting the requirement of a 180-day school year, no more than 5 days may be used for in-service education for teachers, administrative meetings, parent-teacher conferences, records' days and similar activities.

5.02 **Public Preschool Instructional Time**

Instructional time for public preschool program shall be a minimum of 10 hours per week for 35 weeks and shall not include rest time. Public preschool programs shall schedule within the 175 school days that the school administrative unit has designated as instructional time, but does not have to use all days, allowing flexibility as to numbers of days per week.

Extended public preschool program Day: A school administrative unit is encouraged to schedule public preschool for more than 10 hours per week to improve child outcomes and to reduce the risk of later school failure.

Section 6. SCHOOL ADMINISTRATIVE UNIT ORGANIZATION AND SCHOOL SIZE

6.01 **Personnel Ratios**

A. Classroom student-teacher ratios

(1) Maximum adult to child ratio is 1 adult to 8 children

(2) Ratios include, at a minimum, one teacher holding appropriate teacher certification from the Maine Department of Education (as per current statute) and a support staff with a minimum of an Educational Technician Authorization II from the Maine DOE. These ratios are

maintained during both indoor and outdoor activities and during mealtimes.

Section 7. QUALITY OF EDUCATION PERSONNEL

7.01 Specific Requirements

A. **Teacher degree requirement**: Teachers must hold (as per current statue) the required Maine DOE Early Childhood 081 (B-5) endorsement.

B. **Assistant teacher requirements**: An assistant teacher must hold (as per current statute), at a minimum, an Educational Technician II Authorization from the Maine DOE who obtains a Level 4 status on the Maine Roads to Quality Registry within 3 years.

C. All preschool staff must join the Maine Roads to Quality Registry.

Section 8. NUTRITION

8.01 General Requirements

The program shall serve well-balanced meals and/or snack that follow the U.S. Department of Agriculture guidelines in all programs.

8.02 Specific Requirements

A. The program shall serve at least one meal and/or snacks at regularly established times. Meals and snacks are not more than three hours apart.

B. Each child is given sufficient time at mealtimes and snacks to eat at a reasonable, leisurely rate.

C. Classroom ratios will be maintained during mealtimes.

D. Meals and or snacks are culturally responsive to participating families.

E. The meal and snack time offers opportunities for interactions between adults and children.

Section 9. SCHOOL FACILITIES

9.01 **Indoor**: Minimum requirement shall be 35 square feet per child. Areas not to be calculated as usable space include but are not limited to: hallways, lockers, cubbies, door swings, closets, supply cabinets, corridors, bathrooms, teacher spaces, food preparation areas and offices.

A. All classroom spaces must be accessible to all children, including children with disabilities.

B. There shall be a water source in the classroom for hand washing, and drinking water is readily available to children throughout the day.

C. The indoor environment shall be designed so staff can supervise children by sight and sound at all times. Supervision for short intervals by sound is permissible, as long as teachers check frequently on children who are out of sight (e.g., independent toileting).

D. Toilets, accessible for use by all participating children, must be within 40 feet of the indoor areas that children use. It is preferable to have them within the classroom.

E. Electrical outlets in public preschool classrooms shall be protected by safety caps, plugs or other means.

F. Natural light must be present in any classroom used for four-year-old program activities.

G. Easily accessible and individual space shall be made available for children's outside clothing and personal possessions.

9.02 **Outdoor**: The program must have access to an outdoor play area with at least 75 square feet of usable space per child and with equipment of a size suitable to the age and needs of four-year-old children as dictated by the National Safety Standards for playgrounds in public schools.

A. The outdoor play area must be protected by fences or natural barriers.

B. Surfaces used under climbers, swings and at the bottom of slides are energy-absorbing materials such as mulch, sand or bark. Concrete or asphalt shall not be used.

C. Outdoor play areas provide both shade and sun.

D. There are established protocols for emergencies.

E. The playground areas and equipment are accessible to all children.

F. Preschool classrooms schedule outdoor time by themselves, with other preschool classrooms, or with kindergarten children.

Section 10. FAMILY ENGAGEMENT

10.01 Programs identify how they will engage in a process of partnership-building with families to establish mutual trust and to identify child strengths, goals, and necessary services and supports.

10.02 Programs have written policies and procedures that demonstrate intentional practices designed to foster strong reciprocal relationships with families, including, but not limited to: application information, family orientation, parent conferences, parent education-specifically around literacy and numeracy, newsletters, PTA participation, home visits, family events, program evaluations, and these policies and procedures are to be translated in a language understandable to parents/guardians.

Section 11. COMMUNITY ENGAGEMENT

Programs establish relationships with community-based learning resources and agencies, such as libraries, arts education programs, and family literacy programs.

Section 12. COORDINATED PUBLIC PRESCHOOL PROGRAMS

12.01 Any school administrative unit that wishes to develop an early childhood program for children 4 years of age must submit a public preschool program implementation plan for children 4 years of age for submission to and approval by the department. Evaluation of the proposal must include consideration of at least the following factors:

A. Demonstrated coordination with other early childhood programs in the community to maximize resources;

B. Consideration of the extended child care needs of working parents; and

C. Provision of public notice regarding the proposal to the community being served, including the extent to which public notice has been disseminated broadly to other early childhood programs in the community. [20-A MRSA §4502(9)]

D. Demonstrated coordination with Child Development Services.

12.02 Schools offering a public preschool program in partnership with a community agency must submit a Memorandum of Understanding (MOU), signed by all involved parties, on a yearly basis. The elements of the MOU shall, at a minimum, include:

A. Roles and responsibilities of each of the partners;

B. A budget, including the amount of resources that each partner will provide for the implementation of the plan;

C. Describe the organizational capacity and the existing infrastructure of the SAU and the partners to deliver a high quality program;

D. The methods and processes for making different types of decisions (e.g., policy, operational);

E. How the partners will coordinate, but not supplant, the delivery of the public preschool program with existing services for preschool –aged children including,

if applicable, programs and services supported through Title I of ESEA, the *Head Start Act*, and Child Care Development Block Grant;

F. How the partners will coordinate with Child Development Services (under Part B, Section 619 of IDEA) regional site to ensure access for CDS for conducting its statutory obligations under IDEA and Maine law /regulations; and

G. A description of the responsibilities and process of sharing child records that meets Section 16 of this chapter.

12.03 Beginning with 2015-16 school year the Commissioner may provide start-up funding as set forth in 20-A MRSA §4271 to school administrative units to implement or expand public preschool programs for children 4 years of age as required by 20-A MRSA §4502(9).

Section 13 TRANSITION

13.01 Enrollment transition into the public preschool program. Public preschool programs will have a process for enrollment transition from home and or other early childhood programs. The process will involve parents/legal guardians, including parental consent for transition of the pertinent educational records.

13.02 Public preschool to kindergarten transition. Public preschool program will have a process to provide transition between four-year-old programs and the kindergarten program. This includes links, by the elementary school, with other area Head Start and early childhood programs serving young children who will be entering kindergarten. The process will involve parents/legal guardians, including parental consent for transition of pertinent educational records.

Section 14 TRANSPORTATION

14.01 If a school transports public preschool children, it is recommended that the standard of care offered to public preschool students meet the standard of care as defined by "Guideline for the Safe Transportation of Preschool Age Children in School Buses," which is provided by the National Highway Transportation Safety Agency, as follows:

A. Children should be in a child safety restraint system appropriate for the age, weight and height of the student.

B. There should be at least one aide on board the bus to assist with loading, unloading, correct securement and behavior/emotional support.

C. There will be training, communication and operational policy items for drivers, aides, parents, students and routes.

NOTE 1: Head Start children must be in a child safety restraint system and have an aide to assist. This is a federal requirement.

NOTE 2: Pursuant to 20-A MRSA §5401(3-A) school administrative units are not required to provide transportation for public preschool children.

Section 15. RECORDS AND REPORTS

If the public preschool program operates within the school administrative unit (SAU), the SAU addresses these provisions within the basic school approval.

If the public preschool program operates in an external facility and/or under a contract with the SAU, the contract between the SAU and the contractor must address the provisions of this section.

15.01 Student Records

Each school board shall adopt a policy in accordance with the *Family Education Rights and Privacy Act* (FERPA) that establishes the procedure for changing a student record by adding or removing items, and for controlling access to records.

A. Each school administrative unit shall maintain accurate and up-to-date education records on each enrolled student. Education records shall be defined as in FERPA and shall include academic records, disciplinary records, and other information including directory information.

(1) Academic records include information relating to the student's educational performance including student performance on the local assessment system and on other assessments as may be required for an individual student.

(2) Disciplinary records include, but are not limited to, a record of suspensions and expulsions, and other violations of the Student Code of Conduct adopted by the school board.

B. Records shall be entrusted to designated personnel who shall be knowledgeable about the confidentiality provisions applicable to the records. All records shall be safeguarded from unauthorized access. Either student records will be kept in fireproof storage at the school or a duplicate set will be kept off site.

C. Upon request of the parent or school officials, a student's education records, including special education records, shall be forwarded to any school in which the student is enrolled or is intending to enroll. The school administrative unit shall notify parents that all records, including disciplinary records, must be sent to a school administrative unit to which a student applies for transfer.

D. **Parental Access Rights: Confidentiality**

Each school administrative unit shall adopt a policy describing the access rights of parents, students, and educational personnel to student records and the applicable confidentiality rights of parents and students. Student records shall

be made available to the parents, or to the student of majority age, for inspection and copying.

A copy of the policy shall be posted in each school and parents shall be notified annually of the policy. The school administrative unit shall maintain records in accordance with the *Family Education Rights and Privacy Act* (FERPA).

Section 16. PUBLIC PRESCHOOL APPROVAL

16.01 Approval Procedures

A. A school administrative unit shall obtain approval from the Commissioner prior to opening a new public preschool program. All new public preschool programs implemented in the 2015-16 school year must be approved prior to opening. By July 1, 2017 all public preschool programs implemented before 2015-16 must comply with programs standards contained in this rule. The Department will review and approve on a case by case basis implementation strategies that document how and by when a school administrative unit will come into compliance with a specific program standard after the July 1, 2017 date.

B. A school administrative unit seeking approval status for any public preschool program shall make this intention known to the Commissioner in writing at least nine months prior to the school year. School units that have received school construction approval from the State Board of Education shall be deemed to have met this notice requirement.

C. An Implementation Plan for initial approval status shall be made on forms provided by the Commissioner and available on the Maine Department of Education Public Preschool website. The superintendent of the school administrative unit is responsible for supplying all information necessary for a determination that the school is entitled to approval. The implementation plan application form must be signed by the superintendent of the school administrative unit in which the school is located, certifying that the form contains information that is accurate at the time of reporting. Prior to receiving approval from the Commissioner, the facility shall be approved for safety by the State Fire Marshal or local municipal fire department official, and certified as sanitary by the Department of Health and Human Services (DHHS).

D. Two months prior to the initial opening the applicant school must arrange for an on-site inspection by a representative of the Commissioner.

E. Approval status shall be awarded when the Commissioner determines that the school is likely to comply with all approval standards.

F. Upon obtaining approval by the Commissioner, the school administrative unit shall be entitled to operate the public preschool program and to receive state subsidy aid to which it is otherwise entitled.

G. Six weeks after student occupancy, representatives of the Commissioner shall visit the public preschool program while it is in session to determine if all applicable school approval standards are being met. If school approval standards are not being met, approval status shall continue until compliance is demonstrated or until the end of the school year, whichever is the earlier date.

16.02 **Provisional Approval**

A. Any public preschool program that is determined by the Commissioner not to comply with applicable school approval standards shall be placed on provisional approval. Failure to submit School Approval Reports, other than financial reports, in a timely manner, in accordance with Section 15.05 of this rule, shall result in provisional approval status. Failure to submit financial reports in a timely manner shall result in a withholding of state subsidy in accordance with Section 16.03.B.

B. When placing a school on provisional approval status the Commissioner shall take the following action:

(1) The Commissioner shall notify, in writing, the superintendent responsible for any public preschool programs placed on provisional approval status and shall include a statement of the reasons for provisional approval status.

(2) Representatives of the Commissioner shall meet with the superintendent and shall determine a reasonable deadline for achieving compliance with school approval standards.

(3) A school or school administrative unit on provisional approval status shall be required to file with the Commissioner an acceptable written plan of corrective action.

(4) Failure to file a required plan of corrective action shall result in enforcement action by the Commissioner, pursuant to Section 16.03 of this rule.

C. The Commissioner shall restore full approval status upon the Commissioner's determination of compliance with school approval standards.

16.03 **Enforcement Measures**

A. **Notice of Failure to Comply**

The Commissioner shall give written notice of pending enforcement action to the superintendent of any school or school administrative unit that fails to comply with school approval standards by the established deadlines in statute or in the plan of corrective action established in Section 16.02.B.(3). Such notice shall include a statement of the laws and regulations with which the school or school administrative unit fails to comply. School administrative units failing to comply with school approval standards shall be given notice and the opportunity for a hearing.

B. **Penalties**

The Commissioner may impose the following penalties on school administrative units until compliance is achieved:

(1) Withhold state subsidy and other state funds from school administrative unit;

(2) Refer the matter to the Attorney General, who may seek injunctive relief to enjoin activities not in compliance with the governing statute or seek any other remedy authorized by law; or

(3) Employ other penalties authorized in statute or authorized or required by federal law.

Section 17. PRESCHOOL PROGRAM MONITORING

17.01 Public preschool programs, including partnerships, will complete the electronic Public Preschool Program Annual Report online and submit to the Maine Department of Education no later than 30 days after the end of the school year.

17.02 Each public preschool program, including partnerships, will receive a site visit by the Department no less than once every three years.

17.03 The review will utilize observational instruments, implemented by qualified individuals with demonstrated reliability, that assess:

A. Compliance with the program standards,

B. Classroom quality, and

C. Multiple dimensions of teacher-child interactions that are linked to positive child development and later achievement.

17.04 The results of this classroom evaluation will be shared with the teacher and principal and a plan for training and technical assistance will be developed.

STATUTORY AUTHORITY: 20-A MRSA §4271(4)

EFFECTIVE DATE:
December 28, 2014 – filing 2014-293

APPENDIX G

Maine DHHS Rule Chapter 32, Section 7 – Staff
Child Ratios for Childcare Facilities

SECTION 7. STAFF-CHILD RATIOS, SUPERVISION, AND QUALIFICATIONS

A. Children under six weeks of age. No Child under six weeks of age, as verified by a birth certificate or immunization record may be cared for in a Child Care Facility.

B. Limitations on capacity.

1. Children of Child Care Staff Members must be counted in the appropriate age groups and in determining staff-child ratios and capacity when in care at the Child Care Facility.

2. The number of Children allowed may be restricted by the Department when any of the following circumstances are present:

a. Space is limited or unusually configured;

b. A Child Care Staff Member has physical limitations that would impact the Child Care Staff Member's ability to safely care for, supervise or respond to the needs of Children in care.

C. Staff-Child ratios.

1. The number of Children present must not exceed licensed capacity.

2. The maximum number of Children to be assigned per adult, excluding Staff Members with primary responsibility for clerical, cooking, and maintenance functions must be as follows:

a. Ratio requirements for Small Facilities serving 3-12 Children:

CHILD AGES	CHILD CARE STAFF MEMBER-CHILD RATIO		
6 weeks - 2 years	1:4	2:8	3:12
2 years – 5 years	1:8	2:12	Not applicable
Over 5 years	1:12	Not applicable	Not applicable
Mixed ages	1 Staff: 3 Children under 2 years + 3 Children 2 - 5 years + 2 Children over 5 years, **or** 8 Children 2 - 5 years + 2 Children over 5 years.	2 Staff: 6 Children under 2 years + 6 Children over 2 years.	3 Staff: 12 Children (No more than 9 Children may be under 2 years).

b. Ratio requirements for Facilities serving 13 or more Children:

AGE	CHILD CARE STAFF MEMBER-CHILD RATIO	MAXIMUM GROUP SIZE
6 weeks - 1 year	1:4	8
1 year - 2 ½ years	1:4 1:5	12 10
2 ½ years - 3 ½ years	1:7	21
3 years - Under 5 years	1:8 1:10	24 20
5 years (School age) - 12 years	1:13	n/a

c. Ratio requirements for Nursery School programs.

MAXIMUM GROUP SIZE	CHILD CARE STAFF MEMBER-CHILD RATIO
30	1:12

3. In Child care programs serving 13 or more Children:

a. A single Child Care Staff Member may provide care in one classroom within the building for six or fewer Children, regardless of age, for a period of time not to exceed one hour at the beginning and end of the posted hours of operation.

b. At least two Child Care Staff Members must be present in the Child Care Facility whenever seven or more Children, regardless of age, are present.

c. The group size and the number of required Child Care Staff Members must be determined based on the age of the youngest Child, when there is a combination of ages within a group.

d. Older Children may fill younger Children's spaces, but younger Children may not fill older Children's spaces.

e. Special events occurring at the Facility location must provide supervision in accordance with this rule. A Child attending a special event in the care of a parent or legal guardian will not be included in staff-Child ratios. Special events occurring outside of typical hours and days of operation are not subject to this rule.

D. Supervision.

1. Children must be supervised at all times.

a. In Child Care Facilities serving 3-12 Children, Child Care Staff Members must have knowledge of the activity and whereabouts of each Child in care.

i. Child Care Staff Members must be able to see or hear all Children at all times and be able to provide prompt intervention when needed.

ii. Child Care Staff Members must be physically present outside when Children under the age of eight outdoors.

iii. If Children over the age of eight are outdoors and a Child Care Staff Member is not physically present, the play area must be enclosed by fencing and the facility must remain in compliance with Section 7(D)(1)(a)(i) of this rule.

b. In Child Care Facilities serving 13 or more Children, a Child Care Staff Member must be able to see and hear all Children, be responsible for the ongoing activity of the Children, and be able to provide prompt intervention when needed.

2. When Children are grouped by age in programs serving 13 or more Children, groupings of Children must be within an individual room, or a specific area within a large room, separated by a partition which visually and physically separates groups of Children. The area must be defined by a visible barrier, partition or other room divider having a height above the eye level of the Children who will use that area.

3. The Child Care Facility must provide direct supervision, by awake Child Care Staff Members, to Children while maintaining staff-Child ratios during napping and/or sleeping.

a. One Child Care Staff Member may leave the group setting for periods of no longer than five minutes to attend to personal or programmatic needs, as long as that Child Care Staff Member continues to be available in an emergency.

b. Dimmed, but adequate, lighting to allow visual supervision of all Children must be maintained at all times.

c. Monitors providing both video and audio may be considered as an acceptable form of supervision in an adjacent nap space. Sleeping Children must be checked in person at a minimum every 30 minutes.

4. Child Care Staff Members must attend to a Child crying or crying out.

E. Crisis plan. The Facility must develop and follow a written plan for obtaining help in an emergency when only one Child Care Staff Member is present.

F. Personnel Qualifications.

1. All Child Care Staff Members working without supervision must be at least 18 years old. 16 and 17-year-old Child Care Staff Members must be directly supervised by another staff person over the age of 18.

a. All Child Care Staff Members must have a high school diploma or equivalent, be attending high school, or be enrolled in a General Educational Development (GED) preparation program or the High School Equivalency Test (HiSET) preparation program.

b. All Child Care Staff Members must demonstrate the following:

i. The ability and willingness to comply with all applicable laws and rules;

ii. The ability to provide safe and compassionate services;

iii. A history of honest and lawful conduct; and

iv. Child Care Staff Members working alone may not have physical limitations that would impact the Child Care Staff Member's ability to safely care for, supervise or respond to the needs of Children in care.

c. All Child Care Staff Members responsible for, or assisting with, the care of Children must exercise good judgment in the handling of Children, demonstrate consistent compliance with this rule and all relevant laws, and must not engage in any action or practice detrimental to the welfare of the Children.

2. All Child Care Staff Members must be able to perform their assigned tasks and meet all requirements in this rule. No alcohol, tobacco, recreational marijuana, or illegal drugs may be consumed while on duty. Prescribed drugs or certified Medications that do not impair the ability of the Child Care Staff Member to care for Children are allowed.

3. Facilities licensed for 3 – 12 Children must employ a primary caregiver, Director and/or lead teacher who is:

a. At least 18 years of age, and who holds a current certification in adult and pediatric first aid and Cardio-Pulmonary Resuscitation (CPR); and

b. Has completed at least 6 hours of pre-licensing training in healthy, safe environments; Child development; observation and assessment; developmentally appropriate practice; guidance; relationships with families; individual and cultural diversity; Children with special needs; business and professional development; and Child care practices.

4. Facilities licensed for 13-20 Children must employ a minimum of one director or lead teacher. The Director/lead teacher may be the owner of the Child Care Facility. The director and/or lead teacher must be at least 21 years of age and must meet one of the following requirements:

a. Graduation from an accredited high school or its equivalent, and 12 months of employment in a licensed Child Care Program and 12 hours of training in healthy, safe environments; Child development; observation and assessment; developmentally appropriate practice; guidance; relationships with families; individual and cultural diversity; Children with special needs; business and professional development, Child care, or early Childhood education; or

b. 30 credit hours of college courses including six credit hours in early Childhood education or closely related subjects and six months of experience (employment or college practicum) in a licensed Child Care Program; or

c. Current Child Development Associate (CDA) credential as awarded by the Council for Professional Recognition, or a Maine State-approved credential, and six months of direct Child care experience (employment or college practicum).

5. Facilities licensed for 21 – 49 Children must employ a Director and/or lead teacher who is at least 21 years of age, and meets one of the following requirements:

a. An Associate Degree in Arts/Associate in Science (AA/AS) in Early Childhood Education; or

b. An AA/AS with 12 credits in Early Childhood Education or a Department-approved related field, and two years of direct Childcare experience; or

c. 30 college credits in Early Childhood Education, and one year of direct Child care experience; or

d. Child Development Associate (CDA) as awarded by the Council for Professional Recognition or a Maine State-approved credential, and three years' direct Child care experience; or

e. Five years of direct Child care experience, and 135 hours of training in early childhood education including healthy, safe, and inclusive environments; Child development; observation and assessment; developmentally appropriate practice; guidance; relationships with families; and cultural diversity.

6. Facilities licensed for 50 or more Children must employ a Director and/or lead teacher who is at least 21 years of age, and meets one of the following requirements:

a. A Bachelor of Science/Bachelor of Arts (BA/BS) in Early Childhood Education; or

b. A BA/BS in a Department-approved related field with 18 credit hours in Early Childhood Education and three years of direct Child care experience; or

c. An Associate in Arts/Associate in Science (AA/AS) in Early Childhood Education and three years of direct Child care experience; or

d. An AA/AS in a related field with 18 credit hours in Early Childhood Education and three years of direct Childcare experience;

e. Current CDA as awarded by the Council for Professional Recognition or a Maine State-approved credential, with five years of direct Childcare experience;

f. Seven years of experience and 180 hours of training in the topics listed in Section 7(F)(4)(e) above; or

g. Meet Level 5, 6, 7, or 8 on the Maine Roads to Quality Career Lattice.

7. The lead teacher or person having the primary responsibility for a group of Children in a program with 13 or more Children must be at least 18 years of age and meet one of the following requirements:

a. Current CDA as awarded by the Council for Professional Recognition or a Maine State-approved credential; or

b. 12 months of direct Child care experience; or

c. One year (30 credit hours) of college work including one course in a Child related subject and six months experience.

8. Directors and/or lead teachers of school-age Child Care Facilities must have an AA/AS in Early Childhood Education or 30 college credits in a closely related field such as elementary education, Child development, or recreation management.

APPENDIX H

Maine DHHS Rule Chapter 33, Section 7 – Staff Child Ratios for Family Childcare Facilities

SECTION 7. STAFF-CHILD RATIOS, SUPERVISION, AND QUALIFICATIONS

A. Children under six weeks of age. No Child under six weeks of age, as verified by a birth certificate, other than the Provider's own Children may be cared for by the Provider.

B. Children of Providers and Staff Members

1. Children of Staff Members must be counted in the appropriate age groups and in determining staff-Child ratios when in care with the Provider, except as provided for in section 7(C)(2)(b) below.

2. Children living with the Provider who are over four years of age are not counted in determining the staff-Child ratio. Children living with the Provider under four years of age are counted in the staff-Child ratio.

3. All Children in care other than Children identified in Section 7(B)(2) above who are younger than 13 years old must be counted in staff-Child ratios.

4. In determining the number of Children for which a Provider is Licensed, the Department may factor in the needs of Children and Adults who reside in the home. The number of Children allowed may be restricted by the Department when any of the following circumstances are present:

a. Space is limited or unusually configured;

b. The Provider has physical limitations that would impact the Provider's ability to safely care for, supervise or respond to the needs of children in care; or

c. There is a Child or Children who require exceptional amounts of care due to a health or other condition.

C. Staff-Child ratios.

1. The number of Children present must not exceed Licensed Capacity.

2. The maximum number of Children to be assigned per Staff Member must be as follows:

a. Ratio requirements:

CHILD AGES	STAFF-CHILD RATIO		
All Children 6 weeks to 2 years old	1 Provider: 4 Children	2 Providers: 8 Children	3 Providers: 12 Children
All Children 2 to 5 years old	1 Provider: 8 Children	2 Providers: 12 Children	Not applicable
All Children over 5 years old	1 Provider:12 Children	Not applicable	Not applicable
Mixed ages	1 Provider: 3 Children under 2 years old + 3 Children 2 to 5 years old + 2 Children over 5 years old, or 8 Children 2 to 5 years old + 2 Children over 5 years old.	2 Providers: 6 Children under 2 years old + 6 Children over 2 years old.	3 Providers: 12 Children (No more than 9 Children may be under 2 years of age).

b. Older Children may fill younger Children's spaces, but younger Children may not fill older Children's spaces.

3. Capacity may only be exceeded when the following conditions exist: family emergencies or emergency school closings.

a. Planned school closures are considered predictable circumstances and, therefore, capacity may not be exceeded.

b. Proper supervision and ratios, as defined in this rule, must be maintained. Procedures for managing such events must be explained in the written emergency plan and the reasons for exceeding capacity must be documented on the Attendance Record.

c. Special events occurring at the Provider location must provide supervision in accordance with this rule. A Child attending a special event in the care of a Parent or Legal Guardian will not be included in staff-Child ratios. Special events occurring outside of typical hours and days of operation are not subject to this rule.

D. Supervision

1. Children must be supervised at all times by Provider or a Staff Member. The Provider or Staff Member must be present and interacting, intervening, providing direction, feedback and assistance at all times.

a. Providers must have knowledge of the activity and whereabouts of each Child in care.

i. A Provider or Staff Member must be able to see or hear all Children at all times and be able to provide prompt intervention when needed.

ii. A Provider or Staff Member must be physically present outside when Children under the age of eight are outdoors.

iii. If Children over the age of eight are outside, and a Provider or Staff Member is not physically present, the play area must be enclosed by fencing.

2. During napping and/or sleeping hours, the Provider or Staff Member must be awake and supervising all Children, and Child-staff ratios must be maintained. Dimmed, but adequate, lighting to allow visual supervision of all Children must be maintained at all times.

3. Monitors providing both video and audio may be considered as an acceptable form of supervision during quiet indoor activities.

4. The Provider or a Staff Member must attend to a Child crying or crying out.

E. Crisis plan. The Provider must develop and follow a written plan for obtaining help in an emergency when only one provider is present, or when staff-Child ratios are exceeded.

F. Personnel Qualifications. Staff Members must be at least 16 years of age. Any Staff Member under the age of 18 must be supervised by another Staff Member who is 18 years of age or older.

1. The Provider and All Staff Members must have a high school diploma or equivalent, be attending high school, or be enrolled in a General Educational Development (GED) or HISET (High School Equivalency Test) preparation program.

2. Staff Members responsible for, or assisting with, the care of Children must exercise good judgment in the handling of Children, demonstrate consistent compliance with this rule and all relevant laws, and must not engage in any action or practice detrimental to the welfare of the Children.

3. Providers must be able to perform their assigned tasks and meet all Staff Member requirements in this rule. No alcohol, tobacco, recreational marijuana, or illegal drugs may be consumed while on duty. Prescribed drugs or certified Medications that do not impair the ability of the provider to care for Children are allowed.

4. Either the Provider or at least one Staff Member must satisfy the following qualifications:

a. Be at least 18 years of age and hold a current certification in Adult and pediatric first aid and Cardio-Pulmonary Resuscitation (CPR); and

b. Have completed at least 6 hours of pre-licensing training in healthy, safe environments; Child development; observation and assessment; developmentally appropriate practice; guidance; relationships with families; individual and cultural diversity; children with special needs, business, and professional development; or childcare practices.

5. Providers and Staff Members must be properly immunized and have the immunization record readily accessible for inspection by the Department.

Requirements include, documentation of immunity against tetanus, pertussis, and diphtheria.

a. Providers and Staff Members born after 1956 must have available a Certificate of Immunization for measles, mumps, rubella, tetanus pertussis, and diphtheria.

b. Documentation of immunity against measles, mumps and rubella is not required for Providers and Staff Members born prior to 1957. A laboratory blood test proving immunity may also be accepted.

c. Only written documentation from a physician that such immunization is medically inadvisable exempts Providers and Staff Members from these required immunizations.

APPENDIX I

Maine State Board of Education Rule Chapter 115, Part II,
Requirements for Specific Certificates and Endorsements

05-071 STATE BOARD OF EDUCATION

Chapter 115

PART II: REQUIREMENTS FOR SPECIFIC CERTIFICATES AND ENDORSEMENTS

SUMMARY: This part of Chapter 115 provides the specific requirements for each certificate and endorsement for teachers, educational specialists, and administrators. For each certificate or endorsement in Part II, applicants shall meet the requirements of Part I.

SECTION 1: TEACHERS AND EDUCATIONAL SPECIALISTS: GENERAL CERTIFICATES AND ENDORSEMENTS

1.1 Endorsement 029: Early Elementary Teacher

A. **Function**: This endorsement on a teacher certificate allows the holder to teach students pre-kindergarten through grade 3.

B. **Eligibility**: Applicants shall meet eligibility requirements specified in Part I. In addition, eligibility for this endorsement shall be established by one of two pathways. Individuals who are not eligible through either pathway may be eligible for a conditional certificate, in accordance with Section 1.1.B.3, below, and Part I Section 6.6 of this rule.

1. Endorsement Eligibility Pathway 1

(a) Graduated from a Maine program approved for the education of early elementary teachers, together with a formal recommendation from the preparing institution;

(b) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule; and

(c) Completed an approved course for teaching students with exceptionalities in the regular classroom.

2. Endorsement Eligibility Pathway 2

(a) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule;

(b) Completed a minimum of six semester hours in each of the following: English, mathematics, science, and social studies or social sciences;

(c) Completed a minimum of three semester hours in early literacy;

(d) Completed a minimum of three semester hours in children's literature;

(e) Completed a minimum of three semester hours in mathematics for the young child;

(f) Completed a minimum of three semester hours in science for the young child;

(g) Completed a minimum of three semester hours in social studies for the young child;

(h) Completed a minimum of an additional six semester hours in early childhood education;

(i) Completed a minimum of three semester hours in diversity-centered content related to today's classroom (e.g., culturally responsive teaching, multicultural education, intercultural education, second language acquisition or world language teaching methods);

(j) Completed a minimum of three semester hours in human development, educational psychology, developmental psychology, or child development;

(k) Completed an approved course for teaching students with exceptionalities in the regular classroom;

(l) Passed basic skills test in reading, writing, and mathematics, in accordance with Maine Department of Education Regulation 13, or

achieved at least a 3.0 cumulative GPA in all courses required for the certification, or

completed a successful portfolio review demonstrating competency in Maine's Initial Teacher Standards; and

(m) Completed one academic semester or a minimum of 15 weeks of full-time student teaching, or a combination of part-time and full-time student teaching in an amount equivalent to 15 weeks in this endorsement area at the specified grade level. This requirement shall be waived upon completion of one full year of successful teaching under a conditional certificate in this endorsement area for the specified grade level.

3. Conditional Certificate for this Endorsement

(a) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule; and

(b) Completed a minimum of six semester hours in each of the following: English, mathematics, science, and social studies or social sciences.

1.2 Endorsement 020: Elementary Teacher

A. **Function**: This endorsement on a teacher certificate allows the holder to teach students kindergarten through grade 6.

B. **Eligibility**: Applicants shall meet eligibility requirements specified in Part I. In addition, eligibility for this endorsement shall be established by one of two pathways. Individuals who are not eligible through either pathway may be eligible for a conditional certificate, in accordance with Section 1.2.B.3, below, and Part I Section 6.6 of this rule.

1. Endorsement Eligibility Pathway 1

(a) Graduated from a Maine program approved for the education of elementary teachers, together with a formal recommendation from the preparing institution;

(b) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule; and

(c) Completed an approved course for teaching students with exceptionalities in the regular classroom.

2. Endorsement Eligibility Pathway 2

(a) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule;

(b) Completed a minimum of six semester hours in each of the following: English, mathematics, science, and social studies or social sciences;

(c) Completed a minimum of nine semester hours in elementary literacy methods (e.g., teaching reading, teaching writing, children's literature, writing process, foundations of literacy, multicultural literacy);

(d) Completed a minimum of three semester hours in elementary mathematics methods;

(e) Completed a minimum of three semester hours in elementary science methods;

(f) Completed a minimum of three semester hours in elementary social studies methods;

(g) Completed a minimum of three semester hours in diversity-centered content related to today's classroom (e.g., culturally responsive teaching, multicultural education, intercultural education, second language acquisition or world language teaching methods);

(h) Completed a minimum of three semester hours in human development, educational psychology, developmental psychology, adolescent psychology, or child development;

(i) Completed an approved course for teaching students with exceptionalities in the regular classroom;

(j) Passed basic skills test in reading, writing, and mathematics, in accordance with Maine Department of Education Regulation 13, or

achieved at least a 3.0 cumulative GPA in all courses required for the certification, or

completed a successful portfolio review demonstrating competency in Maine's Initial Teacher Standards; and

(k) Completed one academic semester or a minimum of 15 weeks of full-time student teaching, or a combination of part-time and full-time student teaching in an amount equivalent to 15 weeks in this endorsement area at the specified grade level. This requirement shall be waived upon completion of one full year of successful teaching under a conditional certificate in this endorsement area at the specified grade level.

3. Conditional Certificate for this Endorsement

(a) Completed at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule; and

(b) Completed a minimum of six semester hours in each of the following: English, mathematics, science, and social studies or social sciences.

1.16 Endorsement 081: Early Childhood Teacher

A. **Function**: This endorsement on a teacher certificate allows the holder to teach students birth through Kindergarten.

B. **Eligibility**: Applicants shall meet eligibility requirements specified in Part I. In addition, eligibility for this endorsement shall be established by one of two pathways. Individuals who are not eligible through either pathway may be eligible for a conditional certificate, in accordance with Section 1.16.B.3 below, and Part I Section 6.6 of this rule.

1. Endorsement Eligibility Pathway 1

(a) Graduated from a Maine program approved for the education of early childhood teachers, together with a formal recommendation from the preparing institution;

(b) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule; and

(c) Completed a minimum of three semester hours for teaching early childhood special education.

2. Endorsement Eligibility Pathway 2

(a) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule;

(b) Completed a minimum of three semester hours in each of the following: English, mathematics, science, and social studies or social sciences;

(c) Completed a minimum of three semester hours for teaching early childhood special education;

(d) Completed a minimum of three semester hours in language development and early literacy;

(e) Completed a minimum of three semester hours in children's literature;

(f) Completed a minimum of three semester hours in numeracy for the young child;

(g) Completed a minimum of three semester hours in science for the young child;

(h) Completed a minimum of three semester hours in child development or developmental psychology;

(i) Completed a minimum of three semester hours in infant/toddler development;

(j) Completed a minimum of six semester hours in at least two of the following areas: creative arts, family studies/observation of the young child, assessment of the young child, social studies for the young child, advanced child development, early learning environments, or additional early literacy;

(k) Completed a minimum of three semester hours in diversity-centered content related to today's classroom (e.g., culturally responsive teaching, multicultural education, intercultural education, second language acquisition or world language teaching methods);

(l) Passed basic skills test in reading, writing, and mathematics, in accordance with Maine Department of Education Regulation 13, or

achieved at least a 3.0 cumulative GPA in all courses required for the certification, or

completed a successful portfolio review demonstrating competency in Maine's Initial Teacher Standards; and

(m) Completed one academic semester or a minimum of 15 weeks of full-time student teaching, or a combination of part-time and full-time student teaching in an amount equivalent to 15 weeks in this endorsement area at the specified grade level. This requirement shall be waived

upon completion of one full year of successful teaching under a conditional certificate in this endorsement area for birth through kindergarten.

3. Conditional Certificate for this Endorsement

(a) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule;

(b) Completed a minimum of three semester hours in each of the following: English, mathematics, science, and social studies or social sciences; and

(c) Completed a minimum of nine semester hours from Section B.2.c through j, above.

SECTION 2: TEACHERS AND EDUCATIONAL SPECIALISTS: SPECIAL EDUCATION CERTIFICATES AND ENDORSEMENTS

2.1 Endorsement 282: Teacher of Children with Disabilities

A. **Function**: This endorsement on a teacher certificate allows the holder to teach children with disabilities and to consult with teachers, children, and parents/guardians. The endorsement specifies the applicable grade levels: birth to school age 5, kindergarten through grade 8, or grades 7 through 12.

B. **Eligibility**: Applicants shall meet eligibility requirements specified in Part I. In addition, eligibility for this endorsement shall be established by one of two pathways. Individuals who are not eligible through either pathway may be eligible for a conditional certificate, in accordance with 2.1.B.3 and 2.1.B.4, below, and Part I Section 6.6 of this rule.

1. **Endorsement Eligibility Pathway 1**

(a) Graduated from a Maine program approved for teachers of children with disabilities birth to school age 5, kindergarten through grade 8, or grades 7 through 12, together with a formal recommendation from the preparing institution;

(b) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule; and

(c) Completed an approved course for teaching students with exceptionalities in the regular classroom.

2. **Endorsement Eligibility Pathway 2**

(a) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule;

(b) Completed a minimum of 24 semester hours in special education with three courses (at least three semester hours each) in the following areas: evaluation and assessment, specially designed instruction (SDI), and reading instruction, including phonemic awareness and phonics using evidence-based practices.

Additionally, at least one course (at least three semester hours) must address one of the following areas: Universal Design for Learning (UDL), inclusion and least restrictive environment (LRE), types of disabilities, program planning, behavior intervention and supports, special education law and implementation.

The remaining semester hours must come from the above list or other special education courses.

(c) For the birth to school age 5 grade level, completed a minimum of three semester hours for teaching early childhood special education;

(d) Completed a minimum of three semester hours in diversity-centered content related to today's classroom (e.g., culturally responsive teaching, multicultural education, intercultural education, second language acquisition or world language teaching methods);

(e) Completed a minimum of three semester hours in human development, educational psychology, developmental psychology, adolescent psychology, or child development;

(f) Passed basic skills test in reading, writing, and mathematics, in accordance with Maine Department of Education Regulation 13, or

achieved at least a 3.0 cumulative GPA in all courses required for the certification, or

completed a successful portfolio review demonstrating competency in Maine's Initial Teacher Standards; and

(g) Completed one academic semester or a minimum of 15 weeks of full-time student teaching, or a combination of part-time and full-time student teaching in an amount equivalent to 15 weeks in this endorsement area at the specified grade level: birth to school age 5, kindergarten through grade 8, or grades 7 through 12. This requirement shall be waived upon completion of one full year of successful teaching under a conditional certificate in this endorsement area at the specified grade level.

NOTE: Section 2.1.B.2.f, above, does not apply to this endorsement for birth to age 5.

3. **Conditional Certificate for this Endorsement**

(a) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule;

(b) Completed a minimum of nine semester hours in special education; and

(c) In the first year of employment, be enrolled in a Maine approved program for mentoring teachers under a Conditional Certificate for a special education endorsement.

4. **Conditional Certificate for Endorsement: Educational Technician III to Teacher of Children with Disabilities**

(a) Earned at least a bachelor's degree from an accredited college or university, in accordance with Part I Section 6.1 of this rule;

(b) Completed a minimum of three years of experience as an Educational Technician III with positive evaluations from administrator(s);

(c) Employed as a special education classroom teacher and received positive evaluations annually from a school administrator;

(d) Accepted into a post-baccalaureate or graduate program in special education at an accredited university program;

(e) Maintained good standing in the program (e.g., grades, cumulative GPA, successful academic progress); and

(f) In the first year of employment, be enrolled in a Maine approved program for mentoring teachers under a Conditional Certificate for a special education endorsement.

State of Maine
131st Legislature, First Regular and First Special Session

Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSION

Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

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Executive Summary

The Fund for a Healthy Maine was established in 1999 to receive payments from tobacco manufacturers in accordance with the Master Settlement Agreement (MSA), which provides the terms of the legal settlements between states and tobacco manufacturers after states sued manufacturers in an effort to recoup funds the states had spent treating tobacco-related illnesses. The Maine Legislature established the Fund for a Healthy Maine to create parameters for the use of tobacco settlement funds.[1] Over time, as tobacco smoking has waned, so have annual settlement payments to the fund. This trend is expected to continue, resulting in a "structural deficit" for programs and activities supported by the fund at some time in the near future.

Through the passage of Resolve 2023, Chapter 100, the 131st Maine Legislature established the *Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities*, referred to in this report as "the Commission."[2] The resolve language directed the Commission to evaluate funding models and structures that allow for the sustained investment in the health and prosperity of youth and families in the State. The Commission was tasked with prioritizing research and recommendations that:

1. Resolve the structural deficit in the Fund for a Healthy Maine;

2. Identify sources of sustained funding for reducing tobacco use, improving public health, preventing chronic illness, reducing health disparities across demographic and geographic populations and improving the community conditions that support good health and wellness;

3. Identify strategies and structural changes that resolve structural inequities and allow funding and investment plans to extend beyond the Legislature's 2-year budget cycle when doing so is necessary for accomplishing their intents and purposes;

4. Advance the long-term goals established by the Legislature for funds received from legal settlements with manufacturers and excise taxes on products that affect public health and well-being;

5. Identify policy and funding models that maximize alignment between the purpose and intent of public health funding sources and the investments in public health and prevention initiatives those funds support;

6. Identify how funding from various public health-related sources could be blended or pooled to achieve common aims in preventing chronic disease, reducing health disparities among historically disenfranchised and vulnerable populations and improving the community conditions that support the health and resilience of youth in the State; and

[1] 22 MRSA §1511

[2] *See* Appendix A. This legislation was introduced as LD 1722, Resolve, to Establish the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities.

7. Identify strategies and system changes that would allow for the calculation of return on investment of all proposed public health and prevention measures over a period of time using the projected health and productivity benefits of those investments.

The fifteen Commission members appointed to the Commission brought with them a broad range of experience in government, public health, nonprofit management, finance and other areas.[3] Over the course of four meetings, the Commission solicited, received and discussed a substantial amount of information relevant to its charge as set forth in its authorizing legislation.[4] The Commission's website includes all meeting materials.[5]

Based on the information collected by the Commission and following discussion and deliberation by Commission members, the Commission developed the following findings and recommendations.

Findings

1. **Finding**: That the programs currently funded by the Fund for Healthy Maine are vital and require sustained funding by the Legislature.

2. **Finding**: That current allocations will soon outpace revenue, resulting in a structural deficit in the Fund for a Healthy Maine.

3. **Finding**: That reorganization of the administration of MSA funds is necessary for long-term sustainability of funding for prevention and health promotion activities in the State.

4. **Finding**: That additional sources of revenue are necessary for long-term sustainability of public health commitments in the State.

5. **Finding**: That reorganization of the administration of MSA funds is necessary to best track the overall impact of activities funded with MSA funds; to provide accountability over the administration of these funds; and to provide a mechanism for long-term, flexible planning to respond to a changing public health landscape.

Recommendations

1. **Recommendation**: That a new trust fund be created into which all MSA funds will be directly deposited and that is authorized to receive funds from other sources.

2. **Recommendation**: That a new, independent, quasi-state entity be created to administer the fund recommended by the Commission.

[3] *See* Appendix B for a list of appointed Commission members.
[4] *See* Part III of this report for a summary of the Commission process.
[5] https://legislature.maine.gov/sustained-investment-in-preventing-disease-and-improving-health-of-maine-communities-study

3. **Recommendation**: That the entity established in accordance with the Commission's recommendation prioritize funding for the following activities:

    a. Tobacco use prevention and intervention activities; and
    b. Public health activities and interventions to address health equity.

4. **Recommendation**: That the Fund for a Healthy Maine be maintained to fund certain activities currently funded through the Fund, including, but not limited to, MaineCare reimbursements; purchased social services; substance use interventions and treatment; Head Start programing; school breakfasts; medical care payments to providers; the Drugs for the Elderly program; and dental education and other activities currently funded through the Fund for a Healthy Maine and administered by the Finance Authority of Maine.

5. **Recommendation**: That a percentage of the cigarette tax and the tobacco products tax be deposited directly into the Fund for a Healthy Maine and used to support the activities described in Recommendation #4.

6. **Recommendation**: That the entity established to administer the new trust fund be required to report at least annually to the legislative committees of jurisdiction regarding its activities, including:

    a. management of the new trust fund recommended by the Commission;
    b. administrative costs;
    c. distribution of funds to outside entities and to state entities;
    d. coordination of activities with state agencies, including Maine CDC, and the state health plan;
    e. performance data and consideration of return on investments; and
    f. other information requested by the Legislature.

I. INTRODUCTION

Resolve 2023, Chapter 100

Through the passage of Resolve 2023, Chapter 100, the 131st Maine Legislature established the *Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities*, referred to in this report as "the Commission."[6] The resolve directed the Commission to evaluate funding models and structures that allow for the sustained investment in the health and prosperity of youth and families in the State. The Commission was tasked with prioritizing research and recommendations that:

1. Resolve the structural deficit in the Fund for a Healthy Maine;

2. Identify sources of sustained funding for reducing tobacco use, improving public health, preventing chronic illness, reducing health disparities across demographic and geographic populations and improving the community conditions that support good health and wellness;

3. Identify strategies and structural changes that resolve structural inequities and allow funding and investment plans to extend beyond the Legislature's 2-year budget cycle when doing so is necessary for accomplishing their intents and purposes;

4. Advance the long-term goals established by the Legislature for funds received from legal settlements with manufacturers and excise taxes on products that affect public health and well-being;

5. Identify policy and funding models that maximize alignment between the purpose and intent of public health funding sources and the investments in public health and prevention initiatives those funds support;

6. Identify how funding from various public health-related sources could be blended or pooled to achieve common aims in preventing chronic disease, reducing health disparities among historically disenfranchised and vulnerable populations and improving the community conditions that support the health and resilience of youth in the State; and

7. Identify strategies and system changes that would allow for the calculation of return on investment of all proposed public health and prevention measures over a period of time using the projected health and productivity benefits of those investments.

The fifteen Commission members appointed to examine these issues brought a broad range of experience to the table. Resolve 2023, chapter 100 directed the following appointments to the Commission:

1. One member of the Senate from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs;

[6] *See* Appendix A for a copy of the resolve.

2. One member of the Senate from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services;

3. One member with policy expertise or experience in state budgeting and funding improved access to health care for low-income individuals and other populations experiencing inequitable access to health care;

4. One member who has a minimum of 8 years of experience leading a community health coalition and experience working with rural populations;

5. One member who manages a public health endowment for a health system in the State and has experience developing statewide plans for improving health and prosperity;

6. One member who is currently or was formerly employed as senior staff or faculty for a university in the State with expertise in public health, rural health and health equity financing models;

7. One member of the House of Representatives from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services;

8. One member of the House of Representatives from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs;

9. One member who represents a statewide association of public health professionals that works to improve and sustain the health and well-being of all people in the State through health promotion, disease prevention and the advancement of health equity;

10. One member who has a minimum of 8 years of experience serving in the Legislature, including service on both the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services;

11. One member who is employed by a philanthropic organization in the State with experience or expertise funding initiatives in public health and primary prevention that advance racial health equity or reduce health disparities;

12. One member who represents a community development financial institution that advances health and economic equity for people and communities in the State through the integration of finance, business expertise and policy solutions;

13. One member who serves as senior staff for a municipal or county health department;

14. The Director of the Office of Policy Innovation and the Future or the director's designee; and

15. The Attorney General or the Attorney General's designee.

A list of Commission members is included as Appendix B.

Background

The Commission was charged by its authorizing legislation to study the sustainability and administration of the Fund for a Healthy Maine. The Commission fulfilled its duties through the collection and review of information obtained from a variety of sources and invited Commission members and other experts to make multiple substantive presentations to the Commission during the course of its four meetings. The information provided to the Commission serves as the basis for the background information set forth below.

A. The Tobacco Master Settlement and the Fund for a Healthy Maine

i. Tobacco Master Settlement

Faced with rising Medicaid costs related to the treatment of tobacco-related illnesses, states began, in the 1990s, to seek to recoup some of these expenses by filing lawsuits against major tobacco manufacturers, alleging that manufacturers had violated consumer protection laws and despite evidence of the health risks posed by tobacco use, downplayed or ignored those risks. While the manufacturers did not admit fault, they settled numerous legal claims with 52 state and territory attorneys general in 1998.[7] Forty-six states, including Maine, ultimately participated in the settlements.[8]

The result of the settlements, the Master Settlement Agreement (MSA)[9] was unparalleled in scope. The MSA required that participating tobacco manufacturers make annual payments to the plaintiff states and territories indefinitely. Manufacturers also agreed to restrict or discontinue specific tobacco marketing practices and dissolve certain tobacco industry groups. In exchange for these concessions, the states resolved their lawsuits against the tobacco manufacturers. They also committed to protecting the manufacturers from private legal actions based on harm caused by tobacco.

At the time these claims were settled by the states participating in the MSA, more than 45 tobacco manufacturers participated. Not all of these manufacturers remain in business. Those tobacco manufacturers that were not part of the settlement (newer manufacturers) are referred to as "nonparticipating manufacturers."

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[7] The January 2019 printing of the Master Settlement Agreement can be found online here: https://www.naag.org/our-work/naag-center-for-tobacco-and-public-health/the-master-settlement-agreement/

[8] Florida, Minnesota, Texas and Mississippi had previously litigated and settled with tobacco manufacturers.

The MSA contains numerous requirements, and participating states established state-level legislation to meet those requirements. Maine enacted legislation to address the responsibilities of the State and the obligations of tobacco manufacturers and distributors. These laws include:

- The Tobacco Manufacturers Act,[10] which is intended to ensure that tobacco manufacturers who did not participate in the settlement do not hold an unfair advantage over participating manufacturers. It requires nonparticipating manufacturers to place an established percentage per unit sold into an escrow fund. These funds are released from escrow when either the funds are used to pay a judgement on a claim brought by the State or other qualified party or 25 years after the funds are placed in escrow; and

- Other statutory requirements relating to tobacco product manufacturers,[11] including annual certification by nonparticipating manufacturers of its brands with the Office of the Attorney General and certification of compliance with the escrow requirements of the Tobacco Manufacturers Act.

Annual payments to Maine began during the 2000 fiscal year and continue to the present. State law directs payments pursuant to the MSA be deposited into the Fund for a Healthy Maine[12]; funds are allocated from there for a specified array of health-related initiatives. The administration of the Fund for a Healthy Maine funds involves the State Treasurer, responsible for the oversight of revenue in the Fund, and the State Budget Officer, who is responsible for monitoring the Fund balance and the allocation of expenditures from the Fund.

ii. Fund for a Healthy Maine

Maine Revised Statutes, Title 22, section 1511, establishes the Fund for a Healthy Maine (FHM)[13]. The statute provides that funds from the settlement of the tobacco litigation in the case of *State of Maine versus Philip Morris, et al., Kennebec County Superior Court, Docket No. CV-97-134*, as well as from various other sources and the interest and investment income on fund balances be credited to the Fund by the State Controller. The FHM also receives certain funding generated by slot machine operations.[14] The law provides that unencumbered balances remaining at the end of a fiscal year lapse to the Fund.[15] Importantly, statute also provides that allocations from the Fund must be used to supplement, rather than supplant, General Fund appropriations.[16] Allocations from the Fund are limited per the statute to specified "prevention and health promotion purposes." Originally, these allocations included the following purposes:[17]

1. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State;

[10] 22 MRSA §§1580-G – 1580-I
[11] 22 MRSA §§1580-L
[12] 22 MRSA §1511, sub-§2(A)
[13] *See* Appendix C
[14] 8 MRSA § 1036, Sub-§2(E)
[15] 22 MRSA §1511, sub-§3-A
[16] 22 MRSA §1511, sub-§4
[17] 22 MRSA §1511, sub-§6

2. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age;

3. Child care for children up to 15 years of age, including after-school care;

4. Health care for children and adults, maximizing to the extent possible federal matching funds;

5. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds; and

6. Dental and oral health care to low-income persons who lack adequate dental coverage.

In 2007, the Legislature added an additional authorized allocation for comprehensive school health and nutrition programs, including school-based health centers.[18] In 2011, the Legislature added prevention, education and treatment activities concerning unhealthy weight and obesity as an allocable allocation.[19] Finally, in 2017, the Legislature added substance use disorder prevention and treatment as an allowable allocation.

The law authorizes the State Controller to provide an annual advance up to $37,500,000 from the General Fund to the Fund for a Healthy Maine to provide money for allocations from the Fund.[20] This accounts for the delay between the beginning of the state fiscal year and distribution of MSA payments to the State. Funds are returned to the General Fund when the MSA payments are received.

The Legislature's Office of Fiscal and Program Review (OFPR) maintains a publicly accessible website that provides information on the tobacco settlement funds. The website provides information on Fund balance status reports, pie charts on budgeted uses, revenues and expenditure tables, current revenue projections, allocations and uses of tobacco settlement funds by program, and historical information related to allocations and uses of tobacco settlement funds. The website also contains links to reports on allocations to programs within DHHS.[21]

B. Prior Studies Involving the Fund for a Healthy Maine

The Fund for a Healthy Maine and the administration of MSA funds have been studied by various legislative bodies on multiple occasions, and the activities of these legislative bodies are summarized below.

i. Joint Standing Committee on Health and Human Services, Review of the Fund for a Healthy Maine (2008)

[18] 22 MRSA §1511, sub-§6(H)
[19] 22 MRSA §1511, sub-§6(A-1)
22 MRSA §1511, sub-§6(G)
[20] 22 MRSA §1511, sub-§9
[21] https://legislature.maine.gov/ofpr/fund-for-a-healthy-maine

In 2007, pursuant to Public Law 2007, Chapter 629, Part H, the Joint Standing Committee on Health and Human Services (HHS) was directed to assess the structure, accountability and oversight of the Fund for a Healthy Maine. The HHS Committee met twice and subsequently issued a report with key recommendations. First, they proposed that the Government Oversight Committee authorize the Office of Program Evaluation and Government Accountability (OPEGA) to conduct a comprehensive review of the FHM's efficacy, efficiency and accountability. Another recommendation urged the establishment of a subcommittee, jointly involving the HHS and Appropriations and Financial Affairs (AFA) Committees, to deliberate on all budget proposals and other initiatives influencing the FHM, although the actualization of this recommendation remains unclear. Second, the HHS Committee recommended the adoption of a joint rule mandating the review by HHS of any proposed FHM allocation, deallocation or changes to the FHM statute. Joint Rule 317 was originally adopted by the 124th Legislature and has been included in the Joint Rules of each subsequent legislature.

ii. *Office of Program Evaluation and Government Accountability Review: Fund for a Healthy Maine Programs-Frameworks Adequate for Ensuring Cost-Effective Activities but Fund Allocations Should be Reassessed; Cost Data and Transparency Can Be Improved (2009)*

In 2009, the Office of Program Evaluation and Government Accountability (OPEGA), acting on the direction of the Government Oversight Committee (GOC), conducted a comprehensive review of the Fund for a Healthy Maine (FHM). The primary objective was to assess the effectiveness of existing managerial and oversight systems in ensuring that FHM-supported activities were both cost-effective and conducted in an efficient manner, with adequate transparency and accountability for results and expenditures. The ensuing OPEGA report identified significant challenges within the FHM framework, including a reluctance to deviate from original funding uses, a lack of clarity regarding formal responsibilities for ensuring cost-effectiveness, incomplete financial and performance data, vague budgetary program descriptions and a misalignment of financial and performance information. To address these issues, the report provided a set of recommendations, urging the Legislature to assess the current FHM allocations; assign responsibility for periodic reassessment to specific state entities; improve alignment with the State's health goals; and mandate agencies to furnish necessary information within program descriptions. Additionally, the Executive Branch was advised to develop and implement policies to ensure the accuracy of budgetary program descriptions and utilize the State's accounting system for tracking costs associated with major activities.

iii. *Maine State Legislature, Commission to Study Allocations of the Fund for a Healthy Maine (December 2011)*

In response to the 2009 OPEGA study, the Legislature established the Commission to Study Allocations of the Fund for a Healthy Maine in December 2011, as authorized by Resolve 2011, chapter 112. Tasked with a comprehensive review of FHM allocations, this Commission was directed to report its findings and recommendations, including proposed legislation, to the HHS and AFA Committees. The subsequent report presented a series of Commission recommendations, including recommendations to transform the FHM from a group of programs within Other Special Revenue Funds into a separate fund (implemented through the enactment of

Public Law 2011, Chapter 701), to broaden the FHM's application to "prevention and health promotion purposes" and to mandate separate accounts and annual reports for increased transparency. Some recommendations were implemented, such as the recommendation that the HHS Committee review legislative proposals related to the changes to FHM funding allocation pursuant to Rule 317. Other recommendations, such as an ongoing review of FHM allocations every four years were not implemented. Additionally, the Commission advocated for the continued funding of the Office of the Attorney General to enforce the MSA and expressed support for investments in public health and prevention to be consistent with the original intent of the funding.

iv. Joint Standing Committee on Health and Human Services, Study of Allocations of the Fund for a Healthy Maine (2015)

In 2015, the Maine State Legislature, through the passage of Resolve 2015, chapter 47, empowered the Joint Standing Committee on Health and Human Services (HHS) to conduct a thorough study of the allocations of the Fund for a Healthy Maine (FHM). The HHS Committee, gathered information over four meetings to identify and review the State's current public healthcare and preventative health priorities; strategies for addressing these priorities; the potential effectiveness of those strategies; and the required resources to pursue these priorities and strategies. The subsequent report, issued by the Committee, revealed several recommendations. Notably, the Committee refrained from suggesting changes to FHM allocations but advocated for the Department of Health and Human Services (DHHS) to submit an annual report encompassing detailed expenditure information; progress towards health priorities outlined in the Maine State Health Improvement Plan 2013-2017; and data related to audits and submissions to the Department of Administrative and Financial Services (DAFS) pursuant to Public Law 2011, Chapter 701. Additionally, the Committee expressed support for the Office of Program Evaluation and Government Accountability's (OPEGA) plan to study DHHS audit functions; called for the full implementation of the 2011 study recommendations; issued a statement supporting the principles of the FHM statute; and requested regular updates from DHHS on pending Requests for Proposals (RFPs) for Healthy Maine Partnership contracts.

C. Highlights of Prior Legislation Related to the Fund for a Healthy Maine

Changes to the Fund for a Healthy Maine and to the administration of Master Settlement Agreement funds have been considered many times by the Legislature and relatively small changes to the Fund for a Healthy Maine have been implemented. Highlights of legislative efforts are described below.

119th Legislature

- Public Law 1999, Chapter 401: This public law, which enacted a supplemental budget, included language in Part V that established the Fund for a Healthy Maine. This followed consideration by the Legislature of a number of bills that sought to manage the funds received by the State as a result of tobacco manufacturer litigation.

120th Legislature

- Public Law 2001, Chapter 559: This public law, which enacted a supplemental budget, added language to the FHM establishing statute that provided that any unencumbered balance remaining at the end of any fiscal year lapse back into the FHM account.

- Public Law 2001, Chapter 714: This public law, which enacted an additional supplemental budget, added language to the FHM establishing statute that provided that, beginning July 1, 2003, the State Controller was authorized to advance up to 37.5 million dollars annually from the General Fund to the FHM, which the FHM would then return.

121st Legislature

- Public Law 2003, Initiated Bill 1: This public law established slot machine use in Maine. It provided that 10% of the total gross slot machine income must be credited to the FHM.

- Public law 2003, Chapter 687, Section A-9: This public law authorized the State Controller to establish separate accounts within the FHM in order to segregate money received by the Fund from any public or private source that requires as a condition of the contribution to the Fund that the use of the money contributed be restricted to one or more of the allowable uses of the Fund. The law also required that money credited to a restricted account may be applied only to the purposes for which the account is restricted.

- LD 1612, Resolution, Proposing an Amendment to the Constitution of Maine to Preserve the Fund for a Healthy Maine: This bill proposed an amendment to the Constitution of Maine to preserve the FHM and ensure that the Fund be used for health-related purposes only. It died on adjournment.

123rd Legislature

- Public Law 2007, Chapter 539, Section III-3: This public law, which enacted a supplemental budget, added school nutrition programs to the list of allowable uses of the FHM.

124th Legislature

- Public Law 2009, Chapter 1: This public law, which enacted a supplemental budget, added language to the FHM establishing statute that provided that, for state fiscal years beginning on or after July 1, 2009, the State Budget Officer is authorized to adjust allocations in actual revenue collections for the fiscal year that are less than the approved legislative allocation.

125th Legislature

- Resolve 2011, Chapter 112: This resolve established the Commission to Study Allocation of the Fund for a Healthy Maine.

- Public Law 2011 Chapter 617: This public law amended the FHM authorizing legislation to broaden its application from "health-related purpose" to "prevention and health promotion purposes" and to add overweight and obesity prevention, education and treatment activities to the list of allowable uses.

- Public Law 2011, Chapter 701: This public law established the FHM as a separate account, apart from the Other Special Revenue Fund; required annual reporting by DAFS regarding use of allocated funds and required legislative committee review of all legislation affecting the FHM.

126th Legislature

- LD 180, An Act Concerning the Use of Tobacco Settlement Funds for Children's Health Care: This bill proposed to amend current FHM law to require that children's health care funding not be reduced in order to address a budget deficit. The bill received an ONTP vote out of committee.

- LD 1232, An Act to Maintain the Integrity of the Fund for a Healthy Maine: This bill proposed to remove the provision of current law that allows the Legislature to approve transfers of funds from the FHM to the General Fund. The bill was vetoed by the Governor, and the veto was sustained by the Legislature.

127th Legislature

- Resolve 2015, Chapter 47: This resolve directed the HHS Committee to study the alignment of allocations from the FHM with the State's current public health care and preventive health priorities and goals.

129th Legislature

- LD 1961, An Act To Establish the Trust for a Healthy Maine: This bill proposed to establish the Trust for a Healthy Maine to receive money paid to the State pursuant to the tobacco settlement and from other sources and to distribute that money to state agencies or designated agents of the State to fund tobacco use prevention and control, ensure adequate resources for other disease prevention efforts, promote public health, plan and deliver public health and prevention programs and services, support accreditation of the Department of Health and Human Services, Maine Center for Disease Control and Prevention and support public health workforce development. The trust was to be

governed by a board of trustees appointed by the Governor and legislative leaders. The bill received an ONTP/OTPA vote out of committee. It died on adjournment.

130th Legislature

- LD 1523, An Act To Establish the Trust for a Healthy Maine: This bill proposed to establish the Trust for a Healthy Maine to receive money paid to the State pursuant to the tobacco settlement and from other sources and to distribute that money to state agencies or designated agents of the State to fund tobacco use prevention and control, ensure adequate resources for other disease prevention efforts, promote public health, plan and deliver public health and prevention programs and services, support accreditation of the Department of Health and Human Services, Maine Center for Disease Control and Prevention and support public health workforce development. The trust was to be governed by a 15-member board of trustees composed of the Director of the Maine Center for Disease Control and Prevention and 14 members appointed by the Governor. The bill received an OTPA/ONTP vote out of committee. It died on adjournment.[22]

- LD 1693, An Act To Advance Health Equity, Improve the Well-being of All Maine People and Create a Health Trust: This bill proposed to establish the Trust for a Healthy Maine to receive money paid to the State pursuant to the tobacco settlement and from other sources and to distribute that money to state agencies or designated agents of the State to fund tobacco use prevention and control, ensure adequate resources for other disease prevention efforts, promote public health, plan and deliver public health and prevention programs and services, support accreditation of the Department of Health and Human Services, Maine Center for Disease Control and Prevention and support public health workforce development. The trust was to be governed by a 15-member board of trustees composed of the Director of the Maine Center for Disease Control and Prevention and 14 members appointed by the Governor. Part B proposed to establish the Office of Health Equity within the Department of Health and Human Services. The office was tasked with providing advice to the Commissioner of Health and Human Services, the Governor's Office of Policy Innovation and the Future and other state agencies, the Legislature and the Governor on health systems, policies and practices; providing recommendations to advance health equity in all sectors and settings; producing and updating a state health equity plan; and producing an annual Maine Health Equity Report Card. Part C proposed to require the Department of Education to revise its nutrition, physical activity, screen time and sugary drink standards to increase obesity prevention in early care and education and to revise its school nutrition and physical activity standards to increase obesity prevention in public schools and requires those standards to match those specified by various national organizations and federal agencies. Part D proposed to prohibit the sale and distribution of flavored tobacco products, including flavored cigars and electronic smoking devices. Part E proposed to increase the tax on cigarettes from 100 mills to 200 mills per cigarette, effective November 1, 2021, and eliminate the

[22] *See* Appendices H and I for LD 1523 and its adopted amendment.

provision that allows the sale of cigarette stamps to licensed distributors at a discount. The amount of increased revenue from the cigarette tax would be credited to the Fund for a Healthy Maine. Part E also proposed to provide funding for the health initiatives in the bill. The bill received an OTPA/ONTP vote out of committee. It died on adjournment.

II. COMMISSION PROCESS[23]

The Commission held four public meetings on October 24th, November 20th, December 6th and December 11th, 2023. Materials distributed and reviewed at these meetings, as well as additional background and other study-related materials, are posted online at the following website: Sustained Investment in Preventing Disease and Improving Health of Maine Communities Study | Maine State Legislature.[24]

A. First Meeting – October 24, 2023

The Commission held its first meeting on October 24, 2023. All members were present with the exception of Keith Bisson; Amy Winston attended in his place. The meeting began with introductions by Commission members and opening remarks from the Commission's chairs. Commission staff then provided an overview of the Commission's authorizing legislation, including the Commission's duties, the study process and the projected timeline for completion of the Commission's work.

The Commission then received a presentation regarding the financial status of the Fund for a Healthy Maine by Luke Lazure from the Office of Fiscal and Program Review.[25] Members asked a number of clarifying questions. Of particular interest to the Commission members was the question of a structural deficit and whether there indeed was such a deficit. Luke Lazure explained that it was impossible to know for certain, because over time revenue has decreased, largely due to changes in tobacco use patterns, and that, if this pattern continues, eventually there will be a deficit. However, generally forecasting is done conservatively, so historically forecasts have underestimated the Fund for a Healthy Maine. The Commission requested additional information, including more information about the annual negotiation done by the Attorney General's Office, whether any funds get "stuck" in the contracting process and are returned to the Fund for a Healthy Maine, and what the allocations to DHHS are used for and whether they generate matching funds.

After breaking for lunch, the Commission members had a discussion regarding next steps. They discussed the limitations of the two-year budget cycle and how this impacted the ability to engage in long-term planning. They also noted that it is difficult to know how funds are ultimately spent. The Commission discussed how the allowable uses of the Fund have expanded

[23] The below summaries are intended to capture the highlights of the committee discussions during meetings but are not intended to be exhaustive or inclusive of all comments made at the meeting. Videos of meetings are available for review on the legislative website.
[24] https://legislature.maine.gov/sustained-investment-in-preventing-disease-and-improving-health-of-maine-communities-study
[25] *See* Appendices D and E for Mr. Lazure's handouts to the Commission.

over time. They focused particularly on the large percentage of funds allocated to MaineCare. The Commission requested additional information, including information on whether a report is issued to the Legislature regarding the use of Fund dollars; a summary of past studies of the Fund for a Healthy Maine and information on how other states administer their Master Settlement Agreement funds.

B. Second Meeting – November 20, 2023

The Commission held its second meeting on November 20, 2023. All members were present in person. The meeting began with introductions by Commission members. Commission staff then provided the Commission with an overview of materials sent ahead of the meeting. This included a document that summarized the findings of the activities of past Commissions, including their findings and recommendations (and which recommendations were implemented), as well as a 50-state summary document with information on other states' funding models and their structure.[26]

Background information was provided to the Commission by Assistant Attorney General Elizabeth Reardon along with Michael Hering, of the National Association of Attorneys General, who was on hand via Zoom to answer questions. Ms. Reardon noted that the Master Settlement Agreement (MSA) came about as a result of a lawsuit filed in the 1990s. Many states, including Maine, sued major tobacco companies in an attempt to recoup money that states had paid to cover residents' healthcare costs for tobacco-related illnesses. The MSA is what settled the lawsuit, is the guiding document – e.g. determining how money is paid out – and relates only to cigarettes and rolling tobacco; vaping products are not included in the MSA. The major parties in the MSA were the states and certain participating manufacturers. Participating manufacturers agreed to make payments to states provided states do certain things. Among the directives, participating manufacturers required states to reach an agreement by which non-participating manufacturers must pay certain money into an escrow account. In addition, states must do "diligent enforcement" to get MSA payments; however, there is no specific definition of "diligent enforcement," and for years there has been costly arbitration as a result, with disputes taking years to resolve.

Ms. Reardon stressed that payment amounts are uncertain. A key reason for this is that, while the proportion of settlement funds allocated to each state is predictable (Maine currently gets 0.77% of payments nationally), the amount of money available is tied to cigarette and rolling tobacco sales nationally, which change from year to year. Current national trends reflect declining sales of these products. Payment amounts may also be subject to adjustment based on inflation.

After Ms. Reardon's initial overview, Commission members asked questions. In response to a question regarding whether there was any relationship between the size of the MSA payment and health-related costs of tobacco, Ms. Reardon responded that the payment is based on disease burden, the size of the state and how actively the state has been involved in litigation. In response to a question as to whether the share of money allocated to each state can change or be diverted to other states, Michael Hering responded that there is a single payment calculated based on tobacco sales nationwide, not only in Maine. Last year, the payment amount was just

[26] *See* Appendix F for the 50-state summary.

under $7 billion and Maine's allowable share of that amount was 0.77%. This percentage is fixed and is based in part on Medicaid expenses for treatment of smoking-related disease, but there are a number of adjustments that happen after allocation, and there is no impact on other state payments. Further, none of Maine's money would go to another state and adjustments can be applied individually on a state-by-state basis, or they can be applied on a national scale. The Commission also discussed escrow management.

Michael Stoddard, from Efficiency Maine, was available via Zoom to answer Commission members' questions. Mr. Stoddard discussed Efficiency Maine and its funding streams (e.g. the Regional Greenhouse Gas Initiative), structure, which Mr. Stoddard noted as being intentionally open-ended, and how the Efficiency Maine Trust was created as an independent, quasi-state entity, similar to the Finance Authority of Maine, Maine Turnpike Authority and MaineHousing. Decision-making is done by a board of trustees appointed by the Governor and Senate and, for funding decisions to go ahead, a two-thirds majority vote of members of the board is required. There are a number of reporting requirements and practices, e.g. annual reports and presentations to the Joint Standing Committee on Energy, Utilities and Technology. The Commission asked if the Legislature has the ability to impact Efficiency Maine's budget. Mr. Stoddard responded that they do, to an extent, and provided examples. However, the majority of funds cannot be swept by the Legislature because funds never touch the State Treasury.

The Commission then briefly discussed the impact of vaping on MSA payments. Mr. Hering noted that consumption of tobacco products has fallen drastically since the MSA, calling this "a huge success" from a public health perspective. However, use of vaping products has increased. That stated, vaping product sales are not included in the MSA.

Finally, Mr. Hering identified three reasons why payments were larger last year than anticipated: 1) higher inflation; 2) sales by participating manufacturers did not decline as expected; and 3) profit adjustments.

Following a lunch break, the Commission reviewed several of the duties with which they were tasked, as described below.

- *Duty 1- Resolve the structural deficit in the Fund for a Healthy Maine*

  Members discussed how to mitigate for a future structural deficit. Commission members suggested ideas such as increasing taxes on cigarettes and redirecting funding (e.g. by funding programs currently funded with Fund for Healthy Maine dollars with General Fund dollars).

- *Duty 2- Identify sources of sustained funding for reducing tobacco use, improving public health, preventing chronic illness, reducing health disparities across demographic and geographic populations and improving the community conditions that support good health and wellness*

  Members tried to identify new possible sources of revenue and discussed bonds and additional tax revenue. One member suggested tasking the Legislature with studying

products that cause harm (e.g., sugar-sweetened beverages) and taxing those products as a way of generating additional funding.

- *Duty 4- Advance the long-term goals established by the Legislature for funds received from legal settlements with manufacturers and excise taxes on products that affect public health and well-being.*

  Members discussed several topics including additional litigation related to vaping and increasing taxes on tobacco products and trusts as a way of preserving funds for public health and promotion activities.

Commission members asked Attorney General Frey questions about constitutionality and binding future legislatures. Some members vocalized a wish for greater transparency and granularity, suggesting that there is not adequate information, at present, about tobacco product sales within the State. Other members requested an analysis of LD 1523 and asked Attorney general Frey clarifying questions about funding structure. Attorney General Frey responded that money is meant to be directed at abatement activities. A member asked a procedural question about decoupling funding, referencing racino monies and the Drugs for the Elderly Program. Ana Hicks addressed some of Governor Mills' concerns and reasons for opposing the creation of a trust. Ms. Hicks noted concerns that the Legislature would not be involved and that monies would be redirected.

C. Third Meeting – December 6th, 2023

The Commission held its third meeting on December 6, 2023. All members were present with the exception of Senator Bennett and Ana Hicks. Yvonne Jonk attended the meeting remotely. Deputy Attorney General Christopher Taub attended for Attorney General Aaron Frey. The meeting began with introductions by Commission members. The Commission then reviewed the work completed at the last meeting.

Commission staff introduced a document intended to assist the Commission in its decision-making process. This document posed a number of questions for the Commission to consider, as described below.

1. Decision: Should the Commission find that a structural deficient exists or will exist in the Fund for a Healthy Maine, and that reorganization of the administration of the Fund is necessary for long-term viability?

There was general agreement among Commission members to support this proposed finding.

2. Decision: Should the Commission find that additional sources of revenue are necessary to maintain the Fund?

Members agreed that the language in this proposed finding referencing "the Fund" should be replaced with language referencing the "funding." It was asked if staff member Luke Lazure could clarify the actual deficit in the Fund for a Healthy Maine. Mr. Lazure replied that there was

not a definite answer to this question. He noted that the revised revenue forecast reflected lower than expected tobacco settlement payments. However, the current biennium will not see a deficit, and millions will still be in the Fund at the end of the biennium. But a deficit is a possibility in the next biennium, depending on final settlements. Mr. Lazure reminded the Commission that escrow funds sit in escrow as disputed payments until resolved.

It was suggested that the proposed finding might be altered to say that the current revenue will not cover the current allocations and that a deficit will result at some time.

3 Decision: Should the commission find that the current allocations from the Fund should be reconsidered during the next budget cycle or at such time as the Fund administration is restructured?

Members noted that public health priorities change over time and suggested that there needs to be a long enough window to allow for long-term planning and action by public health entities but also a time to reassess.

4. Decision: Should the Commission find that the authorizing statute for the FHM requires revision?

Members suggested that the Fund for a Healthy Maine should remain in statute to cover certain programming, such as the Drugs for the Elderly program. However, others noted that quite some time has passed since the drafting of the authorizing statute and that it makes sense to move that programming out of the Fund.

5. Decision: Should the Commission recommend that a new entity be created to administer the Fund for a Healthy Maine? If so, what type of entity?

Consider:

a. *Legal status of the entity and its relationship to the state (quasi governmental; state agency entity)*
b. *How entity will be governed (if by a board, consider membership, appointments, term limits, leadership)*
c. *Oversight of entity (legislative and or executive branch oversight; ability of legislature to review financials etc.)*
d. *Staffing of entity (numbers; expertise required; administrative cost)*
e. *Administration of funds (who will administer grants and provide subject matter expertise and oversight; relationship with state; will funds be distributed to state agencies or to private sector?)*

It was suggested that the language of this proposed recommendation should reference administration of MSA funds, rather than the Fund for a Healthy Maine. It was also suggested that this recommendation recommend that the Legislature establish a trust to administer MSA funds and that the Fund for a Healthy Maine be maintained.

Members discussed how best to separate out which allocations would shift to the trust and which would remain in the Fund for a Healthy Maine. Some members where in favor of certain programs, such as the Drugs for the Elderly program, MaineCare and Head Start, remaining in the Fund for a Healthy Maine. However, the Fund would no longer receive MSA dollars, so funding from these programs would need to come from another source, either the General Fund or perhaps the tobacco tax. Other members expressed concerns about separating MaineCare reimbursements from the MSA funds, especially considering that the original litigation was related to compensating states for tobacco-related medical treatment costs.

Members had further discussions regarding leveraging cigarette tax and tobacco products tax revenue. Some members were against any tax increase to these products because of the impact on people living in poverty. Others noted that while cigarette use is decreasing, vaping is increasing. It was also noted that there is significant competition for funds to cover various initiatives. Luke Lazure reminded the commission that if tax revenue is redirected it will create a hole in the general fund that the legislature will need to address.

Members discussed whether a finding should be included stating that the current Fund for a Healthy Maine lacks overall guidance and oversight. Members emphasized that the trust structure would allow for long-term planning outside of the two-year budget cycle. There was also discussion about how to deal with the transition to the trust structure.

Members committed to carefully reviewing LD 1523 from the 130th Legislature prior to the fourth meeting.

Members then had a brief discussion about return on investment. It was acknowledged that measuring return on investment in the public health field was challenging. However, there is already existing literature about return on investment for various interventions that the trust may fund, so there is no need to reinvent the wheel if we are funding evidence-based programs.

D. Fourth Meeting – December 11, 2023

The Commission held its final meeting on December 11, 2023. All members were present with the exception of Senator Bennett and Elizabeth Blackwell-Moore. Barbara Leonard, Elsie Flemings and Rebecca Boulos attended the meeting remotely. The meeting began with introductions by Commission members. The Commission then reviewed the work completed at the last meeting and Commission staff explained the process for voting on findings and recommendations. Ana Hicks stated that she will likely abstain from all votes due to the Governor's concerns regarding creation of a trust to administer MSA funds.

The Commission carefully considered LD 1523 and its adopted amendment. This bill served as a useful guide to member discussions and members agreed that any joint standing committee taking up legislation pursuant to the Commission's recommendations would be well served in considering that bill as a template.

The Commission reviewed draft findings and recommendations, which were drafted by Commission staff and intended as a place from which to begin discussion. The Commission discussed each of the draft findings and recommendations, as described below:

1. *Finding: That current allocations will soon outpace revenue, resulting in a structural deficit in the Fund for a Healthy Maine.*

Members were in agreement with this finding.

2. *Finding: That reorganization of the administration of MSA funds is necessary for long-term sustainability of public health funding in the state.*

There was discussion regarding the term "public health funding" and whether that was the best descriptor for the universe of funding this finding was meant to encompass. Some members were in favor of keeping the language broad, while others believe that the language should be altered to more clearly circumscribe the funds that currently sit in the Fund for a Healthy Maine. Ultimately, members agreed that the language should be edited to refer to "health promotion and disease prevention activities," or similar, language which mirrors that of the Fund for a Healthy Maine authorizing statute.

3. *Finding: That additional sources of revenue are necessary for long-term sustainability of public health funding in the state.*

Commission members discussed creation of a structure in which both a new trust is created and the Fund for a Healthy Maine structure is retained. The trust would receive all MSA funds while the Fund for a Healthy Maine would not receive any MSA funds, but would be funded either through the General Fund or other dedicated revenue. Some members were in favor of adding another finding, making it clear that a trust structure was necessary to plan beyond a two-year budget cycle. Members took a straw poll and determined that all members present were in favor of this structure, though Ana Hicks abstained.

4. *Recommendation: That a new fund be created into which MSA funds will be directly deposited; and*

5. *Recommendation: That a new, independent, quasi-state entity be created to administer the fund established per Recommendation #1.*

Committee members were in favor of this recommendation, consistent with the discussion regarding the above draft findings. The committee asked Luke Lazure to describe the current Fund for a Healthy Maine allocations besides those funds allocated to tobacco interventions and prevention and to the Office of the Attorney General. He listed school breakfasts, programs administered by the Finance Authority of Maine, MaineCare, the Drugs for the Elderly program, Head Start, other purchased social services and substance use disorder treatment.

There was also discussion regarding how to deal with the transition period between the Fund for a Healthy Maine and a trust structure. The possibility of a one-time allocation was discussed to

ensure that adequate funding remained in the trust during the initial transition period, but also annually, between when the budget allocations are made and when the State receives its MSA payment.

6. *Recommendation: That additional revenue be allocated to the Fund established per Recommendation #1. (The committee may wish to identify specific sources of funding.)*

It was suggested that language be added recommending that designated funds be deposited directly into the Fund for a Healthy Maine. Otherwise, allocations will need to come from the General Fund. Members discussed the possibility of directing cigarette tax or tobacco products tax revenue directly to the Fund for a Healthy Maine. Currently that tax revenue is deposited into the General Fund.

7. *Recommendation: That the entity established per Recommendation #2 be required to report at least annually to the Legislature regarding its activities, including:*

    a. *management of the Fund established per Recommendation #1;*
    b. *administrative costs;*
    c. *distribution of funds to outside entities and to state entities;*
    d. *performance data; and*
    e. *other information requested by the Legislature.*

Members discussed including some language in this recommendation to require reporting on coordination with DHHS.

Following this discussion, Commission members took votes on the final recommendations of the committee, as described below.

III. FINDINGS AND RECOMMENDATIONS

The final findings and recommendations of the committee, including the votes of committee members are described below. Members who were present at the fourth meeting voted in person or over Zoom. Chairs allowed members who were not present at the fourth meeting to vote via email.[27]

Findings

1. Finding: That the programs currently funded by the Fund for a Healthy Maine are vital and require sustained funding by the Legislature.

Votes: 14 votes in favor; 1 abstention[28]

[27] *See* Appendix G for detailed voting information.
[28] Member Ana Hicks abstained.

While the majority of members agreed that a reorganization of the administration of MSA funds was necessary for long-term viability of public health programming in the State, they were concerned about downstream negative impacts on currently funded programs. The majority of members were in favor of sustained funding for these programs, even if the funds allocated to support the programs were not MSA funds.

2. Finding: That current allocations will soon outpace revenue, resulting in a structural deficit in the Fund for a Healthy Maine.

Votes: 14 votes in favor; 1 abstention[29]

After examination of the financial status of the Fund for a Healthy Maine, including updated revenue forecasting, the majority of members determined that, if current revenue and spending is continued, a structural deficit will eventually result. This will result in the Fund being unable to cover the costs of currently funded activities. The precise time at which a deficit will occur is difficult to predict, because MSA payment totals are uncertain, but trends and forecasting clearly indicate that a deficit is on the horizon.

3. Finding: That reorganization of the administration of MSA funds is necessary for long-term sustainability of funding for prevention and health promotion activities in the State.

Votes: 14 votes in favor; 1 abstention[30]

The majority of members indicated that in order to preserve the prevention and health promotion activities anticipated by the authorizing statute for the Fund for a Healthy Maine, an oversight structure needed to be established to carefully track and administer MSA funds.

4 Finding: That additional sources of revenue are necessary for long-term sustainability of public health commitments in the State.

Votes: 13 votes in favor; 2 abstentions[31]

Members were in agreement that the Fund for a Healthy Maine will soon experience a structural deficit (see Finding #1). Additionally, the majority of members agreed that new sources of revenue were required to assure the long-term sustainability of the State's public health commitments.

5. Finding: That reorganization of the administration of MSA funds is necessary to best track the overall impact of activities funded with MSA funds; to provide accountability over the administration of these funds; and to provide a mechanism for long-term, flexible planning to respond to a changing public health landscape.

Votes: 14 votes in favor; 1 abstention[32]

[29] Member Ana Hicks abstained. Ms. Hicks indicated that she would be abstaining from all votes.
[30] Member Ana Hicks abstained.
[31] Members Ana Hicks and Barbara Leonard abstained.
[32] Member Ana Hicks abstained.

The majority of members indicated that an oversight structure needed to be established to carefully track and administer MSA funds. Members recognized that no single entity currently oversees fund administration; oversight therefore falls to the agencies or entities to which the fund was allocated. This makes it difficult to track the impact of the MSA funds and to thoughtfully plan for the best use of those funds.

Recommendations

1. Recommendation: That a new trust fund be created into which all MSA funds will be directly deposited and that is authorized to receive funds from other sources.

Votes: 14 votes in favor; 1 abstention[33]

The majority of members recommended that the State establish a trust fund and that all MSA funds be deposited directly into that trust fund. They recommended that the fund be set up in such a manner that it is able to receive revenue from any source, public or private.

2. Recommendation: That a new, independent, quasi-state entity be created to administer the fund recommended by the Commission.

Votes: 14 votes in favor; 1 abstention[34]

The majority of members recommended that a new quasi-state entity be created to administer the fund established pursuant to Recommendation #1. They envisioned this entity as a trust, the purpose of which is to provide oversight of the management of MSA funds. While members did not define the exact structure of this entity, they did carefully review LD 1523 and used that piece of legislation as a guide in their discussions. They perceive that a trust would be able to plan long-term for the management of MSA funds outside of the two-year budget cycle.

3. Recommendation: That the entity established in accordance with the Commission's recommendation prioritize funding for the following activities:

- ***a. Tobacco use prevention and intervention activities; and***
- ***b. Public health activities and interventions to address health equity.***

Votes: 14 votes in favor; 1 abstention[35]

The majority of members were in favor of the trust entity using MSA funds to prioritize tobacco use prevention and intervention activities as well as public health activities and interventions addressing issues related to health equity. Members were in favor of prioritizing the least resourced individuals.

[33] Member Ana Hicks abstained.
[34] Member Ana Hicks abstained.
[35] Member Ana Hicks abstained.

4. Recommendation: That the Fund for a Healthy Maine be maintained to fund certain activities currently funded through the Fund, including, but not limited to, MaineCare reimbursements, purchased social services, substance use interventions and treatment, Head Start programming, school breakfasts, medical care payments to providers, the Drugs for the Elderly program, dental education and other activities currently funded through the Fund for a Healthy Maine and administered by the Finance Authority of Maine.

Votes: 14 votes in favor; 1 abstention[36]

While the members largely agreed that a new trust entity should be established to manage MSA funds and to prioritize the activities described in Recommendation #3, they were concerned about maintaining funding for the other activities which the Fund for a Healthy Maine currently supports. Therefore, they recommended that the current Fund for a Healthy Maine and the majority of its statutory structure be maintained, even though MSA funds would be redirected away from the Fund.

5. Recommendation: That a percentage of the cigarette tax and the tobacco products tax be deposited directly into the Fund for a Healthy Maine and used to support the activities described in Recommendation #4.

Votes: 13 votes in favor; 2 abstentions[37]

In order to help ensure that the programs described in Recommendation #4 receive the funding required to be maintained in the absence of MSA funds, a majority of members voted in favor of directing an undetermined percentage of tobacco product and cigarette taxes to be deposited into the Fund for a Healthy Maine. These taxes are currently deposited into the General Fund. Members acknowledged that this would create a significant hole in the General Fund which would need to be backfilled to maintain current allocations.

6. Recommendation: That the entity established per Recommendation #2 be required to report at least annually to the legislative committees of jurisdiction regarding its activities, including:

- ***a. management of the fund established per Recommendation #1;***
- ***b. administrative costs;***
- ***c. distribution of funds to outside entities and to state entities;***
- ***d. coordination of activities with state agencies, including Maine CDC, and the state health plan;***
- ***e. performance data and consideration of return on investments; and***
- ***f. other information requested by the Legislature.***

Votes: 14 votes in favor; 1 abstention[38]

[36] Member Ana Hicks abstained.
[37] Members Ana Hicks and Barbara Leonard abstained.
[38] Member Ana Hicks abstained.

The majority of members voted in favor of requiring the trust entity to provide annual reports to the legislative committee of jurisdiction regarding its activities, including management of the fund established per Recommendation #1; administrative costs; distribution of funds to outside entities and to state entities; coordination of activities with state agencies, including Maine CDC, and the state health plan; performance data and consideration of return on investments; and other information requested by the Legislature. They were particularly concerned with ensuring coordination with state agencies. As regards return on investment, the Commission acknowledged that the limited staff of a trust entity would likely not have the resources to conduct significant calculations regarding return on investment. However, they wanted to ensure that there was some consideration of return on investment, perhaps by consulting existing research.

APPENDIX A

Authorizing Legislation: Resolve 2023, c. 100

LAW WITHOUT GOVERNOR'S SIGNATURE

JULY 19, 2023

CHAPTER 100

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

S.P. 685 - L.D. 1722

Resolve, to Establish the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

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

Whereas, this resolve establishes the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities; and

Whereas, tobacco users are switching to electronic cigarettes, which are not included in the tobacco Master Settlement Agreement pursuant to the lawsuit *State of Maine v. Philip Morris, et al.*, Kennebec County Superior Court, Docket No. CV-97-134; and

Whereas, the switch to electronic cigarettes has diminished the payments to the tobacco Master Settlement Agreement and therefore reduced the funds received by the Fund for a Healthy Maine without reducing the harm to public health from tobacco; and

Whereas, more funds are allocated through the Fund for a Healthy Maine baseline budget than the State receives from the tobacco Master Settlement Agreement, resulting in an unsustainable structural deficit in the Fund for a Healthy Maine; and

Whereas, Fund for a Healthy Maine funds are essential for funding tobacco prevention and treatment, other chronic disease prevention initiatives and health promotion efforts in the State, particularly for the benefit of children and families in the State; and

Whereas, public health problems are seldom solved and health and economic benefits are rarely measurable within a 2-year state budget cycle; and

Whereas, the structural limitations of the State's 2-year budget cycle result in an ongoing loss of opportunities to plan and invest in long-term, evidence-informed primary and secondary chronic disease prevention initiatives; and

Whereas, the State receives funds from multiple legal settlements with manufacturers and excise taxes on products that affect public health and well-being but lacks the system

and structure necessary to maximize benefit through coordinated planning and sustained investment in preventing disease and improving the health of communities in the State; and

Whereas, the work of the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities must be initiated before the 90-day period expires in order that the commission's work may be completed and a report submitted in time for submission to the next legislative session; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities, referred to in this resolve as "the commission," is established.

Sec. 2. Commission membership. Resolved: That, notwithstanding Joint Rule 353, the commission consists of 15 members as follows:

1. Six members appointed by the President of the Senate as follows:

A. One member of the Senate from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs;

B. One member of the Senate from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services;

C. One member with policy expertise or experience in state budgeting and funding improved access to health care for low-income individuals and other populations experiencing inequitable access to health care;

D. One member who has a minimum of 8 years of experience leading a community health coalition and experience working with rural populations;

E. One member who manages a public health endowment for a health system in the State and has experience developing statewide plans for improving health and prosperity; and

F. One member who is currently or was formerly employed as senior staff or faculty for a university in the State with expertise in public health, rural health and health equity financing models;

2. Seven members appointed by the Speaker of the House of Representatives as follows:

A. One member of the House of Representatives from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services;

B. One member of the House of Representatives from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs;

C. One member who represents a statewide association of public health professionals that works to improve and sustain the health and well-being of all people in the State through health promotion, disease prevention and the advancement of health equity;

D. One member who has a minimum of 8 years of experience serving in the Legislature, including service on both the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services;

E. One member who is employed by a philanthropic organization in the State with experience or expertise funding initiatives in public health and primary prevention that advance racial health equity or reduce health disparities;

F. One member who represents a community development financial institution that advances health and economic equity for people and communities in the State through the integration of finance, business expertise and policy solutions; and

G. One member who serves as senior staff for a municipal or county health department;

3. The Director of the Office of Policy Innovation and the Future or the director's designee; and

4. The Attorney General or the attorney general's designee.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair of the commission and the first-named House of Representatives member is the House chair of the commission.

Sec. 4. Appointments; convening of commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the commission to meet and conduct its business.

Sec. 5. Duties. Resolved: That the commission shall evaluate funding models and structures that allow for the sustained investment in the health and prosperity of youth and families in the State and make recommendations for further legislative action. The commission shall prioritize research and recommendations that:

1. Resolve the structural deficit in the Fund for a Healthy Maine;

2. Identify sources of sustained funding for reducing tobacco use, improving public health, preventing chronic illness, reducing health disparities across demographic and geographic populations and improving the community conditions that support good health and wellness;

3. Identify strategies and structural changes that resolve structural inequities and allow funding and investment plans to extend beyond the Legislature's 2-year budget cycle when doing so is necessary for accomplishing their intents and purposes;

4. Advance the long-term goals established by the Legislature for funds received from legal settlements with manufacturers and excise taxes on products that affect public health and well-being;

5. Identify policy and funding models that maximize alignment between the purpose and intent of public health funding sources and the investments in public health and prevention initiatives those funds support;

6. Identify how funding from various public health-related sources could be blended or pooled to achieve common aims in preventing chronic disease, reducing health disparities among historically disenfranchised and vulnerable populations and improving the community conditions that support the health and resilience of youth in the State; and

7. Identify strategies and system changes that would allow for the calculation of return on investment of all proposed public health and prevention measures over a period of time using the projected health and productivity benefits of those investments.

Sec. 6. Staff assistance. Resolved: That, notwithstanding Joint Rule 353, the Legislative Council shall provide necessary staffing services to the commission except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, no later than December 6, 2023, the commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services. After receipt and review of the report, one or both of the joint standing committees may submit legislation relating to the subject matter of the report to any regular or special session of the 131st Legislature.

Sec. 8. Outside funding. Resolved: That the commission may seek funding contributions to fully or partially fund the costs of the study. All funding is subject to approval by the Legislative Council in accordance with its policies.

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

APPENDIX B

Membership List: Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

Membership List

The Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

One member of the Senate from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs	**Sen. Peggy Rotundo, chair**
One member of the House of Representatives from the party holding the largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services	**Rep. Anne Graham, chair**
One member of the Senate from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs or the Joint Standing Committee on Health and Human Services	**Sen. Rick Bennett**
One member of the House of Representatives from the party holding the 2nd largest number of seats in the Legislature who is currently serving on the Joint Standing Committee on Appropriations and Financial Affairs	**Rep. John Ducharme**
One member with policy expertise or experience in state budgeting and funding improved access to health care for low-income individuals and other populations experiencing inequitable access to health care	**Alex Carter (Maine Equal Justice)**
One member who manages a public health endowment for a health system in the State and has experience developing statewide plans for improving health and prosperity	**Barbara Crowley, M.D.**
One member who is currently or was formerly employed as senior staff or faculty for a university in the State with expertise in public health, rural health and health equity financing models	**Yvonne Jonk (Maine Rural Health Research Center)**

One member who has a minimum of 8 years of experience leading a community health coalition and experience working with rural populations	**Elsie Flemings (Healthy Acadia)**
One member who represents a statewide association of public health professionals that works to improve and sustain the health and well-being of all people in the State through health promotion, disease prevention and the advancement of health equity	**Rebecca Boulos (Maine Public Health Association)**
One member who has a minimum of 8 years of experience serving in the Legislature, including service on both the Joint Standing Committee on Appropriations and Financial Affairs and the Joint Standing Committee on Health and Human Services	**Linda Sanborn**
One member who is employed by a philanthropic organization in the State with experience or expertise funding initiatives in public health and primary prevention that advance racial health equity or reduce health disparities	**Barbara Leonard (Maine Health Access Foundation)**
One member who represents a community development financial institution that advances health and economic equity for people and communities in the State through the integration of finance, business expertise and policy solutions	**Keith Bisson (Coastal Enterprises)**
One member who serves as senior staff for a municipal or county health department	**Liz Blackwell Moore (Cumberland County Public Health)**
The Director of the Office of Policy Innovation and the Future or the director's designee	**Ana Hicks**
The Attorney General or the attorney general's designee	**Attorney General Aaron Frey**

APPENDIX C

22 MRSA §1511
(Fund for a Healthy Maine statute)

§1511. Fund for a Healthy Maine established

1. Fund established. The Fund for a Healthy Maine, referred to in this chapter as the "fund," is established for the purposes specified in this chapter as a separate and distinct fund for accounting and budgetary reporting purposes.
[PL 2011, c. 701, §1 (AMD).]

2. Sources of fund. The State Controller shall credit to the fund:

A. All money received by the State in settlement of or in relation to the lawsuit State of Maine v. Philip Morris, et al., Kennebec County Superior Court, Docket No. CV-97-134; [PL 1999, c. 401, Pt. V, §1 (NEW).]

B. Money from any other source, whether public or private, designated for deposit into or credited to the fund; and [PL 1999, c. 401, Pt. V, §1 (NEW).]

C. Interest earned or other investment income on balances in the fund. [PL 1999, c. 401, Pt. V, §1 (NEW).]
[PL 1999, c. 401, Pt. V, §1 (NEW).]

3. Allocation; amounts.
[PL 2001, c. 358, Pt. Q, §1 (RP).]

3-A. Unencumbered balances. Any unencumbered balance remaining at the end of any fiscal year lapses back to the Fund for a Healthy Maine, the account within the Department of Administrative and Financial Services established pursuant to this section, and may not be made available for expenditure without specific legislative approval.
[PL 2001, c. 559, Pt. AA, §3 (NEW); PL 2001, c. 559, Pt. AA, §5 (AFF).]

3-B. Departmental indirect cost allocation plans. Any revenue transfer made on or after July 1, 2000 from a Fund for a Healthy Maine account to another account pursuant to an approved departmental indirect cost allocation plan is determined by the Legislature to be an authorized use of revenue credited to the Fund for a Healthy Maine. The State Budget Officer shall reduce allotment for the amount of any transfer made from a Fund for a Healthy Maine account for the purpose authorized in this subsection.
[PL 2003, c. 513, Pt. Y, §1 (NEW).]

4. Restrictions. This section does not require the provision of services for the purposes specified in subsection 6. When allocations are made to direct services, services to lower income consumers must have priority over services to higher income consumers. Allocations from the fund must be used to supplement, not supplant, appropriations from the General Fund.
[PL 1999, c. 401, Pt. V, §1 (NEW).]

5. General Fund limitation. Notwithstanding any provision to the contrary in this section, any program, expansion of a program, expenditure or transfer authorized by the Legislature using the Fund for a Healthy Maine may not be transferred to the General Fund without specific legislative approval.
[PL 1999, c. 401, Pt. V, §1 (NEW).]

6. Health promotion purposes. Allocations are limited to the following prevention and health promotion purposes:

A. Smoking prevention, cessation and control activities, including, but not limited to, reducing smoking among the children of the State; [PL 1999, c. 401, Pt. V, §1 (NEW).]

A-1. Prevention, education and treatment activities concerning unhealthy weight and obesity; [PL 2011, c. 617, §1 (NEW).]

B. Prenatal and young children's care including home visits and support for parents of children from birth to 6 years of age; [PL 1999, c. 401, Pt. V, §1 (NEW).]

C. Child care for children up to 15 years of age, including after-school care; [PL 1999, c. 401, Pt. V, §1 (NEW).]

D. Health care for children and adults, maximizing to the extent possible federal matching funds; [PL 1999, c. 401, Pt. V, §1 (NEW).]

E. Prescription drugs for adults who are elderly or disabled, maximizing to the extent possible federal matching funds; [PL 1999, c. 401, Pt. V, §1 (NEW).]

F. Dental and oral health care to low-income persons who lack adequate dental coverage; [PL 1999, c. 401, Pt. V, §1 (NEW).]

G. Substance use disorder prevention and treatment; and [PL 2017, c. 407, Pt. A, §71 (AMD).]

H. Comprehensive school health and nutrition programs, including school-based health centers. [PL 2007, c. 539, Pt. IIII, §3 (AMD).]

[PL 2017, c. 407, Pt. A, §71 (AMD).]

7. Investment; plan; report.

[PL 2001, c. 358, Pt. Q, §3 (RP).]

8. Report by Treasurer of State. The Treasurer of State shall report at least annually on or before the 2nd Friday in December to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters. The report must summarize the activity in any funds or accounts directly related to this section.

[PL 2001, c. 358, Pt. Q, §4 (NEW).]

9. Working capital advance. Beginning July 1, 2003, the State Controller is authorized to provide an annual advance up to $37,500,000 from the General Fund to the fund to provide money for allocations from the fund. This money must be returned to the General Fund as the first priority from the amounts credited to the fund pursuant to subsection 2, paragraph A.

[PL 2001, c. 714, Pt. OO, §1 (NEW).]

10. Restricted accounts.

[PL 2003, c. 687, Pt. B, §6 (RP); PL 2003, c. 687, Pt. B, §11 (AFF).]

11. Restricted accounts. The State Controller is authorized to establish separate accounts within the fund in order to segregate money received by the fund from any source, whether public or private, that requires as a condition of the contribution to the fund that the use of the money contributed be restricted to one or more of the purposes specified in subsection 6. Money credited to a restricted account established under this subsection may be applied only to the purposes to which the account is restricted.

[PL 2003, c. 687, Pt. A, §9 (NEW); PL 2003, c. 687, Pt. B, §11 (AFF).]

12. Adjustment to allocations. For state fiscal years beginning on or after July 1, 2008, the State Budget Officer is authorized to adjust allocations if actual revenue collections for the fiscal year are less than the approved legislative allocations. The State Budget Officer shall review the programs receiving funds from the fund and shall adjust the funding in the All Other line category to stay within available resources. These adjustments must be calculated in proportion to each account's allocation in the All Other line category in relation to the total All Other allocation for fund programs. Notwithstanding any other provision of law, the allocation for the identified amounts may be reduced by financial order upon the recommendation of the State Budget Officer and approval of the Governor. The State Budget Officer shall report annually on the allocation adjustments made pursuant to this subsection to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters by May 15th.

[PL 2009, c. 1, Pt. F, §1 (NEW).]

13. Separate accounts; annual reporting. A state agency that receives allocations from the fund and a contractor or vendor that receives funding allocated from the fund shall maintain that money in a separate account and shall report by September 1st of each year to the Commissioner of Administrative and Financial Services providing a description of how those funds for the prior state fiscal year were targeted to the prevention and health-related purposes listed in subsection 6. The Commissioner of Administrative and Financial Services shall by October 1st of each year compile the reports provided under this subsection and forward the information in a report to the Legislature.
[PL 2011, c. 701, §2 (NEW).]

REVISOR'S NOTE: (Subsection 13 as enacted by PL 2011, c. 655, Pt. M, §1 is REALLOCATED TO TITLE 22, SECTION 1511, SUBSECTION 15)

14. Legislative committee review of legislation. Whenever a proposal in a resolve or bill before the Legislature, including but not limited to a budget bill, affects the fund, the joint standing committee of the Legislature having jurisdiction over the proposal shall hold a public hearing and determine the level of support for the proposal among members of the committee. If there is support for the proposal among a majority of the members of the committee, the committee shall request the joint standing committee of the Legislature having jurisdiction over health and human services matters to review and evaluate the proposal as it pertains to the fund. The joint standing committee of the Legislature having jurisdiction over health and human services matters shall conduct the review and report to the committee of jurisdiction and to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.
[PL 2011, c. 701, §2 (NEW).]

15. (REALLOCATED FROM T. 22, §1511, sub-§13) Attrition adjustment. For state fiscal years beginning on or after July 1, 2012, the State Budget Officer is authorized to adjust allocations to address shortfalls that occur as a direct result of Personal Services allocation reductions for projected vacancies. Accrued savings generated from vacant positions within a Fund for a Healthy Maine account's allocation for Personal Services or available balances in the Fund for a Healthy Maine program within the Department of Administrative and Financial Services may be transferred by financial order to offset Personal Services shortfalls in other Fund for a Healthy Maine accounts except that these transfers are subject to review by the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs.
[RR 2011, c. 2, §24 (RAL).]

SECTION HISTORY

PL 1999, c. 401, §V1 (NEW). PL 2001, c. 358, §§Q1-4 (AMD). PL 2001, c. 559, §AA3 (AMD). PL 2001, c. 559, §AA5 (AFF). PL 2001, c. 714, §OO1 (AMD). IB 2003, c. 1, §6 (AMD). PL 2003, c. 513, §Y1 (AMD). PL 2003, c. 687, §§A9,B6 (AMD). PL 2003, c. 687, §B11 (AFF). PL 2007, c. 539, Pt. IIII, §3 (AMD). PL 2009, c. 1, Pt. F, §1 (AMD). RR 2011, c. 2, §24 (COR). PL 2011, c. 617, §1 (AMD). PL 2011, c. 655, Pt. M, §1 (AMD). PL 2011, c. 701, §§1, 2 (AMD). PL 2017, c. 407, Pt. A, §71 (AMD).

APPENDIX D

Fund for a Healthy Maine Allocations FY 2015-16 to FY 2024-25

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
DEPARTMENT OF THE ATTORNEY GENERAL										
024-26A-0947-01 FHM - ATTORNEY GENERAL (FORMERLY 011-26A-0947)										
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)	(1.000)
Pers. Serv.	116,600	$118,540	121,765	$127,517	140,826	$147,220	109,765	$115,063	144,239	$151,768
All Other	21,542	19,628	19,628	19,628	20,860	20,860	21,164	21,164	23,456	23,456
Program Total	138,142	138,168	141,393	147,145	161,686	168,080	130,929	136,227	167,695	175,224
Annual % Increase	-8.11%	0.02%	2.33%	4.07%	9.88%	3.95%	-22.10%	4.05%	23.10%	4.49%
DEPARTMENT OF THE ATTORNEY GENERAL										
Pos. - Leg.	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**	**(1.000)**
Pers. Serv.	**116,600**	**118,540**	**121,765**	**127,517**	**140,826**	**147,220**	**109,765**	**115,063**	**144,239**	**151,768**
All Other	**21,542**	**19,628**	**19,628**	**19,628**	**20,860**	**20,860**	**21,164**	**21,164**	**23,456**	**23,456**
Dept. Total	**138,142**	**138,168**	**141,393**	**147,145**	**161,686**	**168,080**	**130,929**	**136,227**	**167,695**	**175,224**
Annual % Increase	**-8.11%**	**0.02%**	**2.33%**	**4.07%**	**9.88%**	**3.95%**	**-22.10%**	**4.05%**	**23.10%**	**4.49%**
DEPARTMENT OF EDUCATION										
024-05A-Z068-01 FHM - SCHOOL BREAKFAST PROGRAM (FORMERLY 011-05A-Z068-01)										
All Other	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720
Program Total	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720	213,720
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
DEPARTMENT OF EDUCATION										
Pos. - Leg.	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
All Other	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**
Dept. Total	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**	**213,720**
Annual % Increase	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
FINANCE AUTHORITY OF MAINE										
024-94F-0950-02 FHM - HEALTH EDUCATION CENTERS (FORMERLY 011-94F-0950-02)										
All Other	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000
Program Total	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000	110,000
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

		2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
024-94F-0951-01	FHM - DENTAL EDUCATION										
All Other		237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740
Program Total		237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740	237,740
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-94F-Z229-01	MAINE HARVESTED FOOD PRODUCTS FOR RESIDENTS WITH FOOD INSECURITY										
All Other		0	3,000,000	0	0	0	0	0	0	0	0
Program Total		0	3,000,000	0	0	0	0	0	0	0	0
Annual % Increase		0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
FINANCE AUTHORITY OF MAINE											
Pos. - Leg.		**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pos. - Other		**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**	**(0.000)**
Pers. Serv.		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
All Other		**347,740**	**3,347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**
Dept. Total		**347,740**	**3,347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**	**347,740**
Annual % Increase		**0.00%**	**862.71%**	**-89.61%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY DHS)											
024-10A-0143-25	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: ORAL HEALTH) (FORMERLY FHM - BUREAU OF HEALTH - ORAL HEALTH 011-10A-0953-01)										
All Other		300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Program Total		300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000	300,000
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0143-30	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: TOBACCO PREVENTION AND CONTROL) (FORMERLY FHM - BUREAU OF HEALTH - TOBACCO PREVENTION AND CONTROL 011-10A-0953-02)										
Pos. - Leg.		(6.000)	(6.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)	(5.000)
Pers. Serv.		485,716	500,277	421,714	433,766	429,777	455,616	461,328	471,236	480,330	497,608
All Other		5,821,987	5,821,987	3,824,805	3,825,247	8,825,247	8,825,247	3,825,247	11,325,247	11,325,247	11,325,247
Program Total		6,307,703	6,322,264	4,246,519	4,259,013	9,255,024	9,280,863	4,286,575	11,796,483	11,805,577	11,822,855
Annual % Increase		-1.71%	0.23%	-32.83%	0.29%	117.30%	0.28%	-53.81%	175.20%	0.08%	0.15%
024-10A-0143-31	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: FHM - SUBSTANCE ABUSE PREVENTION)										
All Other		0	0	777,504	777,504	777,504	777,504	777,504	777,504	777,504	777,504
Program Total		0	0	777,504	777,504	777,504	777,504	777,504	777,504	777,504	777,504
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
024-10A-0143-26	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: COMMUNITY/ SCHOOL GRANTS & STATEWIDE COORDINATION) (FORMERLY FHM - BUREAU OF HEALTH - COMMUNITY/SCHOOL GRANTS 011-10A-0953-07)									
Pos. - Leg.	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)	(0.000)
Pers. Serv.	204,118	212,539	256,270	262,731	272,447	286,307	295,591	298,900	308,406	313,114
All Other	4,781,144	4,781,144	1,750,939	2,351,108	2,511,108	2,511,108	2,511,108	2,511,108	2,511,108	2,511,108
Program Total	4,985,262	4,993,683	2,007,209	2,613,839	2,783,555	2,797,415	2,806,699	2,810,008	2,819,514	2,824,222
Annual % Increase	-0.67%	0.17%	-59.81%	30.22%	6.49%	0.50%	0.33%	0.12%	0.34%	0.17%
024-10A-0143-27	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: PUBLIC HEALTH INFRASTRUCTURE) (FORMERLY FHM - PUBLIC HEALTH INFRASTRUCTURE 011-10A-0953-08)									
Pos. - Leg.	(1.000)	(1.000)	(1.000)	(1.000)	(7.000)	(7.000)	(7.000)	(7.000)	(8.000)	(8.000)
Pers. Serv.	544,187	714,255	524,984	545,296	1,270,949	1,356,042	606,688	623,348	766,294	784,245
All Other	1,990,109	1,944,926	1,638,542	1,594,225	2,057,483	2,237,980	2,237,980	2,237,980	2,244,581	2,244,585
Program Total	2,534,296	2,659,181	2,163,526	2,139,521	3,328,432	3,594,022	2,844,668	2,861,328	3,010,875	3,028,830
Annual % Increase	86.91%	4.93%	-18.64%	-1.11%	55.57%	7.98%	-20.85%	0.59%	5.23%	0.60%
024-10A-0143-28	MAINE CENTER FOR DISEASE CONTROL AND PREVENTION (ACCOUNT NAME: DONATED DENTAL) (FORMERLY FHM - DONATED DENTAL 011-10A-0958-01)									
All Other	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463
Program Total	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463	36,463
Annual % Increase	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0545-04	HEAD START (FORMERLY FHM - HEAD START 011-10A-0959-01)									
All Other	1,929,580	1,929,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580
Program Total	1,929,580	1,929,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580	1,354,580
Annual % Increase	42.45%	0.00%	-29.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-0147-01	MEDICAL CARE - PAYMENTS TO PROVIDERS (FORMERLY FHM - MEDICAL CARE 011-10A-0960-01)									
All Other	25,901,244	26,036,930	31,036,930	31,036,930	31,036,930	27,118,732	25,618,328	26,261,358	31,028,356	32,022,910
Program Total	25,901,244	26,036,930	31,036,930	31,036,930	31,036,930	27,118,732	25,618,328	26,261,358	31,028,356	32,022,910
Annual % Increase	-6.39%	0.52%	19.20%	0.00%	0.00%	-12.62%	-5.53%	2.51%	18.15%	3.21%
024-10A-0228-01	PURCHASED SOCIAL SERVICES (FORMERLY FHM - PURCHASED SOCIAL SERVICES 011-10A-0961-01)									
All Other	1,971,118	1,971,118	1,971,118	1,971,118	4,471,118	4,471,118	1,971,118	1,971,118	1,971,118	1,971,118
Program Total	1,971,118	1,971,118	1,971,118	1,971,118	4,471,118	4,471,118	1,971,118	1,971,118	1,971,118	1,971,118
Annual % Increase	0.00%	0.00%	0.00%	0.00%	126.83%	0.00%	-55.91%	0.00%	0.00%	0.00%

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

		2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
024-10A-0202-01	LOW-COST DRUGS TO MAINE'S ELDERLY (FORMERLY FHM - DRUGS OF THE ELDERLY AND DISABLED 011-10A-Z015-01)										
All Other		6,217,798	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095
Program Total		6,217,798	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095	6,082,095
Annual % Increase		-9.86%	-2.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
024-10A-Z202-41	OFFICE OF SUBSTANCE ABUSE - MEDICAD SEED (FORMERLY OFFICE OF SUBSTANCE ABUSE - MEDICAD SEED 024-14G-0844-01)										
All Other		1,306,059	1,306,059	1,306,059	1,306,059	1,306,059	1,141,178	1,078,041	1,105,099	1,305,698	1,347,550
Program Total		1,306,059	1,306,059	1,306,059	1,306,059	1,306,059	1,141,178	1,078,041	1,105,099	1,305,698	1,347,550
Annual % Increase		0.00%	0.00%	0.00%	0.00%	0.00%	-12.62%	-5.53%	2.51%	18.15%	3.21%
024-10A-Z199-01	OFFICE OF SUBSTANCE ABUSE (FORMERLY OFFICE OF SUBSTANCE ABUSE 024-14G-0679-01)										
All Other		1,848,306	1,848,306	1,070,802	1,070,802	1,698,223	2,075,644	1,070,802	1,070,802	1,070,802	1,070,802
Program Total		1,848,306	1,848,306	1,070,802	1,070,802	1,698,223	2,075,644	1,070,802	1,070,802	1,070,802	1,070,802
Annual % Increase		0.00%	0.00%	-42.07%	0.00%	58.59%	22.22%	-48.41%	0.00%	0.00%	0.00%
024-10A-Z199-02	OFFICE OF SUBSTANCE ABUSE (FORMERLY OFFICE OF SUBSTANCE ABUSE 024-14G-0679-01)										
All Other		0	0	0	0	2,000,000	3,500,000	1,000,000	1,000,000	0	0
Program Total		0	0	0	0	2,000,000	3,500,000	1,000,000	1,000,000	0	0
Annual % Increase		0.00%	0.00%	0.00%	0.00%	100.00%	75.00%	-71.43%	0.00%	-100.00%	0.00%
DEPARTMENT OF HEALTH AND HUMAN SERVICES (FORMERLY DHS)											
Pos. - Leg.		**(7.000)**	**(7.000)**	**(6.000)**	**(6.000)**	**(12.000)**	**(12.000)**	**(12.000)**	**(12.000)**	**(13.000)**	**(13.000)**
Pers. Serv.		**1,234,021**	**1,427,071**	**1,202,968**	**1,241,793**	**1,973,173**	**2,097,965**	**1,363,607**	**1,393,484**	**1,555,030**	**1,594,967**
All Other		**52,103,808**	**52,058,608**	**51,149,837**	**51,706,131**	**62,456,810**	**60,431,649**	**47,863,266**	**56,033,354**	**60,007,552**	**61,043,962**
Dept. Total		**53,337,829**	**53,485,679**	**52,352,805**	**52,947,924**	**64,429,983**	**62,529,614**	**49,226,873**	**57,426,838**	**61,562,582**	**62,638,929**
Annual % Increase		**-3.47%**	**0.28%**	**-2.12%**	**1.14%**	**21.69%**	**-2.95%**	**-21.27%**	**16.66%**	**7.20%**	**1.75%**

Fund for a Healthy Maine (FHM) Allocations

Adjusted for Departmental Reorganizations[1]

Allocations through 131st Legislature 1st Special Session

FY 2015-16 to FY 2024-25

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
MAINE STATE HOUSING AUTHORITY										
024-99H-Z267-01 LEAD ABATEMENT FUND										
All Other	0	0	0	4,000,000	0	0	0	0	0	0
Program Total	0	0	0	4,000,000	0	0	0	0	0	0
Annual % Increase	0.00%	0.00%	0.00%	0.00%	-100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
MAINE STATE HOUSING AUTHORITY										
All Other	**0**	**0**	**0**	**4,000,000**	**0**	**0**	**0**	**0**	**0**	**0**
Dept. Total	**0**	**0**	**0**	**4,000,000**	**0**	**0**	**0**	**0**	**0**	**0**
Annual % Increase	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**-100.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
GRAND TOTALS - ALL DEPARTMENTS										
Pos. - Leg.	**(8.000)**	**(8.000)**	**(7.000)**	**(7.000)**	**(13.000)**	**(13.000)**	**(13.000)**	**(13.000)**	**(14.000)**	**(14.000)**
Pers. Serv.	**1,350,621**	**1,545,611**	**1,324,733**	**1,369,310**	**2,113,999**	**2,245,185**	**1,473,372**	**1,508,547**	**1,699,269**	**1,746,735**
All Other	**52,686,810**	**55,639,696**	**51,730,925**	**56,287,219**	**63,039,130**	**61,013,969**	**48,445,890**	**56,615,978**	**60,592,468**	**61,628,878**
Grand Total	**54,037,431**	**57,185,307**	**53,055,658**	**57,656,529**	**65,153,129**	**63,259,154**	**49,919,262**	**58,124,525**	**62,291,737**	**63,375,613**
Annual % Increase	**-3.45%**	**5.83%**	**-7.22%**	**8.67%**	**13.00%**	**-2.91%**	**-21.09%**	**16.44%**	**7.17%**	**1.74%**

Notes:

[1]FHM programs and allocations have been modified to reflect the transfer of all FORMERLY BDS funding to new accounts in the FORMERLY DHS Department.

APPENDIX E

Fund for a Healthy Maine Revenue Forecasting Recommendation – May 2023

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2023 FORECAST

Source	FY19 Actual	% Chg.	FY20 Actual	% Chg.	FY21 Actual	% Chg.	FY22 Actual	% Chg.	FY23 Budget	% Chg.	Recom. Chg.	FY23 Revised	% Chg.
Tobacco Settlement Payments:													
- Base Payments	45,465,742	-2.6%	46,272,664	1.8%	48,584,349	5.0%	49,858,288	2.6%	48,227,310	-3.3%	4,006,743	52,234,053	4.8%
- One-time DPA Settlements *	32,488,828	52.9%	0	-100.0%	0	N/A	0	N/A	0	N/A	0	0	N/A
- Strategic Contribution Payments **	0	N/A	0	N/A	0	N/A	0	N/A	0	N/A	0	0	N/A
Subtotal TSPs	77,954,570	14.8%	46,272,664	-40.6%	48,584,349	5.0%	49,858,288	2.6%	48,227,310	-3.3%	4,006,743	52,234,053	4.8%
Casino Revenue ***	3,640,004	-1.09%	2,773,875	-23.79%	3,376,375	21.7%	4,446,875	31.7%	4,776,003	7.4%	(147,190)	4,628,813	4.1%
Income from Investments	583,469	298.5%	496,816	-14.9%	115,798	-76.7%	160,121	38.3%	613,583	283.2%	84,525	698,108	336.0%
Other Adjustments ****	0	N/A	0	N/A	(994,035)	N/A	272,464	127.4%	0	-100.0%	0	0	-100.0%
Total - FHM Revenue	**82,178,042**	**14.6%**	**49,543,354**	**-39.7%**	**51,082,487**	**3.1%**	**54,737,748**	**7.2%**	**53,616,896**	**-2.0%**	**3,944,078**	**57,560,974**	**5.2%**

* FY 18 and 19 include a “one-time” settlement payment from tobacco manufacturers to settle the NPM Adjustment dispute for the years 2004 through 2017.

** Beginning in FY 18, the ten-year strategic contribution payment ended with the funding nationally for this purpose returned to the regular distribution pool.

*** Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the Hollywood Casino in Bangor designated for the Fund for a Healthy Maine.

****Adjustments for prior year balances forward and audit settlements

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2023 FORECAST

Source	FY24 Budget	% Chg.	Recom. Chg.	FY24 Revised	% Chg.	FY25 Budget	% Chg.	Recom. Chg.	FY25 Revised	% Chg.
Tobacco Settlement Payments:										
- Base Payments	34,725,954	-28.0%	0	34,725,954	-33.5%	32,277,028	-7.1%	0	32,277,028	-7.1%
- One-time DPA Settlements *	0	N/A	0	0	N/A	0	N/A	0	0	N/A
- Strategic Contribution Payments **	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Subtotal TSPs	34,725,954	-28.0%	0	34,725,954	-33.5%	32,277,028	-7.1%	0	32,277,028	-7.1%
Casino Revenue ***	5,157,870	8.0%	163,367	5,321,237	15.0%	5,157,921	0.0%	163,369	5,321,290	0.0%
Income from Investments	745,802	21.5%	38,191	783,993	12.3%	329,402	-55.8%	22,623	352,025	-55.1%
Other Adjustments ****	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Total - FHM Revenue	**40,629,626**	**-24.2%**	**201,558**	**40,831,184**	**-29.1%**	**37,764,351**	**-7.1%**	**185,992**	**37,950,343**	**-7.1%**
Change in Biennial Totals								**387,550**		

* FY 18 and 19 include a “one-time” settlement payment from tobacco manufacturers to settle the NPM Adjustment dispute for the years 2004 through 2017.

** Beginning in FY 18, the ten-year strategic contribution payment ended with the funding nationally for this purpose returned to the regular distribution pool.

*** Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the Hollywood Casino in Bangor designated for the Fund for a Healthy Maine.

****Adjustments for prior year balances forward and audit settlements

FUND FOR A HEALTHY MAINE (FHM) REVENUE
(TOBACCO SETTLEMENT PAYMENTS)
REVENUE FORECASTING COMMITTEE RECOMMENDATIONS - MAY 2023 FORECAST

Source	FY26 Budget	% Chg.	Recom. Chg.	FY26 Revised	% Chg.	FY27 Budget	% Chg.	Recom. Chg.	FY27 Revised	% Chg.
Tobacco Settlement Payments:										
- Base Payments	32,277,028	0.0%	0	32,277,028	0.0%	32,277,028	0.0%	0	32,277,028	0.0%
- One-time DPA Settlements *	0	N/A	0	0	N/A	0	N/A	0	0	N/A
- Strategic Contribution Payments **	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Subtotal TSPs	32,277,028	0.0%	0	32,277,028	0.0%	32,277,028	0.0%	0	32,277,028	0.0%
Casino Revenue ***	5,157,973	0.0%	163,370	5,321,343	0.0%	5,158,025	0.0%	163,371	5,321,396	0.0%
Income from Investments	329,402	0.0%	(103,867)	225,535	-35.9%	329,402	0.0%	(171,757)	157,645	-30.1%
Other Adjustments ****	0	N/A	0	0	N/A	0	N/A	0	0	N/A
Total - FHM Revenue	**37,764,403**	**0.0%**	**59,503**	**37,823,906**	**-0.3%**	**37,764,455**	**0.0%**	**(8,386)**	**37,756,069**	**-0.2%**
Change in Biennial Totals								**51,117**		

* FY 18 and 19 include a “one-time” settlement payment from tobacco manufacturers to settle the NPM Adjustment dispute for the years 2004 through 2017.

** Beginning in FY 18, the ten-year strategic contribution payment ended with the funding nationally for this purpose returned to the regular distribution pool.

*** Casino Revenue reflects that portion of the State's share of proceeds from slot machines at the Hollywood Casino in Bangor designated for the Fund for a Healthy Maine.

****Adjustments for prior year balances forward and audit settlements

APPENDIX F

50 State Summary – Administration of MSA Funds

State Survey - Management of Tobacco Settlement Funds

STATE	DESCRIPTION	STATUTES/ REGS	LINKS
Alabama	Alabama established the *21st Century Trust Fund* to receive settlement money. Fund appropriations are controlled by the Legislature. $13 million is used for debt service on economic development bonds. Remaining dollars are split between the *Children First Trust Fund*, Medicaid and several smaller initiatives.	• Children First Trust Fund: Ala. Code § 41-15B-2.2	• Alabama Department of Early Childhood Education. *About the Children First Trust Fund*. https://children.alabama.gov/for-advocates/children-first-trust-fund/ • Alabama Children's Policy Council. Children First Trust Fund Annual Reports. http://www.alcpc.org/childrenfirsttrustfund/
Alaska	Alaska established the *Northern Tobacco Securitization Corporation* in 2000 with the goal of securitizing a portion of MSA funds to direct to public housing. The Corporation is a nonprofit public corporation authorized to issue bonds on behalf of the state. State law also established the *Tobacco Use Education and Cessation Fund,* a non dedicated special account in the general fund into which 20% of settlement money is to be deposited for the purpose of tobacco education and prevention.	• Tobacco Use Education and Cessation Fund: AS 37.05.580	• Alaska Housing Finance Corporation. *Northern Tobacco Securitization Corporation*. https://www.ahfc.us/about-us/subsidiaries/ntsc
Arizona	In 2000, Arizona voters passed Proposition 204, which requires all MSA payments to be directed to the Arizona Health Care Cost Containment System, the state's Medicaid agency.	• Prop 204 resulting statutes: Ariz. Rev. Stat. § 36-2901.01 and .02	• Arizona Attorney General. *Master Settlement Agreement*. https://www.azag.gov/consumer/tobacco/msa • Arizona Attorney General. *Proposition 204*. https://www.azag.gov/opinions/i01-008-r00-072.

Arkansas	Arkansas's MSA funds are deposited into the *Tobacco Settlement Program Fund*, overseen by the Arkansas *Tobacco Settlement Commission*. Seven programs receive funding to provide various services, including services for older adults, public health workforce development, healthcare outreach, biomedical research, tobacco cessation and prevention, Medicaid, and minority health.	• Tobacco Settlement Program Fund: Ark. Code § 19-12-108	• Arkansas Department of Health. *Arkansas Tobacco Settlement Commission*. https://www.healthy.arkansas.gov/programs-services/topics/arkansas-tobacco-settlement-commission • Arkansas Attorney General. *Tobacco.* https://arkansasag.gov/arkansass-lawyer/public-protection-department/tobacco
California	California established the *Golden State Tobacco Securitization Corporation*, a not for profit trust of the state. The Corporation purchases California's rights to future MSA revenues and issues bonds for the purchase of tobacco assets from the state.	• Tobacco Settlement State Securitization: California Government Code §§ 63049 - 63049.55	• Golden State Securitization Corporation http://goldenstatetsc.org/ • California Attorney General. *Tobacco Master Settlement Agreement Summary*. https://oag.ca.gov/tobacco/resources/msasumm#:~:text=The%20Settlement%3A%20Requires%20the%20industry%20each%20year%20for,the%20prevention%20of%20diseases%20associated%20with%20tobacco%20use.
Colorado	Colorado deposits its MSA payments into its *Tobacco Litigation Settlement Cash Fund*, from which funds are distributed by the legislature to various programs, including for children's health, nursing services, youth services, HIV and AIDS services and prevention, health care workforce education, immunizations, state employee insurance costs and veterans' services.	• Tobacco Litigation Settlement Cash Fund: C.R.S. 24-22-115	• Colorado Legislative Council memorandum. *2023 Tobacco Master Settlement Agreement Payment Forecast.* March 3, 2023. https://leg.colorado.gov/sites/default/files/r22-1074_2023_tobacco_msa_forecast.pdf
Connecticut	Connecticut established the *Tobacco Settlement Fund* and the *Tobacco Health and Trust Fund* in 1999. All MSA payments are deposited into the Tobacco Settlement Fund. The Tobacco Health and Trust Fund	• Tobacco Settlement Fund: Conn. Gen. Stat. § 4-28e • Tobacco Health and Trust Fund: Conn. Gen. Stat. § 4-28f	• State of Connecticut Office of Policy and Management. Tobacco and Health Trust Fund Board. https://portal.ct.gov/OPM/PDPD-HHS/Tobacco-and-Health-Trust-Fund-Board

	receives a small portion of MSA funds for tobacco cessation and prevention. The large majority of MSA funds are directed to the General Fund. The Trust Fund ceased to receive MSA funds in 2016 but resumed in 2022.		
Delaware	Delaware established the *Delaware Health Fund* in 1999 to receive MSA funds and the *Delaware Health Fund Advisory Committee* was established to make recommendations for the appropriation of MSA funds from the Delaware Health Fund.	• Delaware Health Fund: 16 Del C. §137	• Delaware Department of Health and Human Services. Delaware Health Fund Advisory Committee. https://www.dhss.delaware.gov/dhss/healthfund/
Florida	Florida settled with tobacco manufacturers prior to the settlement in which the majority of states participated. In 2006, a state constitutional amendment was passed to create a tobacco education and prevention program with a portion of the settlement money. *Tobacco Free Florida* was established as a result.	• Article X, Section 27, Florida Constitution. Comprehensive Statewide Tobacco Education and Prevention Program.	• Tobacco Free Florida. https://tobaccofreeflorida.com/about-us/
Georgia	Georgia directs its MSA payments to the state treasury and funds are allocated by the legislature.		• Office of the Attorney General. *Tobacco.* https://law.georgia.gov/tobacco
Hawai‘i	Hawai‘i established the *Hawai‘i Tobacco Prevention and Control Trust Fund* to receive MSA funds and contracts with the *Hawai‘i Community Foundation* to administer the fund.	• Hawai‘i Tobacco Prevention and Control Trust Fund: Haw. Rev. Stat. § 328L-5	• Hawai‘i Community Foundation. Hawai‘I Tobacco Prevention and Control Trust Fund. https://www.hawaiicommunityfoundation.org/strengthening/hawaii-tobacco-prevention-and-control-trust-fund
Idaho	Most MSA payments are deposited into Idaho’s millennium Fund. A portion is used for anti smoking education and outreach.		• Office of the Attorney General State of Idaho. *Tobacco*. https://www.ag.idaho.gov/consumer-protection/tobacco-settlement/

Illinois	Illinois established the *Railsplitter Tobacco Settlement Authority*, a special purpose corporation and body politic of the state, to oversee the use of MSA funds.	• Railsplitter Tobacco Settlement Authority: 30 ILCS 105/6z-43	• State of Illinois Capital Markets. Railsplitter Tobacco Settlement Authority. https://capitalmarkets.illinois.gov/railsplitter-tobacco-settlement-authority.html
Indiana	Indiana created the *Indiana Tobacco Prevention and Cessation Agency* to receive settlement funds. This independent state agency was eliminated in 2011 and funds were diverted to the Indiana State Department of Health.		• Jay SJ, Torabi MR, Spitznagle MH. A decade of sustaining best practices for tobacco control: Indiana's story. Prev Chronic Dis 2012;9:110144. https://www.cdc.gov/pcd/issues/2012/11_0144.htm
Iowa	In 2001, the *Tobacco Settlement Authority* purchased all of Iowa's MSA payments as well as the state's rights to receive payments pursuant to the MSA. Funds were deposited into the *Tobacco Settlement Trust Fund*. The Authority issued bonds and distributed net proceeds to the state. The unpledged portion of revenues are paid directly to the state.	• Tobacco Settlement Authority: Iowa Code 12E • Tobacco Settlement Trust Fund: Iowa Code 12E.12	• Summary of Iowa's Tobacco Settlement, Iowa Legislature. 2011. https://www.legis.iowa.gov/docs/publications/SD/14467.pdf#:~:text=Iowa%20receives%20annual%20payments%20from%20the%20tobacco%20industry,payments%20range%20from%20%2439.0%20million%20to%20%2462.0%20million. • Tobacco Settlement Authority Financial Report. June 30, 2022. https://www.legis.iowa.gov/docs/publications/DF/1313168.pdf • Iowa Torch. Iowa receives $53.2 million tobacco payment. April 20, 2022. https://iowatorch.com/2022/04/20/iowa-receives-53-2-million-tobacco-payment/
Kansas	Kansas established the *Kansas Endowment for Youth* to receive MSA payments in 1999. The state also established the *Children's Initiatives Fund*, to receive money from the Endowment, and the *Children's Cabinet* to advise the governor and legislature on the best use of funds.	• Kansas Endowment for Youth Fund: K.S.A. 38-2101 and 2103-5 • Children's Initiatives Fund: K.S.A. 38-2102	• Tobacco Settlement Update. Kansas Legislative research Document. Nov. 17. 2020. https://www.kslegresearch.org/KLRD-web/Publications/HealthCare/Tobaccosettlement_Nov2020.pdf

Kentucky	Kentucky created the *Tobacco Settlement Agreement Fund Oversight Committee*, a committee of the Kentucky legislature, to oversee the use of MSA money.		• Kentucky General Assembly. Statutory Committee Tobacco Settlement Agreement Fund Oversight Committee. https://apps.legislature.ky.gov/CommitteeDocuments/166/ • Kentucky Attorney General. Tobacco Master Settlement Agreement. https://www.ag.ky.gov/about/Office-Divisions/OCEL/Pages/Tobacco-Master-Settlement-Agreement.aspx
Louisiana	Louisiana established the *Millennium Trust*, the *Louisiana Fund* and the *Millennium Leverage Fund* to receive a MSA funds. Some funds are invested and other allocated for various state programs.	• The Millennium Trust: CONST 7 10.8 • The Louisiana Fund: CONST 7 10.9 • The Millennium Leverage Fund: CONST 7 10.10	• Louisiana Attorney General. Tobacco Enforcement. http://www.ag.state.la.us/Tobacco
Maryland	Maryland created *the Cigarette Restitution Fund* in 2001 to receive MSA funds. Funds are allocated to support the tobacco use prevention and cessation; cancer screening, education and treatment; Medicaid services; and other public health initiatives.	• Cigarette Restitution Fund: Md Code. State Finance and Procurement §7–317	• Maryland Attorney General. *Frequently Asked Questions About the Tobacco Settlement*. https://www.marylandattorneygeneral.gov/Pages/Tobacco/FAQ.aspx#q10
Massachusetts	Maryland appears to direct most of its MSA funds to the general fund, but information is scant.		• Massachusetts Office of the Attorney General. The Tobacco Master Settlement Agreement. https://www.mass.gov/info-details/the-tobacco-master-settlement-agreement
Michigan	In 2005, a portion of MSA funds were securitized to fund the *21st Century Jobs Fund* and in 2017 additional funds were securitized to balance the state budget. As a result, a portion of annual MSA funds are used in debt service. A portion of funds are also	• Michigan Tobacco Settlement Finance Authority Act: MCL 12.194 • 21st Century Jobs Fund: MCL 12.257	• House Fiscal Agency. Memorandum Re. Tobacco Settlement Funds. December 11, 2013. https://www.house.mi.gov/hfa/PDF/Tobacco_Settlement_Funds.pdf

	deposited in the *Merit Award Trust Fund.* The Tobacco Settlement Finance Authority is a public body corporate and politic within the treasury and authorized to issue bonds.	• Michigan Merit Award Trust Fund: MCL 12.259 • Michigan Tobacco Settlement Finance Authority: MCL 129.264	
Minnesota	Minnesota settled with manufacturers prior to the MSA. The state created the *Tobacco Securitization Authority* to manage the funds and issue bonds.	• Tobacco Securitization Authority: Minn. Stat. 16A.98	
Mississippi	Mississippi settled with manufacturers prior to the MSA. In 1999, a trust fund was created to distribute funds for tobacco prevention, but funds were gradually used for other purposes and the trust eventually repealed.		• Harrison, Bobby. Mississippi Today. Landmark tobacco lawsuit settled 25 years ago — what happened to money? June 26, 2022. https://mississippitoday.org/2022/06/26/landmark-tobacco-lawsuit-settled-25-years-ago-what-happened-to-money/
Missouri	The state created the *Tobacco Settlement Financing Authority*, a body corporate and politic, to implement and administer the securitization of MSA funds.	• Tobacco Settlement Financing Authority Act: Mo. Rev. Stat Sections 8.500 to 8.565	• Missouri Foundation for Health. *Tobacco master Settlement Agreement Factsheet: Current Impact on Missouri*. 2016. https://mffh.org/wp-content/uploads/2016/04/Tobacco-Master-Settlement-Agreement-Factsheet2016.pdf
Montana	Montana passed a constitutional amendment in 2000 dedicating a minimum of 40% of tobacco settlement funds to a permanent income producing *Tobacco Trust Fund*. 90 percent of the fund's interest must be used for health care benefits, services, education programs and tobacco disease prevention. Subsequent initiatives and legislative changes have altered the distribution of MSA funds so that 40% is	• Constitution of Montana -- Article XII • Montana Tobacco Settlement Trust Fund: Mont. Code Ann.§ 17-6	• Montana Attorney General. *Tobacco Sales and Directory and Tobacco Settlement.* https://dojmt.gov/consumer/tobacco-sales-and-directory-tobacco-settlement/

	deposited in the Tobacco Trust Fund, 32% spent on tobacco prevention and cessation activities, 17% on Medicaid and 11% to the general fund.		
Nebraska	Nebraska created the *Nebraska Tobacco Settlement Trust Fund* in 1998 to receive and hold MSA funds. Money from the Nebraska Tobacco Settlement Trust Fund is transferred to the *Nebraska Health Care Cash Fund* in accordance with state law. Remaining funds may be invested.	• Nebraska Tobacco Settlement Trust Fund: Neb. Rev. State. §71-7608. • Nebraska Health Care Cash Fund: Neb. Rev. Stat. §71-7611	• Nebraska Legislative Fiscal Office. *Nebraska Health Care Cash Fund and Related Funds*. 2022. https://www.nebraskalegislature.gov/pdf/reports/committee/health/nhccf_2022.pdf
Nevada	Nevada passed legislation in 1999 directing that 60% of Nevada's annual MSA payment goes towards the *Fund for a Healthy Nevada* and 40% funds Nevada's *Millennium Scholarship Program*	• Administration of Certain Proceeds from Manufacturers of Tobacco Products: NRS 439.600	• Nevada Department of Health and Human Services. Fund for a Healthy Nevad . https://dhhs.nv.gov/Programs/Grants/Funding/FHN/
New Hampshire	New Hampshire sends the first 40 million in MSA payments to the *Education Trust Fund*, which funds public schools. Any excess funds are sent to the general fund.	• Education Trust Fund: N.H. Rev. Stat. Ann. §193.39	• American Lung Association. 20th Annual 'State of Tobacco Control' Report Reveals New Hampshire Still Lags Behind on Policies to Reduce Tobacco Use, January 25, 2922. https://www.lung.org/media/press-releases/state-of-tobacco-control-report-2022-nh
New Jersey	New Jersey established the *New Jersey Tobacco Settlement Financing Corporation* to sell issued tobacco bonds beginning in 2002; the state has experienced difficulty paying back bondholders.	• Tobacco Settlement Financing Corporation: N.J.R.S.A. § 52:18B-3	• New Jersey Attorney General. Tobacco Manufacturers Directory. https://www.njoag.gov/resources/tobacco-manufacturers-directory/
New Mexico	New Mexico created the *Tobacco Settlement Permanent Fund* in 2000. While the fund originally received about half of the annual MSA payments, in recent years, nearly all funds have been otherwise appropriated.	• Tobacco Settlement Permanent Fund: NMSA 6-4-9	• New Mexico State Investment Council. *Tobacco Settlement Permanent Fund*. https://www.sic.state.nm.us/investments/permanent-funds/tobacco-settlement-permanent-fund/

New York	New York established the *Tobacco Settlement Financing Corporation* as a public benefit corporation of the state to purchase all or a portion of MSA funds, which are deposited into the *Tobacco Settlement Fund*.	• Tobacco Settlement Fund: N.Y. STF § 92-x	• Tobacco Settlement Financing Corporation https://hcr.ny.gov/tobacco-settlement-financing-corporation-tsfc
North Carolina	North Carolina established the *Settlement Reserve Fund* to receive MSA payments. The state previously deposited 25% its tobacco settlement money into the *Health and Wellness Trust Fund*, which funded the state's tobacco prevention and cessation program. However, in 2011 the Trust was dissolved and in 2013 the program was totally defunded.	• Settlement Reserve Fund; N.C.G.S. § 143C-9-3	• Website of the Health and Wellness Trust Fund http://www.hwtfc.org/ • North Carolina Health and Wellness Trust Fund. Brief Overview of the Tobacco Settlement in N. Carolina. http://www.hwtfc.org/pdffiles/hwOverviewTobaccoSettlement.pdf • Schofield, Rob. NC Newsline. Report: North Carolina ranks 45th in protecting kids from tobacco. Dec. 10, 2013. https://ncnewsline.com/briefs/report-north-carolina-ranks-45th-in-protecting-kids-from-tobacco/
North Dakota	North Dakota created the *Tobacco Settlement Trust Fund* to receive MSA payments. Statute provides that moneys in the fund must be transferred to a community health trust fund within 30 days of receipt and may be appropriated for community-based public health programs and other public health programs	• Tobacco Settlement Trust Fund: NDCC 54-27-25	• North Dakota legislative Council. Budget Committee on Health Care. *Analysis of the Tobacco Settlement Trust Fund for the 1999-2001 biennium.* https://www.ndlegis.gov/sites/default/files/resource/committee-memorandum/1925101_0.pdf#:~:text=North%20Dakota%20Century%20Code%20Section%20%28NDCC%29%2054-27-25%2C%20created,45%20percent%20to%20the%20water%20development%20trust%20fund.
Ohio	Ohio established several funds to receive MSA payments. One of those funds, the *Tobacco Use Prevention and Cessation Trust Fund* was governed by a 20 member Board of Trustees. In 2008, funds were diverted to the state's general revenue fund. A new fund, the *Tobacco use prevention fund*, was created to receive MSA funds. Statute provides	• Tobacco use prevention fund: Ohio Rev. Code § 3701.841	• Slenkovich, Ken. The Center for Community Solutions. Ohio's Tobacco Master Settlement Agreement; History, Lessons Learned, and Considerations /. October 15, 2020. https://www.communitysolutions.com/research/ohios-tobacco-master-settlement-agreement-history-lessons-learned-considerations-ohio/

	that moneys in the fund shall be used to pay outstanding expenses of the former tobacco use prevention and control foundation		
Oklahoma	Oklahoma established the *Tobacco Use Reduction Fund* to receive settlement funds and the *Oklahoma Tobacco Settlement Endowment Trust* to manage funds and award grants.	• Tobacco Use Reduction Fund Okla. State. Ann. Tit. 63-1-229.3.	• Forman, Carmen. The Oklahoman. *Watchdog report questions TSET spending, Oklahoma's tobacco cessation efforts*. June 22, 2001. https://www.oklahoman.com/story/news/2021/06/22/oklahoma-legislative-watchdog-office-questions-tobacco-settlement-endowment-spending/7770584002/ • Tobacco Settlement Endowment Trust. https://oklahoma.gov/tset.html
Oregon	Oregon deposits its MSA funds into its *Tobacco Settlements Funds Account*. has in recent years allocated much of its settlement funds towards its Medicaid program.		• Gray, Chris. The Lund Report. *Oregon Putting All Its Declining Tobacco Settlement Funds into Health Expenses*. July 3, 2015. https://www.thelundreport.org/content/oregon-putting-all-its-declining-tobacco-settlement-funds-health-expenses#:~:text=The%20bulk%20of%20the%20funds%20will%20be%20geared,grants%20for%20physical%20education%20programs%20at%20Oregon%20schools. • Oregon Legislative Fiscal Office. *Fiscal Impact of Proposed Legislation.* Measure HB 2128-C. https://olis.oregonlegislature.gov/liz/2023R1/Downloads/MeasureAnalysisDocument/80974#:~:text=Under%20current%20law%2C%20the%20Tobacco%20Settlement%20Funds%20Account,into%20the%20OHAF%20for%20expenses%20of%20the%20OHP.
Pennsylvania	Pennsylvania created the *Tobacco Settlement Fund* to receive MSA payments. In 2017 bonds were issued using MSA funds in order to balance the state budget, and revenues are now used to pay debt service on those bonds. The *Tobacco Revenue Bond Debt Service Account* was created to	• Tobacco Revenue Bond Debt Service Account 72 Pa Cons. Stat.. § 9805.	• Pennsylvania Alliance to Control Tobacco. *PACT Recommendation: Maintain level state funding for fiscal year 2024 and seek to increase funding for comprehensive tobacco prevention and control programs*. https://pactonline.org/program-funding/ • The Tobacco Settlement Annual report to the General Assembly. July 1, 2020- June 30, 2021. https://www.dhs.pa.gov/docs/Publications/Documents/

	receive MSA funds certified by the secretary for the payment of principal and interest for bonds		Highlighted%20Reports/DHS%20Tobacco%20Settlement%20Report%20FY20-21%20Final.pdf • Tobacco Settlements Fund Primer. House Appropriations Committee. Dec. 16, 2013. Tobacco Settlement Fund Primer (pahouse.com)
Rhode Island	Rhode Island established the *Tobacco Settlement Financing Corporation*, a public corporation of the State of Rhode Island, to finance the acquisition from the State of the State's interest in the moneys due under the Master Settlement. The corporation has issued bonds on multiple occasions	• Tobacco Settlement Financing Act R.I. Gen. Laws § 42-133-2	• Rhode Island Tobacco Settlement Financing Corporation https://tsfc.ri.gov/
South Carolina	South Carolina established the *Tobacco Settlement Revenue Management Authority*, a public body corporate and politic and an instrumentality of the State, to receive MSS payments and issue bonds	• Tobacco Revenue Management Authority Act S.C. Code Ann § 11-49	• Tobacco Settlement Revenue Management Authority Financial Statements. June 30, 2021. https://www.osa.sc.gov/wp-content/uploads/2021/10/Final-Audit-TSRMA.pdf
South Dakota	South Dakota established the *Health Care Trust Fund* in the state constitution to receive tobacco settlement funds. The constitution directs the South Dakota Investment Council to invest the trust fund in stocks, bonds, mutual funds and other financial instruments as provided by law.	• Health Care Trust Fund Article 12, §5	• South Dakota Investment council 2022 Annual Report https://sdic.sd.gov/docs/Annual%20Report%202022.pdf
Tennessee	Tennessee deposits its tobacco settlement funds into the General Fund. At least some funds have been allocated for anti smoking activities by the Tennessee Tobacco Settlement Program		• Tennessee Department of Health. *Tennessee Tobacco Settlement Program History*. https://www.tn.gov/health/health-program-areas/tennessee-tobacco-settlement-program.html

Texas	Texas settled with manufacturers prior to the MSA. Texas established the *Tobacco Settlement Permanent Trust Account* as a cooperative project between the Texas Department of Health and the State Comptroller of Public Accounts to provide local health departments and hospital districts a portion of the payments from the state's tobacco settlement. The *Tobacco Settlement Permanent Trust Account Investment Advisory Committee* provides advice to the comptroller regarding fund management	• Tobacco Settlement Permanent Trust Account Tex. Exec. Branch Code Ann. §. 403.1041 • Tobacco Settlement Permanent Trust Account Investment Advisory Committee Tex. Exec. Branch Code Ann § 403.1042	• Tobacco Settlement Distribution Program https://www.dshs.texas.gov/tobacco/tobacco-settlement-distribution-program
Utah	Utah amended its constitution to establish the *Permanent State Trust Fund* to receive MSA payments. Until July 2007, a portion of MSA funds were deposited into the trust fund. After July 2007, current law requires that 40% of MSA funds be deposited into the General Fund. The state also created the *Tobacco Settlement Restricted Account*, into which the remaining 60% of MSA funds are deposited.	• Tobacco Settlement Funds and Endowment UC § 51-9	
Vermont	Vermont established the Tobacco Litigation Settlement Fund in 1999 to receive tobacco settlement funds. The law reserves $19.2 million of the fund for the sole purpose of long-term sustainable tobacco education, prevention, cessation and control programs.	• Tobacco Litigation Settlement Fund 32 Vt. Stat. Ann § 435a	• Vermont Office of the Attorney General. *Tobacco Litigation*. https://ago.vermont.gov/divisions/consumer-protection/consumer-resources/health-and-product-safety/tobacco/tobacco-litigation. • Tobacco control Program. *2014 Community Prevention Summary* https://www.healthvermont.gov/sites/default/files/documents/pdf/hpdp_CommunityPrevention16.pdf

Virginia	Virginia established the *Tobacco Settlement Fund* to receive MSA payments and the *Tobacco Settlement Financing Corporation* to purchase Virginia's interests in MSA payments and to issue bond secured with Corporation funds.	• Virginia Tobacco Settlement Fund Va. Code Ann. § 32.1-360	• Tobacco Settlement Financing Corporation https://trs.virginia.gov/Boards-Authorities/Tobacco-Settlement-Financing-Corporation
Washington	Washington established the *Tobacco Settlement Account* to receive MSA funds and the *Tobacco Settlement Authority* to issue revenue bonds backed by not more than 30% of the state's allocable share of the MSA revenue	• Tobacco Settlement authority Wash. Rev. Code § 43.340.030	• Washington State Tobacco Settlement Authority https://tsa-wa.org/ • Washington State Office of the Attorney General. *Master Settlement Agreement.* https://www.atg.wa.gov/master-settlement-agreement
West Virginia	West Virginia established two funds in 1999 to receive tobacco settlement funds—the *West Virginia Tobacco Settlement Medical Trust Fund* and the *West Virginia Tobacco Settlement Fund*, each of which receive 50% of the MSA funds. The Legislature also established the *Tobacco Settlement Finance Authority*, governed by a five-member board of directors, to issue bonds. The law also authorizes the Authority to purchase from the state the state's share of MSA funds upon executive order of the Governor. It is unclear if this sale has actually taken place.	• West Virginia Tobacco Settlement Medical Trust Fund W. Va. Code §4-11A-2 • West Virginia Tobacco Settlement Fund W. Va. Code §4-11A-3. • Tobacco Settlement Finance Authority W. Va. Code §4-11A-6	• Casemen, Kelli and Davidson, Diana. West Virginia Watch. *Up in smoke: WV squandered tobacco settlement funding. Now's the time to bring it back.* https://westvirginiawatch.com/2023/09/21/up-in-smoke-west-virginia-squandered-tobacco-settlement-funding-nows-the-time-to-bring-it-back/
Wisconsin	Through calendar year 2003, settlement payments were generally deposited to the general fund as general fund revenues. Beginning with calendar year 2004, unrestricted settlement payments owed to	• Sale of state's rights to tobacco settlement agreement payments Wis. Stat. Ann. § 16.63	• Wisconsin Legislative Fiscal Bureau. *Tobacco Settlement and Securitization and Repurchase Transactions*. January 2019. https://docs.legis.wisconsin.gov/misc/lfb/informational_papers/january_2019/0079_tobacco_settleme

	Wisconsin under the MSA were primarily being utilized to make payments to bond holders under the state's initial tobacco securitization transactions. Under the 2007 Act 226 repurchase transaction, beginning in the 2009-11 biennium, $50 million annually in unrestricted MSA settlement payments is deposited to the permanent endowment fund for transfer to the medical assistance trust fund. The remaining amount of unrestricted MSA settlement payments is deposited to the general fund.		nt_and_securitization_and_repurchase_transactions_informational_paper_79.pdf
Wyoming	Wyoming established the *Tobacco settlement Trust Fund* for receipt of MSA funds / revenues are to be used to fund tobacco prevention and cessation efforts and for programs to combat substance abuse.	• Tobacco Settlement Funds Wyo. Stat. Ann. 9-4-1211	• Wyoming Attorney General Tobacco Settlement Unit https://ag.wyo.gov/law-office-division/consumer-protection-and-antitrust-unit/tobacco-settlement-unit • Wyoming Office of the State Treasurer memo re Tobacco Settlement Accounts. Nov 1, 2015 https://www.wyoleg.gov/InterimCommittee/2015/SCF1102AppendixH.pdf

APPENDIX G

Findings and Recommendations (with votes)

Blue Ribbon Commission to Design a Plan for Sustained Investment in Preventing Disease and Improving the Health of Maine Communities

Proposed Findings and Recommendations

12.11.23

Findings

1. Finding: That current allocations will soon outpace revenue, resulting in a structural deficit in the Fund for a Healthy Maine.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	
Blackwell-Moore	Yea	

2. Finding: That reorganization of the administration of MSA funds is necessary for long term sustainability of funding for prevention and health promotion activities in the state.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	

Blackwell-Moore	Yea	

3. Finding: That additional sources of revenue are necessary for long term sustainability of public health commitments in the state.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	abstained	
Boulos	Yea	
Blackwell-Moore	Yea	

4. Finding: That reorganization of the administration of MSA funds is necessary to best track the overall impact of activities funded with MSA funds; to provide accountability over the administration of these funds; and to provide a mechanism for long term, flexible planning to respond to a changing public health landscape.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	
Blackwell-Moore	Yea	

5. That the programs currently funded by the Fund for Healthy Maine are vital and require sustained funding by the Legislature.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	
Blackwell-Moore	Yea	

Recommendations

1. Recommendation: That a new trust fund be created into which all MSA funds will be directly deposited and that is authorized to receive funds from other sources.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	
Blackwell-Moore	Yea	

2. Recommendation: That a new, independent, quasi-state entity be created to administer the fund established per Recommendation #1.

Member	**Vote**	notes

Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	
Blackwell-Moore	Yea	

3. Recommendation: that the entity established per Recommendation #2 prioritize funding for the following activities:

    a. tobacco use prevention and intervention activities; and
    b. public health activities and interventions addressing issues related to health equity.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	
Blackwell-Moore	Yea	

4. Recommendation: That the Fund for a Healthy Maine be maintained to fund certain activities currently funded through the Fund, including but not limited to MaineCare reimbursements, purchased social services, substance use interventions and treatment, Headstart programing, school breakfasts, medical care payments to providers, the Drugs for the Elderly program, dental education and other activities currently funded through the Fund for a Healthy Maine and administered by the Finance Authority of Maine.

Member	**Vote**	notes

Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	
Blackwell-Moore	Yea	

5. Recommendation: That a percentage of the cigarette tax and the tobacco products tax be deposited directly into the Fund for a Healthy Maine and used to support the activities described in Recommendation #4.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	abstained	
Boulos	Yea	
Blackwell-Moore	Yea	

6. Recommendation: That the entity established per Recommendation #2 be required to report at least annually to the legislative committees of jurisdiction regarding its activities, including:

    a. management of the fund established per Recommendation #1;
    b. administrative costs;
    c. distribution of funds to outside entities and to state entities;
    d. coordination of activities with state agencies, including Maine CDC, and the state health plan;

e. performance data and consideration of return on investments; and
f. other information requested by the legislature

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	Yea	
Boulos	Yea	
Blackwell-Moore	Yea	

7. Recommendation: That a committee of jurisdiction put forth legislation based on the recommendations above.

Member	**Vote**	notes
Rotundo	Yea	
Graham	Yea	
Bennett	Yea	
Bisson	Yea	
Hicks	abstained	
Frey	Yea	
Sanborn	Yea	
Ducharme	Yea	
Jonk	Yea	
Crowley	Yea	
Carter	Yea	
Flemings	Yea	
Leonard	abstained	
Boulos	Yea	
Blackwell-Moore	Yea	

APPENDIX H

LD 1523 *An Act To Establish the Trust for a Health Maine*

130th MAINE LEGISLATURE

FIRST SPECIAL SESSION-2021

Legislative Document **No. 1523**

H.P. 1127 House of Representatives, April 19, 2021

An Act To Establish the Trust for a Healthy Maine

Received by the Clerk of the House on April 15, 2021. Referred to the Committee on Health and Human Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

ROBERT B. HUNT
Clerk

Presented by Representative MILLETT of Cape Elizabeth.
Cosponsored by President JACKSON of Aroostook and
Representatives: CRAVEN of Lewiston, SACHS of Freeport, TALBOT ROSS of Portland,
Senators: CARNEY of Cumberland, VITELLI of Sagadahoc.

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

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

14-J.

Health	Trust for a Healthy Maine Board	Expenses Only	22 MRSA §1515

Sec. 2. 22 MRSA c. 260-A, sub-c. 1 is enacted by adding before section 1511 the following to read:

SUBCHAPTER 1

FUND FOR A HEALTHY MAINE

Sec. 3. 22 MRSA §1511, sub-§2, as enacted by PL 1999, c. 401, Pt. V, §1, is amended to read:

2. Sources of fund. The State Controller shall credit to the fund:

A. ~~All~~ If the Trust for a Healthy Maine established in section 1515 is repealed or dissolved, all money received by the State in settlement of or in relation to the lawsuit State of Maine v. Philip Morris, et al., Kennebec County Superior Court, Docket No. CV-97-134;

B. Money from any other source, whether public or private, designated for deposit into or credited to the fund; ~~and~~

C. Interest earned or other investment income on balances in the fund~~.~~; and

D. If the Trust for a Healthy Maine established in section 1515 is repealed or dissolved, all money transferred from the trust to the fund.

Sec. 4. 22 MRSA c. 260-A, sub-c. 2 is enacted to read:

SUBCHAPTER 2

TRUST FOR A HEALTHY MAINE ACT

§1513. Short title

This subchapter may be known and cited as "the Trust for a Healthy Maine Act."

§1514. Definitions

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

1. Administrative costs. "Administrative costs" means staffing, overhead and related operational costs, including costs for a coordinator, professional assistance and bond premiums, incurred by the trust in carrying out its duties under this subchapter.

2. Board. "Board" means the Trust for a Healthy Maine Board established under Title 5, section 12004-G, subsection 14-J.

3. Community health worker. "Community health worker" means a person who provides outreach and public health services to a social group using the person's understanding of the experiences, socioeconomic needs, language or culture of that social group.

4. Community resilience. "Community resilience" means the capacity of individuals, communities, institutions, businesses and systems within a community to survive, adapt and grow no matter what kinds of chronic stresses and acute shocks they experience.

5. Coordinator. "Coordinator" means the coordinator of the Trust for a Healthy Maine under section 1519, subsection 2.

6. Designated agent. "Designated agent" means an entity with which the department has entered an agency relationship for the purpose of applying for federal funds to support public health research and programming and that is authorized by the Federal Government to receive those funds.

7. Disbursement. "Disbursement" means a decision of the trust governing how settlement funds are to be distributed by the trust for the purposes set forth in this subchapter.

8. Health equity. "Health equity" means the attainment of the highest level of health for any social group in this State, regardless of whether a social group is subject to a structural inequity.

9. Medical care. "Medical care" means direct health care, including but not limited to care provided under the MaineCare program and the prescription drug program established under section 254-D. "Medical care" does not include treatments provided under the Tobacco Prevention and Control Program established in section 272 or the delivery of preventive health screenings or services in a school setting.

10. Settlement funds. "Settlement funds" means any money received by the State or any component of the State in settlement of or in relation to the lawsuit State of Maine v. Philip Morris, et al., Kennebec County Superior Court, Docket No. CV-97-134.

11. Social determinants of health. "Social determinants of health" means the conditions in which people are born, grow, live, work and age, as well as the social structures and economic systems that shape these conditions, including the social environment, physical environment and health services.

12. Social group. "Social group" means a group of people in this State that share similar social, economic, demographic, geographic or other characteristics, including, but not limited to, race, ethnicity, gender, gender identity, sexual orientation, class, zip code, age or disability.

13. State health plan. "State health plan" means the most recent plan for improving public health and health equity prepared by the Department of Health and Human Services, Maine Center for Disease Control and Prevention for accreditation by a nonprofit public health accreditation board dedicated to advancing the continuous quality improvement of tribal, state, local and territorial health departments or any successor plan identified by the Maine Center for Disease Control and Prevention.

14. Structural inequity. "Structural inequity" means the systemic disadvantage of one social group in the State compared to other social groups in the State as a result of law, policy, culture or other social structure, including, but not limited to, poverty, discrimination, powerlessness or access to job opportunities, quality education, housing or health care.

15. Systemic racism. "Systemic racism" means the laws and institutionalized policies, practices or social structures that maintain and perpetuate domination by and advantages for the race that is socially constructed as being white to the detriment of or with the purpose of imposing influence or control over any other race that is socially constructed to be non-white, including through color-blind discourse or derogatory and inaccurate stereotypes.

16. Trust. "Trust" means the Trust for a Healthy Maine established in section 1515, subsection 1.

17. Trustee. "Trustee" means a member of the board.

18. Trust fund. "Trust fund" means the Trust for a Healthy Maine Trust Fund established in section 1520-E, subsection 1.

§1515. Trust for a Healthy Maine; Trust for a Healthy Maine Board

1. Establishment; purposes. The Trust for a Healthy Maine is established for the purposes of receiving all settlement funds and other funds, redistributing that money to state agencies or designated agents of the State to fund tobacco use prevention and control at levels recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention and to ensure adequate resources for other disease prevention efforts and promoting public health. The purposes of the trust also include supporting state agencies in planning and delivering public health and prevention programs and services, supporting accreditation of the Department of Health and Human Services, Maine Center for Disease Control and Prevention and supporting public health workforce development. The trust also provides public health expertise and evidence-based information to the Legislature.

2. Governance; board. The trust is created as a body corporate and politic and a public instrumentality of the State and is governed by the Trust for a Healthy Maine Board in accordance with this subchapter.

3. Trustees; appointment. The board consists of 15 trustees in accordance with this subsection. A person who stands to benefit from the tobacco products, as defined in section 1551, subsection 3, alcohol or marijuana industry is not eligible to serve as a trustee.

A. The Director of the Maine Center for Disease Control and Prevention within the Department of Health and Human Services or the director's designee serves as an ex officio voting trustee.

B. The Governor shall appoint 3 trustees in accordance with this paragraph:

(1) A person who has clinical expertise or public health expertise, or both, in the science and prevention of addiction as a brain disease, selected from recommendations provided by a statewide organization dedicated to supporting physicians, advancing the quality of medicine and promoting the health of citizens in the State;

(2) A person who is an employer with experience recruiting and retaining a healthy workforce; and

(3) A person who has experience as a member of an advisory board of a local community health coalition, selected from recommendations provided by a statewide network of community coalitions working to enhance physical, social, emotional, environmental and economic health in the State.

C. The Governor shall appoint trustees from nominations made in accordance with this paragraph within 30 days of receiving the nominations.

(1) The President of the Senate shall, for each of the following 3 qualifications, submit to the Governor within 30 days of a vacancy 3 names for consideration:

(a) A person who has expertise in epidemiology and infectious disease or in hospital-based prevention, screening and early prevention of infectious disease, selected from recommendations provided by the integrated health care delivery systems in the State and by a statewide hospital organization that provides advocacy, information and education in its mission to improve the health of patients and communities;

(b) A person who has clinical expertise or public health expertise, or both, in rural primary care, selected from recommendations provided by a statewide organization that represents community health centers in the State; and

(c) A person who has expertise in systemic racism and structural inequity and is serving on the Permanent Commission on the Status of Racial, Indigenous and Maine Tribal Populations, in accordance with Title 5, section 25002.

(2) The Speaker of the House of Representatives shall, for each of the following 2 qualifications, submit to the Governor within 30 days of a vacancy 3 names for consideration:

(a) A person who has expertise in public health policy related to the leading causes of chronic disease, selected from recommendations provided by a statewide, nonprofit membership organization that promotes a healthy State through advocacy, education, community connection and coalition-building; and

(b) A person who has expertise in preventing the use of tobacco products and other addictive substances by youth and young adults.

(3) The member of the Senate who is the leader of the party with the 2nd-largest number of members in the Senate shall, for each of the following 2 qualifications, submit to the Governor within 30 days of a vacancy 3 names for consideration:

(a) A person who has expertise in trauma, community resilience and social determinants of health, selected from recommendations provided by a statewide network dedicated to building community strengths and reducing the effects of trauma; and

(b) A person who represents a statewide association of public health professionals.

(4) The member of the House of Representatives who is the leader of the party with the 2nd-largest number of members in the House shall, for each of the following 2 qualifications, submit to the Governor within 30 days of a vacancy 3 names for consideration:

(a) A person who is employed as a member of the senior staff or faculty in a public health academic program; and

(b) A person who has expertise in maternal and child health issues, including early childhood education and out-of-school child care, or school-based health.

(5) The chiefs of the 4 federally recognized Indian tribes in the State shall, for each of the following 2 qualifications, submit to the Governor within 30 days of a vacancy 3 names for consideration:

(a) A person who has expertise in environmental health; and

(b) A person who has expertise in health equity or health disparity issues.

The trustees appointed pursuant to paragraphs B and C must be reviewed by the joint standing committee of the Legislature having jurisdiction over public health matters and approved by the Senate.

4. Terms; vacancies. Trustees serve 3-year terms. Trustees may serve no more than 3 consecutive terms. A trustee shall serve on the board until a replacement is appointed and qualified. If a trustee is unable to complete a term, the Governor shall consult with the board and appoint a replacement for the remainder of the unexpired term. The replacement trustee must hold the same qualifications, set forth in subsection 3, as those of the departing trustee.

5. Chair; officers. The board shall elect a chair, a vice-chair, a secretary and a treasurer from among the trustees. Each officer serves a one-year term in that office and is eligible for reelection.

6. Meetings; quorum. The board shall meet at least 4 times each year at regular intervals and may meet at other times at the call of the chair or the Governor. A majority of the trustees constitutes a quorum. Meetings of the board are public proceedings as provided by Title 1, chapter 13, subchapter 1. Notwithstanding any provision of law to the contrary, a trustee who is not physically present may participate by telephone or other remote access technology in accordance with procedures established by the board.

7. Election of subcommittees. The board may elect an executive committee of not fewer than 5 trustees who, between meetings of the board, may transact such business of the trust as the board authorizes. The board may also elect a planning committee.

8. Liaison to Legislature. The chair is the trust's liaison to the joint standing committee of the Legislature having jurisdiction over public health matters.

9. Advisory groups. The board may establish advisory groups as needed to gather technical knowledge on any aspect of public health policy, infrastructure or funding disbursement and to make recommendations to the board. Advisory groups may include persons who are not trustees.

10. Removal of trustee for disciplinary reasons. The board shall develop the process of removal and replacement of trustees for disciplinary reasons.

11. Expenses; reimbursement. Trustees are not entitled to compensation for service on the board, except that, in accordance with Title 5, section 12004-G, subsection 14-J, the trust may reimburse travel and other board-related expenses.

12. Fiduciary duties. A trustee has a fiduciary duty to the people of the State in the administration of the trust. Upon accepting appointment as a trustee, each trustee shall acknowledge the fiduciary duty to use the trust fund only for the purposes set forth in this subchapter. It is the duty of each trustee to ensure that the purposes of the trust set forth in this subchapter are fulfilled.

13. Conflict of interest. A trustee is deemed to be an executive employee for purposes of Title 5, sections 18, 18-A and 19. In the operation or dissolution of the trust, a trustee, employee of the trust, officer of the trust or a spouse or dependent child of any of those individuals may not receive any direct personal benefit from the activities of the trust, except that the trust may pay reasonable compensation for services rendered and otherwise hold, manage and dispose of the trust's property in furtherance of the purposes of the trust. This subsection does not prohibit corporations or other entities with which a trustee is associated by reason of ownership or employment from participating in activities funded directly or indirectly by the trust if ownership or employment is made known to the board and the trustee abstains from all matters directly relating to that participation immediately upon discovery of the association.

§1516. Powers and duties

1. Powers. The trust may:

A. Receive all settlement funds;

B. Receive money from any other source, whether public or private, designated for deposit into or credited to the trust;

C. Receive funds transferred from the Fund for a Healthy Maine under subchapter 1;

D. Through funding disbursement plans under section 1517, disburse funds; and

E. Make recommendations to the Governor, the Legislature and other public officials regarding improving public health outcomes and promoting public health awareness and understanding.

2. Duties. The trust shall:

A. Administer the trust and the trust fund;

B. Promote the visibility and understanding of public health issues among children and adults;

C. Participate in the development and promotion of a state health plan by the Department of Health and Human Services, Maine Center for Disease Control and Prevention or another planning entity and provide funding for the planning process if necessary;

D. Promote multilevel planning and coordination that includes state, district, community and municipal decision-making and advisory boards; and

E. Take other actions necessary and appropriate to fulfill the purposes of this subchapter.

§1517. Funding disbursement plan

1. Funding disbursement plan. By December 31, 2022 and every year thereafter, the board shall develop and approve a funding disbursement plan to disburse settlement funds and other funds it may hold or receive in the subsequent biennium. The funding disbursement plan must advance the purposes of this subchapter and be based on the most recent state health plan and the most recent data available to the board.

2. Input from interested parties. Prior to adopting a funding disbursement plan pursuant to subsection 1 or substantially amending an existing funding disbursement plan, the trust shall hold at least one public hearing to receive input from interested parties, including but not limited to the Department of Health and Human Services, Maine Center for Disease Control and Prevention, other state agencies, organizations engaged in smoking cessation and public health efforts, other nongovernmental organizations, interested stakeholders, patients and members of the public. The board shall establish the procedure and timelines for seeking input from interested parties. The board shall also determine what circumstances, consistent with this subsection, would require the board to initiate a public hearing. When considering the input of interested parties, the trust must consider principles of zero-based budgeting, as defined in Title 35-A, section 102, subsection 25, and long-term returns on investment.

3. Funding disbursement plans. The funding disbursement plan approved by the board pursuant to subsection 1 for fiscal year 2023-24 must disburse an amount equal to 0.30 of the settlement funds projected to be received in fiscal year 2023-24 for the purpose of providing medical care. The funding disbursement plan approved by the board for fiscal year 2024-25 and subsequent years may not disburse funds for the purpose of providing medical care. When approving other elements of the funding disbursement plans, the board shall consider funding levels in the most recent fiscal year and disburse funding in amounts that minimize disruption of existing programs and ensure smooth and efficient transitions to the funding levels required under subsection 4.

4. Designated disbursements. Each funding disbursement plan approved by the board must disburse funds in accordance with the following designated disbursements:

A. An amount that, when combined with amounts from other funding sources received by the Department of Health and Human Services, Maine Center for Disease Control and Prevention, yields a total amount available for purposes of providing evidence-based tobacco prevention and control programs in the State that is in accordance with the following:

(1) Beginning in fiscal year 2023-24, at least 0.70 of the level recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention must be disbursed to the Department of Health and Human Services, Maine Center for Disease Control and Prevention or its designated agent; and

(2) Beginning in fiscal year 2024-25 and in subsequent years, at least the level recommended by the United States Department of Health and Human Services, Centers for Disease Control and Prevention must be disbursed to the Department of Health and Human Services, Maine Center for Disease Control and Prevention or its designated agent;

B. An amount of the settlement funds received in the previous fiscal year must be disbursed to the Department of the Attorney General in accordance with the following:

(1) Beginning in fiscal year 2023-24, an amount equal to 0.005 of the settlement funds; and

(2) Beginning in fiscal year 2024-25 and in subsequent years, an amount equal to the amount the Department of the Attorney General received in accordance with subparagraph (1) adjusted by the Chained Consumer Price Index, as defined in Title 36, section 5402;

C. An amount of the settlement funds received in the previous fiscal year must be disbursed to the administration fund established pursuant to section 1519, subsection 1 in accordance with the following:

(1) Beginning in fiscal year 2023-24, an amount equal to 0.003; and

(2) Beginning in fiscal year 2024-25 and in subsequent years, an amount equal to the amount the administration fund received in accordance with subparagraph (1) adjusted by the Chained Consumer Price Index as defined in Title 36, section 5402;

D. An amount not to exceed 0.05 of the settlement funds received in the previous fiscal year may be disbursed to the internal stabilization account established in subsection 6;

E. An amount not to exceed 0.05 of the settlement funds received in the previous fiscal year may be disbursed to the internal flexible account established in subsection 7; and

F. The funds remaining after making the disbursements required by paragraphs A to C and authorized by paragraphs D and E must be disbursed to the health equity and health improvement account established in subsection 5.

The designated disbursements approved by the board may not disburse settlement funds for the purpose of providing medical care.

5. Health equity and health improvement account. A health equity and health improvement account is established and funded with settlement funds in accordance with subsection 4, paragraph F.

A. The funding disbursement plan approved by the board must disburse funds from the health equity and health improvement account to prioritize the advancement of health equity and the elimination of structural inequity. For fiscal year 2023-24, the funding disbursement plan must disburse an amount equal to or greater than 0.15 of the funds in the health equity and health improvement account. For fiscal year 2024-25 and subsequent years, the funding disbursement plan must disburse an amount equal to or greater than 0.20 of the funds in the health equity and health improvement account. Funds disbursed in accordance with this paragraph must be distributed to achieve all or some of the following:

(1) Improving data collection, analysis and reporting, particularly for, among and co-led by populations experiencing health disparities, which includes social determinants of health, community resilience, racial impacts and health equity;

(2) Enhancing health improvement and health equity planning at the local, district and state levels that addresses and confronts systemic racism and structural inequity;

(3) Supporting public-private partnerships at the local and district levels, including comprehensive community health coalitions, as defined in section 411, and organizations that prioritize health equity and derive meaningful leadership from the communities they serve;

(4) Supporting the expansion, recruitment, retention and presence of the public health workforce at local, district and state levels, including supporting a robust network of community health workers and government employees in the State dedicated to addressing systemic racism and structural inequity; and

(5) Providing training and technical assistance for local health officers, boards of health, community and municipal leaders, community organizations, community partnerships and other organizations providing public health services or serving the functions of the State's public health and safety system.

B. Funds remaining in the health equity and health improvement account after the disbursements required in paragraph A must be for state entities or their designated agents that, in the board's sole determination, will use the funds efficiently and effectively to promote the purposes of this subchapter, implement evidence-based prevention and screening strategies to address the priorities of the state health plan, support efforts by the Department of Health and Human Services, Maine Center for Disease Control and Prevention to prevent disease and promote public health and implement strategies for building and sustaining public health capacity and infrastructure at the state and local levels. These funds may not be disbursed for the purpose of providing medical care.

6. Internal stabilization account. An internal stabilization account is established within the trust. In order to prevent disruptions from year to year in the amounts disbursed pursuant to designated disbursements under subsection 4 and to ensure continuity in the event of fluctuations in the amount of settlement funds received by the State, the board may draw upon the internal stabilization account to make additional disbursements. The trust may not cause the balance in the internal stabilization account at any one time to exceed the amount of settlement funds received by the trust in the most recent year. The funds within the internal stabilization account are nonlapsing and carry forward from year to year for future use consistent with this subsection and do not revert to the trust fund.

7. Internal flexible account. An internal flexible account is established within the trust. The funds in the internal flexible account may be drawn upon by the board for the purpose of rapidly addressing emerging public health threats, promptly implementing innovative promising practices or addressing other immediate unmet needs identified by the board in the period between approval of funding disbursement plans, consistent with the purposes of this subchapter. Trustees shall consult regularly with the commissioner regarding emerging funding needs. Year-end balances remaining in the internal flexible account lapse to the trust fund and are available for a subsequent year's funding disbursement plan.

8. Informational copies of funding disbursement plans. Upon final approval by the board of a funding disbursement plan, the trust shall transmit informational copies of the funding disbursement plan to the Governor and to the joint standing committee of the Legislature having jurisdiction over public health matters. A funding disbursement plan

does not require approval of the Governor or the joint standing committee of the Legislature having jurisdiction over public health matters.

9. Report. The trust shall produce annually a report on the results of the tobacco prevention and control programs funded pursuant to subsection 4, paragraph A and all other activities of the trust. The report must include an accounting of the funding disbursement plan created pursuant to this section, including identification of recipients, activities and amounts disbursed. The report must include information and outcomes from the trust's investments pursuant to subsection 4, paragraph C. The report may include information on actual health and economic outcomes from funding disbursed to date and projected outcomes from undertakings funded by the trust but not yet complete. The report may also include recommendations for changes to the laws relating to activities under the jurisdiction of the trust. The board must approve the report prior to its release. Upon release, the trust shall transmit copies of the report to the Governor and to the joint standing committee of the Legislature having jurisdiction over public health matters. The board shall establish policies and practices for reporting in accordance with this subsection.

10. Audit. The trust must be audited at least annually by an independent certified public auditor. A copy of the audit must be provided to the Governor and to the joint standing committee of the Legislature having jurisdiction over public health matters.

§1518. Restrictions; construction

The trust's activity is restricted to receiving and disbursing funds and any actions necessary and appropriate to receive and disburse funds. The trust may not create, manage or operate public health or health delivery programs. Nothing in this subchapter may be construed to empower the trust to direct, manage or oversee any program, fund or activity of any other state agency.

§1519. Administration

1. Administration fund. The board shall establish an administration fund to be used solely to defray administrative costs approved by the board or the coordinator. The trust may annually deposit funds authorized to be used for administrative costs under this subchapter into the administration fund. Any interest on funds in the administration fund must be credited to the administration fund, and any funds unspent in any fiscal year carry forward and remain in the administration fund to be used to defray administrative costs. In any year, the board may not disburse to the administration fund an amount greater than the amount allowed pursuant to section 1517, subsection 4, paragraph C. The board may also use the administration fund to contract for reasonable professional assistance to help review input received from interested parties, to develop the funding disbursement plan under section 1517 and to allow the board to fulfill its responsibilities under this subchapter. The board shall define the roles and responsibilities of any professional assistance in accordance with this subsection.

2. Coordinator. The board shall appoint, using a full and competitive search process, a qualified full-time coordinator of the trust. The coordinator serves at the pleasure of the board. The coordinator must have demonstrated experience in research and analysis of public health issues, coordination of public health programs or administrative support of a board in the public health sector, public health finance or policy or closely related experience. The coordinator shall assist the board in gathering and disseminating information, preparing for meetings, analyzing public health issues at the direction of the

board, communicating with stakeholders, writing reports and such other board support and administrative functions as the board may assign. The board shall establish the rate and amount of compensation of the coordinator. The coordinator may exercise any powers lawfully delegated to the coordinator by the board.

3. Bylaws. The board shall adopt bylaws for the governance of its affairs consistent with this subchapter.

4. Coordination with other entities. Consistent with the requirements of this subchapter and other applicable law, the board shall coordinate the development of its funding disbursement plans with the Statewide Coordinating Council for Public Health, established under Title 5, section 12004-G, subsection 14-G, and other state agencies and authorities the missions of which relate to the purposes of this subchapter in order to minimize inefficiency and duplication and to ensure consistency and effectiveness. Notwithstanding any provision of law to the contrary, upon request of the trust and upon the approval of the commissioner or director of the state agency receiving the request, other state agencies, officials and employees shall cooperate and assist in the administration of the trust as needed to further the purposes of this subchapter.

5. Recommendations. The trust may receive and shall consider any recommendations made by the Governor, other state agencies, the joint standing committee having oversight under section 1520-A and other interested entities and individuals.

§1520. Rulemaking

The trust shall adopt rules regarding establishing and administering the trust, receiving public input and developing and approving funding disbursement plans. Rules adopted pursuant to this section are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A.

§1520-A. Legislative oversight

The trust is subject to the oversight of the joint standing committee of the Legislature having jurisdiction over public health matters.

§1520-B. Construction by court

The court shall liberally construe this subchapter to give the greatest possible effect to the powers and duties accorded to the trust.

§1520-C. Freedom of access; confidentiality

The proceedings of the board and records of the trust are subject to the freedom of access laws under Title 1, chapter 13, subchapter 1.

§1520-D. Liability

1. Bond. All officers, trustees, employees and other agents of the trust entrusted with the custody of funds of the trust or authorized to disburse the funds of the trust must be bonded either by a blanket bond or by individual bonds with a minimum of $100,000 coverage for each person, or equivalent fiduciary liability insurance, conditioned upon the faithful performance of their duties. The premiums for the bond or bonds are administrative costs of the trust.

2. Indemnification. Each trustee must be indemnified by the trust against expenses actually and necessarily incurred by the trustee in connection with the defense of any action

or proceeding in which the trustee is made a party by reason of being or having been a trustee and against any final judgment rendered against the trustee in that action or proceeding.

§1520-E. Trust for a Healthy Maine Trust Fund

1. Establishment. The Trust for a Healthy Maine Trust Fund is established as a nonlapsing fund administered exclusively by the trust solely for the purposes established in this subchapter.

2. Tobacco settlement funds. Notwithstanding any provision of law to the contrary, the State Controller shall credit to the trust fund all settlement funds immediately upon receipt by the State.

3. Administration of trust fund. The trust fund may not be used for any purposes other than those set forth in this subchapter, and money in the trust fund is held in trust for the purposes of this subchapter. All money received by the trust must be deposited in the trust fund for distribution by the trust in accordance with this subchapter. The trust is authorized to receive settlement funds and may also seek and accept funding from other public or private sources if the trust determines that such acceptance advances the purposes of this subchapter. Any balance in the trust fund not spent in any fiscal year does not lapse but must carry forward in the trust fund available to be used immediately for the purposes of this subchapter, upon the sole direction of the trust. Any interest or investment income earned by the trust fund must be credited to the trust fund. The trust may use administrative services of the Department of Administrative and Financial Services for the management of the trust fund, but the role of the Department of Administrative and Financial Services is nondiscretionary and the Department of Administrative and Financial Services shall carry out all lawful instructions of the trust for all matters relating to accessing the trust fund without the requirement of an additional legislative authorization or a financial order.

4. Working capital advance. The State Controller is authorized to provide an annual advance from the General Fund to the trust fund to provide money for disbursements from the trust fund. The money must be returned to the General Fund as the first priority from the amounts credited to the trust fund pursuant to subsection 2.

5. Transfer of funds upon repeal or dissolution of the trust fund. If the trust fund is repealed or dissolved for any reason, the State Controller shall transfer the balance of funds in the trust fund to the Fund for a Healthy Maine established in section 1511.

Sec. 5. Staggered terms. Notwithstanding the Maine Revised Statutes, Title 22, section 1515, subsection 4, at the initial meeting of the Trust for a Healthy Maine Board, trustees shall draw lots to determine trustees' initial term lengths so that the initial terms of 5 trustees expire after one year, the initial terms of 4 trustees expire after 2 years and the initial terms of 5 trustees expire after 3 years.

Sec. 6. Initial appointments. Notwithstanding the Maine Revised Statutes, Title 22, section 1515, subsection 3, paragraph C, the President of the Senate, Speaker of the House, member of the Senate who is the leader of the party with the 2nd-largest number of members in the Senate, member of the House of Representatives who is the leader of the party with the 2nd-largest number of members in the House and the chiefs of the 4 federally recognized Indian tribes in the State shall make the initial nominations of trustees for the

Trust for a Healthy Maine Board to the Governor within 60 days of the effective date of this legislation.

Sec. 7. Transfer from Fund for a Healthy Maine. The State Controller, no later than July 1, 2023, shall transfer all settlement funds, as defined in the Maine Revised Statutes, Title 22, section 1514, subsection 10, in the Fund for a Healthy Maine and a pro rata share of investment income in the Fund for a Healthy Maine to the Trust for a Healthy Maine Trust Fund.

SUMMARY

This bill establishes the Trust for a Healthy Maine to receive money paid to the State pursuant to the tobacco settlement and from other sources and to distribute that money to state agencies or designated agents of the State to fund tobacco use prevention and control, ensure adequate resources for other disease prevention efforts, promote public health, plan and deliver public health and prevention programs and services, support accreditation of the Department of Health and Human Services, Maine Center for Disease Control and Prevention and support public health workforce development. The trust is governed by a 15-member board of trustees composed of the Director of the Maine Center for Disease Control and Prevention and 14 members appointed by the Governor.

APPENDIX I

Amendment to LD 1523

An Act To Establish the Trust for a Health Maine

L.D. 1523

Date: (Filing No. H-)

HEALTH AND HUMAN SERVICES

Reproduced and distributed under the direction of the Clerk of the House.

STATE OF MAINE

HOUSE OF REPRESENTATIVES

130TH LEGISLATURE

SECOND REGULAR SESSION

COMMITTEE AMENDMENT " " to H.P. 1127, L.D. 1523, "An Act To Establish the Trust for a Healthy Maine"

Amend the bill in section 1 in the first line (page 1, line 2 in L.D.) by striking out the following: "**sub-§14-J**" and inserting the following: '**sub-§14-K**'

Amend the bill in section 1 in subsection 14-J in the first line (page 1, line 3 in L.D.) by striking out the following: "**14-J.**" and inserting the following: '**14-K.**'

Amend the bill in section 4 in sub-c. 2 in §1514 in subsection 2 in the last line (page 2, line 2 in L.D.) by striking out the following: "14-J" and inserting the following: '14-K'

Amend the bill in section 4 in sub-c. 2 in §1514 in subsection 7 in the 2nd line (page 2, line 17 in L.D.) by inserting after the following: "funds" the following: 'and other funds in the trust'

Amend the bill in section 4 in sub-c. 2 in §1514 by inserting after subsection 7 the following:

'**8. Extraordinary receipts.** "Extraordinary receipts" means funds received by the trust pursuant to section 1516, subsection 1, paragraph B or C.'

Amend the bill in section 4 in sub-c. 2 in §1514 in subsection 9 in the 2nd line (page 2, line 23 in L.D.) by striking out the following: "prescription drug" and inserting the following: 'elderly low-cost drug'

Amend the bill in section 4 in sub-c. 2 in §1514 by renumbering the subsections to read consecutively.

Amend the bill in section 4 in sub-c. 2 in §1515 in subsection 3 in paragraph B by striking out all of subparagraph (2) (page 4, lines 1 and 2 in L.D.) and inserting the following:

'(2) A person who has experience recruiting, employing, developing and retaining a healthy workforce; and'

Amend the bill in section 4 in sub-c. 2 in §1515 in subsection 3 in paragraph C in the first 2 lines (page 4, lines 7 and 8 in L.D.) by striking out the following: "trustees from nominations made in accordance with this paragraph" and inserting the following: 'one trustee from nominations made under each of the divisions described below'

Amend the bill in section 4 in sub-c. 2 in §1515 in subsection 3 in paragraph C in subparagraph (1) in division (b) in the 2nd line (page 4, line 18 in L.D.) by striking out the following: "care," and inserting the following: 'care or rural oral health care,'

Amend the bill in section 4 in sub-c. 2 in §1515 in subsection 6 in the 4th line (page 5, line 29 in L.D.) by striking out the following: "chapter 13, subchapter 1. Notwithstanding any provision of law" and inserting the following: 'section 403-B. Notwithstanding any provision of that section'

Amend the bill in section 4 in sub-c. 2 in §1515 in subsection 11 in the 2nd line (page 6, line 2 in L.D.) by striking out the following: "14-J" and inserting the following: '14-K'

Amend the bill in section 4 in sub-c. 2 in §1517 by striking out all of subsection 3 (page 7, lines 19 to 27 in L.D.) and inserting the following:

'**3. Funding disbursement plans.** A funding disbursement plan approved by the board may not disburse funds for the purpose of providing medical care except as provided in subsection 7. When approving elements of the funding disbursement plans, the board shall consider funding levels in the most recent fiscal year and disburse funding in amounts that minimize disruption of existing programs and ensure smooth and efficient transitions to the funding levels required under subsection 4.'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph A in subparagraph (1) in the first line (page 7, line 35 in L.D.) by striking out the following: "Beginning in" and inserting the following: 'In'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph B in the 2nd line (page 8, line 2 in L.D.) by striking out the following: "Department" and inserting the following: 'Office'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph B in subparagraph (1) in the first line (page 8, line 3 in L.D.) by striking out the following: "Beginning in fiscal year 2023-24, an amount equal to 0.005" and inserting the following: 'In fiscal year 2023-24, an amount equal to 0.006'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph B in subparagraph (2) in the 2nd line (page 8, line 6 in L.D.) by striking out the following: "Department" and inserting the following: 'Office'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph B in subparagraph (2) in the last line (page 8, line 8 in L.D.) by inserting after the following: "5402" the following: 'except that the date the State Tax Assessor determines the cost-of-living adjustment is on or about September 15th of each year, beginning in 2024, and "cost-of-living adjustment" means the Chained Consumer Price Index for the 12-month period ending June 30th of the preceding calendar year divided by the Chained Consumer Price Index for the 12-month period ending June 30, 2024. The State Tax Assessor shall calculate the cost-of-living adjustment under this subparagraph'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph C by striking out all of subparagraph (1) (page 8, line 12 in L.D.) and inserting the following:

'(1) In fiscal year 2023-24, an amount equal to 0.006 of the settlement funds; and'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph C in subparagraph (2) in the last line (page 8, line 15 in L.D.) by inserting after the following: "5402" the following: 'except that the date the State Tax Assessor determines the cost-of-living adjustment is on or about September 15th of each year, beginning in 2024, and "cost-of-living adjustment" means the Chained Consumer Price Index for the 12-month period ending June 30th of the preceding calendar year divided by the Chained Consumer Price Index for the 12-month period ending June 30, 2024. The State Tax Assessor shall calculate the cost-of-living adjustment under this subparagraph'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph D in the last line (page 8, line 17 in L.D.) by inserting after the following: "year" the following: ', plus any extraordinary receipts,'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in paragraph F in the first line (page 8, line 20 in L.D.) by inserting after the following: "remaining" the following: ', including any remaining extraordinary receipts,'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 4 in the last blocked paragraph in the first line (page 8, line 23 in L.D.) by striking out the following: "The" and inserting the following: 'Except as provided in subsection 7 for the first funding disbursement plan, the'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 5 in paragraph A in subparagraph (4) in the first line (page 9, line 5 in L.D.) by inserting after the following: "Supporting the" the following: 'development,'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 7 in the 7th line (page 9, line 38 in L.D.) by inserting after the following: "needs." the following: 'If the biennial or supplemental budget enacted for fiscal year 2022-23 appropriates less than $2,400,000 from the General Fund to the elderly low-cost drug program established under section 254-D, the board shall disburse in its first funding disbursement plan an amount from the internal flexible account to the elderly low-cost drug program established under section 254-D that when added to the General Fund appropriation to that program for that fiscal year totals $2,400,000. The internal flexible account may not otherwise be used to fund medical care.'

Amend the bill in section 4 in sub-c. 2 in §1517 in subsection 9 in the 5th and 6th lines (page 10, lines 7 and 8 in L.D.) by striking out the following: "from the trust's investments pursuant to" and inserting the following: 'regarding the fund described in'

Amend the bill in section 4 in sub-c. 2 in §1519 in subsection 2 in the 5th line (page 10, line 43 in L.D.) by striking out the following: "sector," and inserting the following: 'sector or'

Amend the bill by inserting after section 6 the following:

'**Sec. 7. Transfer; Fund for a Healthy Maine; General Fund.** Notwithstanding any provision of law to the contrary, the State Controller shall transfer $36,604,210 from

the Fund for a Healthy Maine to the General Fund unappropriated surplus no later than June 30, 2023.'

Amend the bill by inserting after section 7 the following:

'**Sec. 8. Appropriations and allocations.** The following appropriations and allocations are made.

HEALTH AND HUMAN SERVICES, DEPARTMENT OF

Head Start 0545

Initiative: Provides an ongoing deallocation of Fund for a Healthy Maine funds from the Head Start program.

FUND FOR A HEALTHY MAINE	**2021-22**	**2022-23**
All Other	$0	($1,354,580)
FUND FOR A HEALTHY MAINE TOTAL	$0	($1,354,580)

Head Start 0545

Initiative: Provides an ongoing appropriation to retain state funding for the Head Start program.

GENERAL FUND	**2021-22**	**2022-23**
All Other	$0	$1,354,580
GENERAL FUND TOTAL	$0	$1,354,580

Low-cost Drugs To Maine's Elderly 0202

Initiative: Provides an ongoing deallocation of Fund for a Healthy Maine funds from the Low-cost Drugs To Maine's Elderly program.

FUND FOR A HEALTHY MAINE	**2021-22**	**2022-23**
All Other	$0	($2,413,057)
FUND FOR A HEALTHY MAINE TOTAL	$0	($2,413,057)

Low-cost Drugs To Maine's Elderly 0202

Initiative: Provides an ongoing appropriation to retain state funding for the Low-cost Drugs To Maine's Elderly program.

GENERAL FUND	**2021-22**	**2022-23**
All Other	$0	$2,413,057
GENERAL FUND TOTAL	$0	$2,413,057

Medical Care - Payments to Providers 0147

Initiative: Provides an ongoing deallocation of Fund for a Healthy Maine funds from the Medical Care - Payments to Providers program.

FUND FOR A HEALTHY MAINE	**2021-22**	**2022-23**
All Other	$0	($30,865,455)

FUND FOR A HEALTHY MAINE TOTAL	$0	($30,865,455)

Medical Care - Payments to Providers 0147

Initiative: Provides an ongoing appropriation to retain state funding for the Medical Care - Payments to Providers program.

GENERAL FUND	**2021-22**	**2022-23**
All Other	$0	$30,865,455
GENERAL FUND TOTAL	$0	$30,865,455

Purchased Social Services 0228

Initiative: Provides an ongoing deallocation of Fund for a Healthy Maine funds from the Purchased Social Services program.

FUND FOR A HEALTHY MAINE	**2021-22**	**2022-23**
All Other	$0	($1,971,118)
FUND FOR A HEALTHY MAINE TOTAL	$0	($1,971,118)

Purchased Social Services 0228

Initiative: Provides an ongoing appropriation to retain state funding for the Purchased Social Services program.

GENERAL FUND	**2021-22**	**2022-23**
All Other	$0	$1,971,118
GENERAL FUND TOTAL	$0	$1,971,118

HEALTH AND HUMAN SERVICES, DEPARTMENT OF DEPARTMENT TOTALS	**2021-22**	**2022-23**
GENERAL FUND	**$0**	**$36,604,210**
FUND FOR A HEALTHY MAINE	**$0**	**($36,604,210)**
DEPARTMENT TOTAL - ALL FUNDS	**$0**	**$0**

'

Amend the bill by relettering or renumbering any nonconsecutive Part letter or section number to read consecutively.

SUMMARY

This amendment:

1. Adds a definition of "extraordinary receipts";

2. Removes the requirement that one of the board members be an employer and replaces it with a requirement that the member have experience recruiting, employing, developing and retaining a healthy workforce;

3. Adds experience in rural oral health care to the allowable background requirements for one of the board members;

4. Increases the amount of funds dedicated to the Office of the Attorney General in the first year of operation of the trust fund from 0.005 to 0.006 of settlement funds;

5. Increases the amount of funds dedicated to administration in the first year of operation of the trust fund from 0.003 to 0.006 of settlement funds;

6. Changes references to the Department of the Attorney General to the Office of the Attorney General;

7. Adds development of the public health workforce to the allowable uses of the funds in the health equity and health improvement account;

8. Adds language stating that if the Legislature enacts a biennial or supplemental budget for fiscal year 2022-23 in which it appropriates less than $2,400,000 from the General Fund to the elderly low-cost drug program established under the Maine Revised Statutes, Title 22, section 254-D, the Trust for a Healthy Maine Board is required to disburse an amount from the internal flexible account to the elderly low-cost drug program that when added to the General Fund appropriation to that program for that fiscal year totals $2,400,000; and

9. Deallocates funding for the Head Start, Low-cost Drugs To Maine's Elderly, Medical Care - Payments to Providers and Purchased Social Services programs within the Department of Health and Human Services from the Fund for a Healthy Maine and adds ongoing appropriations from the General Fund to maintain these programs.

FISCAL NOTE REQUIRED

(See attached)

State of Maine
131st Legislature, First Regular and First Special Session

Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard-of-hearing Patients

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR SESSION AND FIRST SPECIAL SESSION

Task Force on Accessibility to Appropriate Communications Methods for Deaf and Hard-of-hearing Patients

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Terry Morrell
Sitara N. Sheikh

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Appendices

Executive Summary

The 131st Maine Legislature established the Task Force on Accessibility to Appropriate Communications Methods for Deaf and Hard-of-hearing Patients (referred to in this report as the "task force") with the passage of Resolve 2023, chapter 97 (Appendix A). Pursuant to the resolve, seven members were appointed to the task force:

- One member of the Senate appointed by the President of the Senate who serves on the Joint Standing Committee on Health and Human Services;
- One member of the House of Representatives appointed the Speaker of the House who serves on the Joint Standing Committee on Health and Human Services;
- One member representing the Department of Health and Human Services, Office of Aging and Disability Services, appointed by the Commissioner of Health and Human Services;
- One member representing Disability Rights Maine, appointed by the Commissioner of Health and Human Services;
- One member representing the Maine Educational Center for the Deaf and Hard of Hearing and the Governor Baxter School for the Deaf, appointed by the Commissioner of Health and Human Services;
- One member representing the Department of Labor who works with compliance issues regarding deaf and hard-of-hearing persons, appointed by the Commissioner of Labor; and
- One member of the public who is a person who is deaf or hard of hearing, appointed by the Speaker of the House.

A list of task force members can be found in Appendix B.

The duties of the task force, which are set forth in Resolve 2023, chapter 97, are as follows:

1. The availability of American Sign Language interpreters in health care settings;

2. The availability of other communication technologies in health care settings, such as video interpreters, automatically generated voice transcriptions and automatically generated captions;

3. Staff education and training programs on overcoming barriers to health care experienced by deaf and hard-of-hearing patients; and

4. Successful models for overcoming barriers to health care experienced by deaf and hard-of-hearing patients.

Due to a compressed timeframe, the task force was only able to hold two meetings instead of the typical four meetings that studies authorized by Legislative Council generally undertake. Therefore, the task force was only able to take a preliminary look into its many duties described in the authorizing legislation. As such, the task force developed short-term recommendations

that the Legislature can enact, but also recommends reconstituting to further consider the duties required by the authorizing legislation.

Over the course of its meetings, the task force developed the following recommendations:

- That the task force be reconstituted in the interim following the Second Regular Session of the 131st Legislature with the same membership and one additional member with expertise in medical interpreting;
- Require data collection to better inform long-term solutions and solicit policy proposals from relevant agencies that address barriers to ASL interpreter licensure;
- Require the implementation of language access plans at all healthcare providers in the state as well as the development of statewide guidelines for the appropriate use of VRI services in healthcare settings;
- Require that the Maine Association for the Deaf's Sign Language Interpreting Committee annually present to the Legislature's Committee on Health and Human Services; and
- Mandate that medical providers attempt to provide an in-person ASL interpreter when one has been requested and that those requests and outcomes are recorded and reported regularly.

I. INTRODUCTION

The 131st Maine Legislature established the Task Force on Accessibility to Appropriate Communications Methods for Deaf and Hard-of-hearing Patients (referred to in this report as the "task force") with the passage of Resolve 2023, chapter 97 (Appendix A). Pursuant to the resolve, seven members were appointed to the task force:

- One member of the Senate appointed by the President of the Senate who serves on the Joint Standing Committee on Health and Human Services;
- One member of the House of Representatives appointed the Speaker of the House who serves on the Joint Standing Committee on Health and Human Services;
- One member representing the Department of Health and Human Services, Office of Aging and Disability Services, appointed by the Commissioner of Health and Human Services;
- One member representing Disability Rights Maine, appointed by the Commissioner of Health and Human Services;
- One member representing the Maine Educational Center for the Deaf and Hard of Hearing and the Governor Baxter School for the Deaf, appointed by the Commissioner of Health and Human Services;
- One member representing the Department of Labor who works with compliance issues regarding deaf and hard-of-hearing persons, appointed by the Commissioner of Labor; and
- One member of the public who is a person who is deaf or hard of hearing, appointed by the Speaker of the House.

A list of task force members can be found in Appendix B.

The task force was charged to study the accessibility to appropriate communication methods for Deaf and hard of hearing patients in healthcare settings. As laid out in the resolve, those duties specifically include but are not limited to:

1. The availability of American Sign Language interpreters in health care settings;

2. The availability of other communication technologies in health care settings, such as video interpreters, automatically generated voice transcriptions and automatically generated captions;

3. Staff education and training programs on overcoming barriers to health care experienced by deaf and hard-of-hearing patients; and

4. Successful models for overcoming barriers to health care experienced by deaf and hard-of-hearing patients.

Because of the truncated timeframe, the task force was only able to hold two meetings instead of the typical four meetings that authorized studies are typically allowed. Therefore, the task force was only able to do a preliminary look into many of its duties described in the authorizing

legislation. As such, the task force developed short-term recommendations that the Legislature can enact, but also recommends re-constituting to further consider the duties required by the authorizing legislation.

II. TASK FORCE PROCESS

The task force held two meetings on the following dates: December 4 and December 11.

A. First meeting: December 4, 2023

The first meeting of the task force was held on December 4, 2023. Legislative staff provided an overview of the enabling legislation (Resolve 2023, chapter 97 in Appendix A) covering the duties, process and timeline for the task force's work.

Task force members gave extended introductions and had preliminary discussions. Each member spoke of their background, which organization/constituency they were representing, experience with the topic of the task force and any hopes and desires for the study direction or study outcomes.

The task force heard a presentation on communication accessibility in Maine hospitals from Malvina Gregory, Director of Interpreter and Cross-Cultural Services, at MaineHealth. Jeffrey Austin, Vice President of Government Affairs and Communications for Maine Hospital Association, supplemented that presentation by making himself available for any questions or data requests that task force members had for him.

The task force then discussed its next meeting date and who members wished to hear from.

B. Second meeting: December 11, 2023

The second and final meeting of the task force was held on December 11, 2023. Legislative staff provided a draft outline of the task force's report based on its discussions at the previous meeting.

The task force then heard a presentation from Polly Lawson, CI, CoreCHI, a medical interpreter from Pine Tree Society.

The task force next heard from Dr. Judy Shepard-Kegl, Professor of Linguistics, Emeritus, at the University of Southern Maine.

Then, the task force heard from Regan Thibodeau, PhD, and Sandra Wood, both of the University of Southern Maine Interpreter Training Program.

Legislative staff provided an updated outline of a draft report by the task force and task force members discussed and voted on recommendations.

III. PROBLEM IDENTIFICATION

Task force members had robust discussions at their first and second meetings about communication problems in healthcare settings as members of the Deaf, hard-of-hearing, Late Deafened, DeafDisabled, and DeafBlind communities. As described above, the task force was only able to meet twice and has not yet fully flushed out all of its recommendations. Despite the shortened meeting period, the task force did identify several areas for consideration that it hopes to examine if the task force is re-constituted by the Second Regular Session of the 131st Legislature.

A recurring theme from the task force's discussions was the diversity of needs among the Deaf, hard-of-hearing, Late Deafened, DeafDisabled, and DeafBlind communities with regard to communication accessibility, and the extent to which needs can vary across those groups and among individuals. The services offered in medical settings, however, do not reflect these varied needs. As discussed above, many Deaf individuals prefer in-person ASL interpreter services. However, an individual in the hard-of-hearing community may prefer Communication Access Real Time (CART) services, with an individual seeing real-time captioning of the words spoken by their provider. Assumptions made by a medical office or medical provider about what a patient needs for communication aids often leads to miscommunication and frustration – a theme that repeatedly arose throughout discussions.

Members expressed that often when a member goes to a medical appointment, the provider relies on video remoting interpreting (VRI) technology, with an interpreter providing interpreting services from a remote location to the patient on-site. This occurs even though the patient had requested an in-person American Sign Language (ASL) interpreter. Task force members discussed that reliance on VRI technology has numerous limitations. To start, the internet connection upon which the medical office relies upon may be spotty or lack the bandwidth to properly display the person providing VRI services. The patient (and provider) may also be unaware of the qualifications, if any, of the individual providing the remote interpreting services, and there is no accountability for any mistakes or misinterpretations made by the VRI provider. Similarly, the VRI interpreter may not be aware of regional/appropriate cultural signs and technology, potentially leading to further misinterpretations and misunderstandings. Finally, the staff within the medical office may not be properly trained or knowledgeable on how to operate the VRI equipment. This leads to delays in patient care and means the patient may spend less time with the provider than necessary when VRI-related issues take up time during the appointment. This issue alone is evidence that when patients' communication accessibility requests are not honored, critical information can be lost or misunderstood, emphasizing the importance of honoring requests.

Members said they often make medical appointments several months in advance and inform the medical office that they need in-person ASL interpreter services. However, several members shared that providers frequently make arrangements for an interpreter in the days leading up to the appointment – despite the ample notice that one has been requested – and are unable to find one in that short period of time. This leads to situations where a patient shows up to the medical office for an appointment and is told that an ASL interpreter is unavailable. Some task force members said that they have felt pressure to use VRI services because upon arriving to the medical office and finding out there is no ASL interpreter, they are offered the option to either

use VRI or to reschedule their appointment for a future date – sometimes a date that is months away. Rather than delay their medical care, they reluctantly choose to use VRI services.

Occasionally, patients or providers may rely on a patient's friend or family member to provide interpreting services when an in-person professional interpreter is not available. This practice can be inappropriate in medical settings for a variety of reasons, task force members said. One reason is that they are not a neutral party, meaning that friend or family member may choose to describe a medical condition or medical care option to the patient in a way that shields them from emotional harm. This leads to the patient not receiving all of the information from the provider. Another reason that this practice can be inappropriate or insufficient is that medical terminology is particularly complex and specialized, meaning that the friend or family member may fail to accurately convey to the patient the diagnosis or treatment options that the provider is discussing. Again, task force members emphasized that when providers do not honor patients' specific requests for communication accommodations, the quality of care ultimately declines when communication issues inevitably arise in these situations.

An important aspect of the task force's discussion – and a significant obstacle in forming solutions to these issues – is the general lack of data, including on the availability of ASL interpreters, the number of qualified medical interpreters and the number of complaints from the Deaf, hard-of-hearing, Late Deafened, DeafDisabled and DeafBlind communities. As noted above, a patient may go to a medical office for an appointment and be told that an ASL interpreter is not available despite a request for one. It is not known how often this happens because the recording and tracking of these data is not required nor kept by any entity. It is also not known how many times an individual requests a particular service, such as an in-person ASL interpreter, and whether that request is honored or not fulfilled. There is no state entity or independent organization in the State that compiles these data, nor is there any state entity that tracks how many ASL interpreters are qualified medical interpreters. In Maine, there is no state-level licensing of medical interpreters, just ASL interpreters generally. Therefore, there is no one location where a list of qualified medical interpreters in the state can be accessed. This dearth of information adds challenges and complexities to the task force's work, and underscores that any potential solutions may need to be reevaluated if these data become available.

Task force members also discussed a common issue in the State's workforce and services: regional disparity between Southern Maine and Northern Maine. Though there is no data, task force members discussed the reasonable belief that, because of Southern Maine's population density compared to the rest of the State, the need for ASL interpreters is likely more necessary in that region. Given that Southern Maine is much more populated than Northern Maine, task force members also believe that this means there is more availability of ASL interpreters in Southern Maine as compared to Northern Maine. Therefore, it makes sense that there is a regional disparity in requests and services received in Northern Maine as compared to Southern Maine.

The task force acknowledges that much of their discussion around problem identification relied on anecdotal evidence rather than empirical data. This is partly due to the difficulty of obtaining data during the task force's truncated meeting period, but it is also important to note that much of the data that would be of great use to the task force simply does not exist for the State of Maine.

Although these discussions were largely anecdotal, the task force emphasizes that these problems are persistent, widespread, and complex, and that these discussions would be supported by data gathered pursuant to their following recommendations.

IV. SHORT-TERM RECOMMENDATIONS

As noted above, the task force's work was significantly impacted by the short time period within which it could complete its duties, and these challenges were exacerbated further by the task force's determination that a lack of relevant data would hinder any long-term solutions. However, the task force believes that the implementation of some short-term solutions would result in great strides being made related to these issues, though more long-term work would still be necessary. In a show-of-hands vote, all members of the task force unanimously endorsed the following recommendations:

Recommendation 1: That the task force be reconstituted with the same membership and one additional member with expertise in medical interpreting. In response to not only the time constraints discussed above but the complexity and wide scope of the task force's duties, the first and most concrete recommendation of the task force is for legislation to be put forward to reconstitute the task force in the legislative interim following the Second Regular Session of the 131st Legislature. In order for the task force to be able to immediately resume their work upon enactment, the task force also recommends that they be reconstituted with the same membership appointments with one addition. Because medical interpreting is a relatively specialized skill, the task force recommends adding one member who has expertise in this field to be able to better guide the task force's work.

Recommendation 2: Require data collection to better inform long-term solutions and solicit solution proposals. The second recommendation of the task force reflects the difficulty of addressing this issue without sufficient data around interpreters, access, and licensing. The recommendation comprises of two separate – but interrelated – components.

i. The task force recommends that the Committee on Health and Human Services put forth legislation that would require two different reports to the committee: first, the task force recommends directing the Department of Health and Human Services, the Department of Labor, and the Department of Professional and Financial Regulation to collaboratively design and propose policy solutions that would ease the barriers to becoming licensed/certified as an ASL interpreter with specific consideration to the licensing/certification of Deaf interpreters. These agencies would present their findings and proposals in a report to the Committee on Health and Human Services for their consideration of further legislation. The task force believes that this, along with the recommendation below, will help to expand the pool of ASL/Deaf interpreters in the state and increase their availability when requested in healthcare settings and beyond.

ii. The task force also recommends legislation that would direct the Department of Health and Human Services, the Department of Labor, and the Department of Education (and/or the University of Maine System) to gather data on the overall

availability of ASL/Deaf interpreters in the state, an estimated statewide need for medical interpreters, and the landscape of available training opportunities for ASL/Deaf interpreters in the state. This would also include a request for recommendations from these entities on how to increase more workforce development opportunities in the state for ASL/Deaf interpreters, how to increase recruitment and retention of ASL/Deaf interpreters, and proposals that could ensure increased wages for ASL/Deaf interpreters that are commensurate to an interpreter's level of licensing/certification and experience. These proposals may include providing more opportunities for mid-career ASL/Deaf interpreters to audit classes at low/no cost to further develop and maintain their skillset. These entities would present their findings in a report to the Committee on Health and Human Services and the Committee on Education and Cultural Affairs for their consideration of legislation.

Recommendation 3: Require the implementation of language access plans at healthcare offices across the state and the development of guidelines on the appropriate use of VRI technology. The third recommendation of the task force involves change at the level of each healthcare office – including, but not limited to, hospitals, doctors' offices, long-term rehabilitation and care facilities, and others. The task force recommends that healthcare offices be required to develop and implement language access plans, much like those that are recommended (but not currently required) for hospitals. The task force feels that MaineHealth's language access plan could be an appropriate model for other hospitals and healthcare offices to meet this requirement. The implementation of a language access plan would standardize the steps needed for a patient to access the services that they need and outline clear steps for healthcare staff to take to meet the needs of the patient. Furthermore, the task force also recommends that language access plans are easily accessible to the public or made immediately available upon request. This is an integral step to help inform patients of not only how this aspect of the healthcare system functions, but to help inform each patient of their rights with regard to language and communication access.

Similarly, the task force recommends that the Department of Health and Human Services, in consultation with Deaf community leaders, develop and distribute statewide guidelines on the suitability of VRI services as a communication option with specific regard for its application in emergency situations. These guidelines would outline best practices for the use of VRI and emphasize that, when an in-person interpreter is requested, those arrangements should always be made ahead of a patient's arrival and VRI may be used very briefly until the arrival of an in-person interpreter. This recommendation addresses the overreliance on VRI services by healthcare providers and seeks to better inform providers about its shortcomings and best uses.

Recommendation 4: Require that the Maine Association for the Deaf's Sign Language Interpreting Committee present before the Committee on Health and Human Services. The task force recommends that the Maine Association for the Deaf's (MeAD) Sign Language Interpreting Committee be annually invited to present to the Committee on Health and Human Services, much like the presentation of agency annual reports or introductions from lobbying organizations at the beginning of the legislative session. The regularity of this presentation would help ensure that issues around sign language interpreting – and perhaps other general

issues affecting the Deaf community – are brought to the attention of the Legislature as they arise.

Recommendation 5: Mandate that an attempt is made to provide an in-person interpreter when one has been requested, and that these requests and outcomes are recorded and reported regularly. A problem that the task force repeatedly discussed during their meetings was a concern that, when a patient requests an in-person interpreter in a healthcare setting, the healthcare provider may not be attempting to provide that service and instead make the decision to only provide, for example, VRI instead of what was requested. To prevent decisions being made on behalf of patients, the task force recommends that healthcare providers be mandated to *attempt* to provide an in-person interpreter when it has been requested. To aid enforcement and to help gather the much-needed data around these issues, the task force also recommends that these requests, attempts, and outcomes be recorded by healthcare offices and reported to the Department of Health and Human Services. Recording these data would help shape a picture of the overall availability of interpreters and where the most requests are unable to be met. These data can then inform future solutions and identify where the highest needs are in the state.

V. ADDITIONAL CONSIDERATIONS; FURTHER STUDY

The task force emphasizes that the short-term solutions outlined above are only first steps to addressing issues around communication accessibility in healthcare settings and that there is much additional work to be done. This work was made especially difficult by the time constraints faced by the task force, which informed their prior recommendation to reconvene next legislative interim and continue their work on finding long-term solutions to issues around communication accessibility. Still, the task force wishes to highlight the importance of the following issues:

Patient rights: While the implementation of language access plans would help inform patients of their rights for communication accessibility, the task force emphasizes that there is much work to be done. The task force discussed a potential recommendation to require that all patients are provided with a list of available communication aids and services, a brief description of each service, and information on how to make requests for those services and what steps to take if those requests are not honored. This recommendation requires some additional discussion of its details, but would be directed specifically at patients and build on the short-term recommendation around language access plans.

Training and technical assistance: The task force recognizes that one aspect of communication accessibility may be that healthcare staff at all levels are simply inadequately informed on appropriately communicating with Deaf, hard-of-hearing, Late Deafened, DeafDisabled and DeafBlind patients. Thus, the task force hoped to recommend the development and requirement of ongoing training on such issues for staff members at all levels of the healthcare system as well as development of technical assistance materials, perhaps by DHHS, to support this endeavor.

Ongoing data collection: In addition to asking the above public entities with gathering one-time data on the availability and need for ASL/Deaf interpreters, the task force hoped to

recommend that one or more state agencies develop a mechanism to continuously track real-time availability of ASL/Deaf interpreters, hours worked by interpreters, availability of qualified medical interpreters, and gaps in access with particular attention to disparities between rural and urban areas (or the northern and southern regions of the state).

Wages and incentives: Recognizing the shortage of ASL/Deaf interpreters in the state as well as Maine's uncompetitive wages for interpreters, the task force also hoped to develop recommendations on how to increase wages and incentivize interpreters to remain and work in the state. At their first meeting, the task force did discuss legislation in New Hampshire that waives or reimburses tuition for ASL/Deaf interpreter programs if graduates remain and work in the state for a certain period of time. (Appendix C) However, this was too significant of an undertaking for the task force to explore in their extremely limited timeframe.

Improved access to written materials: The task force frequently discussed that, when communication service requests are not honored, misunderstandings between provider and patient are a common consequence. To address this, the task force discussed the possibility of expanding access to written materials such as discharge plans and informational brochures by offering those documents in alternate formats. This may take shape as documents available in video format with an ASL/Deaf interpreter, for example. This issue primarily arose in discussion at the task force's second and final meeting, and could not be worked on enough to make a concrete recommendation, but the task force still notes its importance.

VI. CONCLUSION

Given the challenges that the task force faced in completing its work this interim with regard to its limited timeline, members would like to reiterate the importance that their work continue in the next legislative interim. There remain many unanswered questions and long-term solutions to be sought, as well as more perspectives that the task force wishes to hear and engage in their work. The complexity of the issues identified in this report warrants long-term attention and ongoing solution development, and the task force is deeply appreciative for the opportunity to continue that work in the future.

The task force would like to thank those that gave their time to present information and perspectives to the task force during their two meetings. These presentations were instrumental in the development of this report and its recommendations, and the task force is grateful for the assistance of those presenters.

Finally, the task force would like to make a final endorsement of the short-term solutions recommended in this report. While these issues need further attention, implementation of these solutions would begin the important work of ensuring equitable access to appropriate communication methods for all Deaf, hard-of-hearing, Late Deafened, DeafDisabled, and DeafBlind patients in healthcare settings, and build momentum for long-term work to get off the ground and take shape.

APPENDIX A

Authorizing Legislation: Resolve 2023, c. 97

APPROVED
JULY 11, 2023
BY GOVERNOR

CHAPTER
97
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

H.P. 623 - L.D. 976

Resolve, to Establish the Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard-of-hearing Patients

Sec. 1. Task force established. Resolved: That the Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard-of-hearing Patients, referred to in this resolve as "the task force," is established.

Sec. 2. Task force membership. Resolved: That, notwithstanding Joint Rule 353, the task force consists of 7 members appointed as follows:

1. One member of the Senate who serves on the Joint Standing Committee on Health and Human Services, appointed by the President of the Senate;

2. One member of the House of Representatives who serves on the Joint Standing Committee on Health and Human Services, appointed by the Speaker of the House;

3. One member representing the Department of Health and Human Services, Office of Aging and Disability Services, appointed by the Commissioner of Health and Human Services;

4. One member representing Disability Rights Maine, appointed by the Commissioner of Health and Human Services;

5. One member representing the Maine Educational Center for the Deaf and Hard of Hearing and the Governor Baxter School for the Deaf, appointed by the Commissioner of Health and Human Services;

6. One member representing the Department of Labor who works with compliance issues regarding deaf and hard-of-hearing persons, appointed by the Commissioner of Labor; and

7. One member of the public who is a person who is deaf or hard of hearing, appointed by the Speaker of the House.

Sec. 3. Chairs. Resolved: That the Senate member is the Senate chair and the House of Representatives member is the House chair of the task force.

Sec. 4. Appointments; convening of task force. Resolved: That all appointments must be made no later than 30 days following the effective date of this

resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the task force. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the task force to meet and conduct its business.

Sec. 5. Duties. Resolved: That the task force shall study accessibility to appropriate communication methods for deaf and hard-of-hearing patients in health care settings and how that accessibility may be improved. The task force shall consider, but is not limited to, the following:

1. The availability of American Sign Language interpreters in health care settings;

2. The availability of other communication technologies in health care settings, such as video interpreters, automatically generated voice transcriptions and automatically generated captions;

3. Staff education and training programs on overcoming barriers to health care experienced by deaf and hard-of-hearing patients; and

4. Successful models for overcoming barriers to health care experienced by deaf and hard-of-hearing patients.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the task force, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, no later than December 6, 2023, the task force shall submit a report that includes its findings and recommendations, including suggested legislation, for presentation to the Joint Standing Committee on Health and Human Services. The Joint Standing Committee on Health and Human Services is authorized to report out legislation related to the report to the Second Regular Session of the 131st Legislature.

APPENDIX B

Membership List: Task Force on Accessibility to Appropriate Communication Methods for Deaf and Hard-of-hearing Patients

Task Force on Accessibility to Appropriate Communications Methods for Deaf and Hard-of-hearing Patients

Resolve 2023, Ch. 97

Membership List

Name	Representation
Senator Henry Ingwersen - Chair	Member of the Senate
Representative Colleen Madigan – Chair	Member of the House
Elizabeth Hopkins	Member representing the Department of Health and Human Services, Office of Aging and Disability Services
Thomas Minch	Member representing Disability Rights Maine
Emily Blachly	Member representing the Maine Educational Center for the Deaf and Hard of Hearing and the Governor Baxter School for the Deaf
Terry Morrell	Member representing the Department of Labor who works with compliance issues regarding deaf and hard-of-hearing persons
Sitara N. Sheikh	Member of the public who is a person who is deaf or hard of hearing

APPENDIX C

New Hampshire Tuition Reimbursement Statute

TITLE XV
EDUCATION

Chapter 200-M
CART PROVIDER AND SIGN LANGUAGE INTERPRETER NET TUITION REPAYMENT PROGRAM

Section 200-M:1

200-M:1 Definitions. –
In this chapter:
I. "CART provider" means a person who provides computer-aided, realtime translation of spoken language into English text by using a stenotype machine, notebook computer, and real time software to display the spoken text on a computer monitor, or other display device for individuals who are deaf or hard of hearing.
II. "Net tuition" means tuition costs for postsecondary school education that was directed toward the completion of a degree or certificate in judicial reporting, broadcast captioning, real time transcription, or sign language interpretation, or any other degree or certificate that the department of education, division of workforce innovation deems acceptable for purposes of CART provider and sign language interpreter net tuition repayment.
III. "Sign language interpreter" means a person who provides American Sign-Language based interpreting, which is the process of conveying information between American Sign Language and English.

Source. 2009, 207:1, eff. July 15, 2009. 2011, 224:137, eff. July 1, 2011. 2018, 315:27, eff. Aug. 24, 2018. 2019, 118:2, eff. July 1, 2019.

Section 200-M:2

200-M:2 CART Provider and Sign Language Interpreter Net Tuition Repayment Program Established. – The department of education, division of workforce innovation shall administer a program for the promotion, acquisition, and retention of CART providers and sign language interpreters in the state.

Source. 2009, 207:1, eff. July 15, 2009. 2011, 224:138, eff. July 1, 2011. 2018, 315:28, eff. Aug. 24, 2018. 2019, 118:3, eff. July 1, 2019.

Section 200-M:3

200-M:3 Application; Repayment. – An individual who has completed eligible CART or sign language interpreter training in accordance with rules adopted pursuant to RSA 200-M:5, including internships and residencies, and agrees to work as a CART provider or a sign language interpreter in this state, may apply to the department of education, division of workforce innovation for repayment under the CART provider and sign language interpreter net tuition repayment program and become eligible to be reimbursed up to 100 percent of his or her qualifying tuition not to exceed the cost of 4 years of in-state tuition at the university of New Hampshire, during a 5-year period of working as a CART provider or sign language interpreter. A 10 percent net tuition repayment shall be made upon completion of the first year of employment in this state, with an additional 10 percent made after the second year of work, an additional 20 percent after the third year of work, an additional 30 percent after the fourth year of work, and an additional 30 percent after the fifth

year of work.

Source. 2009, 207:1, eff. July 15, 2009. 2011, 224:138, eff. July 1, 2011. 2018, 315:29, eff. Aug. 24, 2018. 2019, 118:3, eff. July 1, 2019.

Section 200-M:4

200-M:4 Repealed by 2017, 195:17, eff. Sept. 3, 2017. –

Section 200-M:4-a

200-M:4-a CART Provider and Sign Language Interpreter Net Tuition Repayment Fund. – There is hereby established a fund to be known as the CART provider and sign language interpreter net tuition repayment fund. The fund shall include any sums appropriated for such purpose. In addition, the department of education, division of workforce innovation may accept public sector and private sector grants, gifts, or donations of any kind for the purpose of funding the provisions of this chapter. The moneys in this fund shall be nonlapsing and shall be continually appropriated to the department of education. The fund may be expended by the department of education to accomplish the purposes of this chapter.

Source. 2019, 118:1, eff. July 1, 2019.

Section 200-M:5

200-M:5 Administration; Rulemaking. – The department of education, division of workforce innovation shall adopt rules, pursuant to RSA 541-A, relative to procedures, eligibility, and qualifications for applicants, qualifying educational costs, criteria for terms of service by a CART provider and/or sign language interpreter, procedures for repayment of net tuition costs, and the administration of the program by the department of education, division of workforce innovation. The commissioner of the department of education shall annually report to the general court on the effectiveness of this program.

Source. 2009, 207:1, eff. July 15, 2009. 2011, 224:140, eff. July 1, 2011. 2018, 315:30, eff. Aug. 24, 2018. 2019, 118:4, eff. July 1, 2019.

State of Maine
131st Legislature, First Regular and First Special Sessions

Task Force to Evaluate the Impact of Facility Fees on Patients

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSIONS

Task Force to Evaluate the Impact of Facility Fees on Patients

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Mark Souders
Michelle Probert
Meg Garratt-Reed

Table of Contents

Executive Summary

The Task Force to Evaluate the Impact of Facility Fees on Patients, referred to in this report as the "task force" was established by Public Law 2023, chapter 410 to evaluate the impact on patients of paying facility fees charged by health care providers. Traditionally, facility fees have been charged by hospitals to account for the "overhead" to maintain hospital inpatient and emergency services and cover the operating and administrative expenses to keep hospitals open and accessible to patients at all times. More recently, facility fees have become more commonly charged to patients receiving health care services in non-hospital settings, such as a physician office acquired by a hospital or a health system. With more health care services being delivered in outpatient settings and more patients being responsible for paying a greater portion of costs, more patients are being directly impacted by facility fees.

During the First Regular Session of the 131st Legislature, Senator Troy Jackson, President of the Senate, proposed legislation to address facility fees charged by health care providers. The bill, LD 1795, An Act to Protect Patients by Prohibiting Certain Medical Facility Fees, was introduced following a Portland Press Herald investigative report that chronicled the problems faced by Mainers with medical billing, including the charging of high facility fees that may not be covered by insurance. In the article, Maine patients recounted their experiences with being charged for facility fees that were not explained prior to receiving services or being charged amounts for facility fees that the patients believed were too high. Given the limited time left in the legislative session and the lack of data on the extent to which Maine patients and Maine's health care system were being adversely impacted by facility fees, the Joint Standing Committee on Health Coverage, Insurance and Financial Services recommended that LD 1795 be amended to replace the bill and do two things: 1) to require the Maine Health Data Organization to annually report on payments made by payors in this State for facility fees charged by health care providers; and 2) to establish the Task Force to Evaluate the Impact of Facility Fees on Patients to further study the issue and report back to the Legislature. The Legislature followed the Committee's recommendation and enacted Public Law 2023, chapter 410 to establish the task force.

The task force was chaired by Senator Donna Bailey and Representative Poppy Arford. Other voting members of the task force were appointed to represent stakeholder interests, including a member with expertise, knowledge and background in health care policy and members representing the interests of health care consumers, health insurance carriers, hospitals and retired persons. The Director of the Office of MaineCare Services within the Department of Health and Human Services and the Director of the Office of Affordable Health Care participated as ex officio non-voting members. A copy of the complete membership list is included as Appendix B.

The task force held three public meetings at the State House on December 1, December 7 and December 13. Over the course of the three meetings, the task force used its limited time to fulfill the duties set forth in the authorizing legislation. The task force solicited input from the following stakeholders about industry practices related to facility fees and the impact of facility fees on patients: the Maine Association of Health Plans, Maine Hospital Association, Maine Medical Association, Health Care Purchaser Alliance of Maine and Consumers for Affordable

Health Care. The task force reviewed and considered current federal and State laws related to transparency of cost information for hospitals and health insurance carriers and to standardized billing requirements. The task force also reviewed model legislation on facility fees developed by the National Academy for State Health Policy and the laws enacted in other states that address facility fees.

Given the limited time available, the task force focused on the following policy areas during their discussions: 1) the definition of facility fee; 2) data collection and reporting associated with facility fees; 3) notice or transparency requirements related to facility fees; 4) limitations on facility fees associated with telehealth services; 5) limitations on facility fees based on type of service or location; 6) assistance to patients experiencing general bills issues, including billing of facility fees; and 7) the financial impact on patients for services depending on the setting or site of service. In this report, the task force proposes broad recommendations related to these policy areas that are based on the information available to members at the time of the meetings. The task force acknowledges that, in the time available, it was not possible to consider and understand all of implications and consequences of the proposed recommendations. The task force encourages the Legislature to engage task force members and other stakeholders in additional discussion before moving forward on any of the recommendations.

The task force believes that any policy recommendations related to facility fees should be made in a manner that aligns with federal law, regulations and guidelines as they currently exist and continue to evolve with the goal of requiring providers and facilities to be transparent with respect to facility fees, and of minimizing the burden to patients that result from imposing facility fees. With these considerations in mind, the task force provides the following comments and recommendations. Unless otherwise noted, the task force's recommendations are unanimously supported by all members.

1. Definition of facility fee

- **Recommend that the Legislature review current definitions of "facility fee" and consider how best to define "facility fee", including whether charges billed by ambulatory care facilities or other independent non-hospital based facilities should be included in the scope of any legislation limiting the charging of a facility fee**

2. Data collection and reporting associated with facility fees

- **Recommend that the Maine Health Data Organization and the Office of Affordable Health Care be directed to review the available data reported by MHDO related to facility fees pursuant to the annual reporting requirement established by Public Law 2023, chapter 410; identify any gaps in the data being reported and collected related to facility fees; and make recommendations for any additional data reporting requirements related to facility fees to the Legislature no later than December 31, 2024**

3. Notice or transparency requirements related to facility fees

- **Recommend that the Legislature consider the introduction of legislation to require health care providers that charge a facility fee post notice on their website and on signs in common areas of the facility, including information on how to access the Maine Health Data Organization website for more information about facility fees and under what circumstances facility fees may be charged depending on the payor for a service and the setting in which a service is provided to patient**

- **Recommend that the Maine Health Data Organization be directed to develop information on its publicly accessible website designed to educate patients about facility fees and whether and in what circumstances depending on payor and type of service a facility fee may be charged**

- **Recommend that the Legislature consider the introduction of legislation to require health care providers to notify patients prior to a scheduled service if they will be charged a facility fee associated with their scheduled service** *(Task Force Vote: 6-2)*

- **Recommend that the Legislature consider the introduction of legislation to require that, if a health care provider charges a patient a facility fee, a health care provider and any health care payor must identify any facility fee separately in an itemized manner on any bill or explanation of benefits sent to a patient, to the extent possible** *(Task Force Vote: 6-2)*

4. Limitations on facility fees associated with telehealth services

- **Recommend that the Legislature consider the introduction of legislation to prohibit a health care provider from charging a facility fee for telehealth services when a patient is not in a facility** *(Task Force Vote: 6-2)*

5. Limitations on facility fees based on location or type of service

- **Recommend that the Maine Health Data Organization be directed to review its available data to determine if any health care providers have charged more than one facility fee per medical encounter on the same date of service and report back to the Legislature on its findings**

- **Recommend that the Office of Affordable Health Care be directed to review other state laws that impose limitations or prohibitions on facility fees to determine if similar limitations or prohibitions would reduce the cost of care for consumers in Maine and report back to the Legislature on its findings**

- **Recommend that the Legislature consider the introduction of legislation to require hospitals to bill uninsured patients using a single invoice that itemizes any facility fees and professional fees on the invoice in order to eliminate any confusion for patients who**

may have previously received separate bills for facility fees and professional fees associated with the same service

- ❖ **Recommend that the Legislature consider the introduction of legislation to regulate facility fees charged, billed or collected by a health care provider, except for the charging, billing or collection of facility fees from MaineCare, by imposing the limitations on facility fees included in the NASHP model legislation as follows:**
  - o **Prohibit facility fees charged by hospital-affiliated providers except for services provided on a hospital's campus (all buildings within 250 yards of main building); at a facility that includes a licensed hospital emergency department; or emergency services provided at a licensed freestanding emergency facility; and**
  - o **Prohibit facility fees for outpatient evaluation and management services regardless of where the services are provided. (***Task Force Vote: 5-3 vote*)

6. Assistance to patients experiencing general billing issues, including billing of facility fees

- ❖ **Recommend that the Legislature consider the introduction of legislation to establish a complaint mechanism for patients experiencing billing issues with health care providers, including facility fees**

7. Financial impact on patients for services depending on the setting or site of service

- ❖ **Does not recommend any action related to this issue as cost sharing obligations are applied by health insurance carriers in a consistent manner according to the terms and benefits of a patient's health plans**

The task force believes it is important that policymakers understand how facility fees charged by health care facilities and health care providers impact Maine patients and Maine's health care system: determine how facility fees should be communicated to patients in a transparent manner; and take steps to minimize the burden to patients that result from imposing facility fees. With these considerations in mind, the task force has made the recommendations included in this report. In the limited time available, however, it was not possible for the task force to consider and understand all of the implications and consequences of its recommendations. The task force encourages the Legislature to carefully consider its recommendations and engage task force members and other stakeholders in further discussions before moving forward with these recommendations.

I. INTRODUCTION

The Task Force to Evaluate the Impact of Facility Fees on Patients, referred to in this report as the "task force" was established by Public Law 2023, chapter 410 to evaluate the impact on patients of paying facility fees charged by health care providers. The law directs the task force to submit a report that includes its findings and recommendations to the Maine Legislature no later than December 6, 2023. Pursuant to Joint Rule 353, an extension of that deadline was requested and granted until December 15, 2023. A copy of the law establishing the task force is included as Appendix A.

Public Law 2023, chapter 410 became effective on October 25, 2023. Pursuant to the law, members were required to be appointed within 30 days of that date. The task force has 8 voting members and 2 ex officio non-voting members. Senator Donna Bailey was named the Senate chair and Representative Poppy Arford was named as the House Chair of the task force. The remaining members of the task force were appointed to represent the interests articulated in the law as follows:

- A member representing a statewide organization supporting the interests of health care consumers;
- A member representing the interests of health insurance carriers;
- A member with expertise, knowledge and background in health care policy;
- A member representing a statewide organization of retired persons[1];
- A member representing a statewide organization of hospitals; and
- A member representing a hospital in the State.

The Director of the Office of MaineCare Services within the Department of Health and Human Services and the Director of the Office of Affordable Health Care participated as the ex officio non-voting members. A copy of the complete membership list is included as Appendix B.

The task force held three public meetings at the Maine State House on December 1, December 7 and December 13. Materials distributed and reviewed at each meeting, as well as additional background and other study-related materials were posted on the task force's webpage and are available at this link: https://legislature.maine.gov/task-force-to-evaluate-the-impact-of-facility-fees-on-patients.

II. Background

Traditionally, facility fees have been charged by hospitals to account for the "overhead" to maintain hospital inpatient and emergency services and cover the operating and administrative expenses to keep hospitals open and accessible to patients at all times. For two decades, Medicare and Medicaid billing rules have required hospitals to bill for a facility fee for use of a facility and to bill for a professional fee for the health care services provided to a patient. More recently, facility fees have become more commonly charged to patients receiving health care

[1] With the approval of the chairs, Jess Maurer, who was appointed by the Speaker of the House as this member, designated another staff member of the Maine Council on Aging, Jena Jones, to participate in her place.

services in non-hospital settings, such as a physician office owned or acquired by a hospital or a health system. Medicare and Medicaid regulations permit the billing of facility fees for visits in hospital-based inpatient and outpatient settings and also for services rendered in certain physician-owned ambulatory surgical centers. As a result, the services rendered by the physician practices owned or acquired by hospitals can be and are billed as a part of the overall health system that regularly charges facility fees, even when that physician office may not be located in a hospital or on a hospital campus. With respect to patients that are commercially insured, State law requires that all services provided in an "office setting" be submitted to health insurers on a single standardized claim form. The law effectively prohibits carriers from paying separate facility fees for services provided in office settings. However, with more health care services being delivered in outpatient settings and more patients being responsible for a greater portion of costs, more patients are being directly impacted by facility fees.

During the First Regular Session of the 131st Legislature, Senator Troy Jackson, President of the Senate, proposed legislation to address facility fees charged by health care providers. The bill, LD 1795, An Act to Protect Patients by Prohibiting Certain Medical Facility Fees, was introduced following a Portland Press Herald investigative report that chronicled the problems faced by Mainers with medical billing, including the charging of high facility fees that may not be covered by insurance. In the article, Maine patients recounted their experiences with being charged for facility fees that were not explained prior to receiving services or being charged amounts for facility fees that the patients believed to be too high. As originally drafted, the bill proposed to prohibit certain health care providers from charging, billing or collecting a facility fee in certain situations and requires annual reporting on the amount of facility fees charged or billed. At the public hearing on LD 1795, Senator Jackson spoke about the rising costs of health care in Maine and that facility fees were one factor that was contributing to rising costs. His testimony noted that the health care billing system is complex and patients are not made fully aware about how facility fees may significantly impact the cost of the health care they receive. The Legislature also received other testimony about patients receiving facility fees for routine care or outpatient services even when the provider office is not located in a hospital or on a hospital campus. Based on calls to their HelpLine, the testimony from Consumers for Affordable Health Care provided several anecdotal examples of seemingly unwarranted facility fees, including the charging of multiple facility fees for a single visit, the charging of facility fees for visits to a freestanding urgent care clinic and the charging of a facility fees for a telehealth visit.

Given the limited time left in the legislative session and the lack of data on the extent to which Maine patients and Maine's health care system were being adversely impacted by facility fees, the Joint Standing Committee on Health Coverage, Insurance and Financial Services recommended that LD 1795 be amended to replace the bill and do two things: 1) to require the Maine Health Data Organization to annually report on payments made by payors in this State for facility fees charged by health care providers; and 2) to establish the Task Force to Evaluate the Impact of Facility Fees on Patients to further study the issue and report back to the Legislature. The Legislature followed the Committee's recommendation and enacted Public Law 2023, chapter 410 to establish the task force.

Public Law 2023, chapter 410 directed the task force to:

- Review the industry practices for charging facility fees, uses of the funds received as facility fees and impacts on patients of paying facility fees charged by health care providers;
- Review federal transparency requirements for hospitals and health insurance carriers regarding cost of treatment, identify any gaps or redundancies between state laws and federal laws and identify any problems with enforcement of those laws;
- Consider efforts in other states and by national organizations related to regulation of, or minimization of, facility fees and the potential effects such efforts might have on health care costs in this State; and
- Make recommendations for changes in laws or rules regarding facility fees and medical cost transparency based on the information examined under this subsection.

III. Task Force Process

Over the course of three meetings, the task force used its limited time to fulfill the duties set forth in the authorizing legislation. The task force solicited input from the following stakeholders about industry practices related to facility fees and the impact of facility fees on patients: the Maine Association of Health Plans, Maine Hospital Association, Maine Medical Association, Health Care Purchaser Alliance of Maine and Consumers for Affordable Health Care.

Task force staff presented materials on current federal and State laws related to transparency of cost information for hospitals and health insurance carriers and to standardized billing requirements. An overview of these laws is provided below. The Maine Health Data Organization also provided an update on the annual reporting on facility fee payments required by Public Law 2023, chapter 410. While work on the report is ongoing, the first annual report is expected to be provided to the Legislature in January 2024.

In addition, the task force invited Maureen Hensley-Quinn, one of the task force members, to present information on the development of National Academy of State Health Policy (NASHP) Model Legislation on facility fees. The task force also received a presentation on Connecticut's laws related to facility fees from Vicki Veltri, Senior Policy Fellow, NASHP, and former Executive Director of the Office of Health Strategy in Connecticut. Finally, task force staff provided information and materials related to the laws enacted in other states that address facility fees. An overview of the NASHP model legislation and other state laws is provided below.

At the conclusion of its meetings, the task force voted to put forth for consideration by the 13st Legislature the recommendations described in section IV.

- **Current Federal and State Law and Regulations Related to Transparency and Information about Health Care Costs**

The following is a brief outline of the federal law and regulations and State laws related to requirements for hospitals and other health care providers to be transparent about their prices and disclose information about health care costs to patients.

Federal law and regulations related to hospital price transparency. Hospitals are required to provide clear, accessible pricing information online about the items and services they provide in two ways: (1) as a comprehensive machine-readable file with all items and services; and (2) in a display of at least 300 shoppable services in a consumer-friendly format. Under the federal rule, the penalty for noncompliance is progressive: hospitals receive a written warning and are permitted to file a corrective action plan; only if the corrective action plan is not satisfactory are hospitals then subject to civil monetary penalties.

Federal law and regulations related to good faith estimates. Federal law also sets forth requirements for health care providers to provide "good faith estimates" to patients prior to a scheduled health care service (or set of services). Currently, providers must provide these estimates to uninsured patients, but the implementation of the requirements for insured patients has been delayed pending federal rulemaking. Once federal rules are in place, health insurance health insurance carriers will also be required to provide "advance explanation of benefits" for scheduled services upon request; consumers can request advance information from their health insurance carrier about how services will be covered before they are provided. For scheduled services, consumers can submit requests and, generally within three business days, the carrier must provide written information including about whether the provider/facility participates in-network, and a good faith estimate of what the plan will pay and what patient will have to pay.

Federal law and regulations related to price information from health insurance carriers. Most group health plans and issuers of group or individual health insurance coverage are required to disclose personalized pricing information for 500 covered items and service to their participants, beneficiaries, and enrollees through an online consumer tool, by phone, or in paper form, upon request. Cost estimates must be provided in real-time based on cost-sharing information that is accurate at the time of the request. Detailed price information must also be made available in machine-readable files: 1) rates for all covered items and services between the plan or issuer and in-network providers; and 2) allowed amounts for, and billed charges from, out-of-network providers.

State laws. There are several provisions in current law that require disclosure of information about the costs of health care services and that relate to billing for health care services, including:

- 22 MRSA §1712 requiring hospitals to provide itemized bills to patients within 30 days of a request;
- 22 MRSA §1718 requiring hospitals and ambulatory surgical centers to provide the average charge for any inpatient service or outpatient procedure upon request;
- 22 MRSA §1718-B requiring health care entities to provide information about prices of most frequently provided health care services, about the MHDO's CompareMaine website and about the "right to shop" for certain services;

- 22 MRSA §1718-C requiring health care entities to provide estimate of the total price of medical services rendered during a single encounter to uninsured patients upon request, including identification of third-party health care entities, and to notify patient of charity care policy;
- 22 MRSA §1718-D prohibiting balance billing for surprise bills and out-of-network emergency services;
- 22 MRSA §1721 prohibiting a patient or patient's insurer from being charged by a health care facility for health care services provided as a result of or to correct a mistake or preventable adverse event;
- 22 MRSA §8712 requires the Maine Health Data Organization to create a publicly accessible interactive website with information related to payments for services rendered by health care facilities and practitioners to residents of the State; see MHDO's CompareMaine website. Beginning January 2024, MHDO must also post on its website and provide annual reports on payments for facilities fees made by payors to the extent the information is available; and
- 24-A MRSA §4303, subsection 21 requires health insurance carriers to make information available to consumers about estimated costs of certain comparable health care services (Physical and occupational therapy services; radiology and imaging services; laboratory services; and Infusion therapy services). Carriers may comply by providing this information on its publicly accessible website or by consumers to the publicly accessible health care costs website of the Maine Health Data Organization.

- **Current Federal and State Law Related to Standardized Claims Forms for Billing**

Federal standardized claim forms. Federal law regulations require that health care providers use the following standardized claim forms or formats to bill for services provided by Medicare and Medicaid. These same standardized forms have been adopted for use by all payors of health care claims, including health insurers and self-insured employer health plans. Claims from institutional providers, such as hospitals, are billed on a form referred to as the UB 4 or CMS 1450. Claims from health care professionals, such as physicians, are billed on a form referred to as the CMS 1500.

State laws related to standardized claim forms. The following state laws govern the use of standardized claims forms, including:

- 24 MRSA §2985 requiring health care practitioners who directly bills for health care services to use the current standardized claim form for professional services approved by the federal Government;
- 24-A MRSA §2753 requiring insurers providing individual health coverage to accept the standardized claim for professional services from a health care practitioner:
    - requires all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers;
    - insurers may not be required to accept a claim submitted on another form
    - services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner;

- *"office setting" defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility:*

- 24-A MRSA §2823-B requiring insurers providing group health coverage to accept the standardized claim for professional services from a health care practitioner:
  - requires all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers;
  - insurers may not be required to accept a claim submitted on another form;
  - services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner;
  - *"office setting" defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility;*
- 24-A MRSA §4235 requiring health maintenance organizations providing individual or group health coverage to accept the standardized claim for professional services from a health care practitioner:
  - requires all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers;
  - health maintenance organizations may not be required to accept a claim submitted on another form;
  - services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner;
  - *"office setting" defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility; and*
- 24-A MRSA §1912 requiring third-party administrators who administer claims must accept the standardized claim for professional services from a health care practitioner:
  - requires all services provided by a health care practitioner in an office setting to be submitted on the standardized federal form used by noninstitutional providers;
  - administrators may not be required to accept a claim submitted on another form
  - services in a nonoffice setting may be billed as negotiated between the insurer and health care practitioner;
  - *"office setting" defined as a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility.*

- **National Academy of State Health Policy Model Legislation**

In response to requests from state officials and policymakers to develop policy proposals that address rising health care costs, the National Academy of State Health Policy (NASHP) identified facility fees as one factor contributing to health care costs and developed model legislation related to one facility fees in 2020. The model bill proposes to prohibit certain facility fees from being charged to consumers accessing primary care services. The NASHP model legislation does not eliminate all facility fees, but it restricts their use by location and service. With regard to location, the model prohibits any health care facility that is located more

than 250 yards from a hospital campus from charging a facility fee for services provided at that location, eliminating the ability of certain physician practices acquired by hospitals from adding facility fees simply because the doctor's office is no longer independent from a hospital or health system. With regard to the type of service, the model also prohibits providers from charging facility fees for certain classes of outpatient services, including but not limited to evaluation and management services, regardless of the location where that specific service was provided. Finally, the model also includes a requirement for health systems to report their facility fee charges to the state on an annual basis.

- **State Legislation to Address Facility Fees**

There are currently 12 states that have enacted legislation to address facility fees in some manner. The actions taken by states have focused on requiring reporting and disclosure related to facility fees, establishing state oversight over facility fees, limiting or restricting the instances when health care providers may charge facility fees and prohibiting the charging of facility fees for certain telehealth visits.

Connecticut, Colorado, Indiana and Maryland have laws requiring annual reporting to the state on facility fees.

Connecticut, Colorado, Florida, Indiana, Maryland, Massachusetts, Minnesota, New York, Texas and Washington have laws requiring providers to post notice in their facilities or to specifically disclose facility fees to patients prior to delivering care.

Connecticut, Colorado, Indiana, Maryland, New York and Texas have laws limiting or restricting the charging of facility fees for certain services or in certain outpatient settings not on a hospital campus.

Connecticut, Georgia, Maryland, Minnesota, Ohio and Washington have laws prohibiting facility fees for certain telehealth visits.

An overview of the laws enacted in other states is included as Appendix C. The consideration of legislative proposals by state policymakers related to facility fees is expected to continue in 2024.

IV. Recommendations

Given the limited time available, the task force focused on these policy areas during their discussions: 1) the definition of facility fee; 2) data collection and reporting associated with facility fees; 3) notice or transparency requirements related to facility fees; 4) limitations on facility fees associated with telehealth services; 5) limitations on facility fees based on type of service or location; 6) assistance to patients experiencing general billing issues, including billing of facility fees; and 7) financial impact on patients for services depending on the setting or site of service. In this report, the task force proposes broad recommendations in these policy areas that are based on the information available to members at the time of the meetings and the task force acknowledges that it was not possible to consider and understand all of the implications and

consequences of the recommendations. The task force encourages the Legislature to engage task force members and other stakeholders in additional discussion before moving forward on any of the recommendations.

The task force believes that any policy recommendations related to facility fees should be made in a manner that aligns with federal law, regulations and guidelines as they currently exist and continue to evolve with the goal of requiring providers and facilities to be transparent with respect to facility fees, and of minimizing the burden to patients that result from imposing facility fees. With these considerations in mind, the task force provides the following comments and recommendations. Unless otherwise noted, the task force's recommendations are unanimously supported by all members.

1. Definition of facility fee

- **Recommend that the Legislature review current definitions of "facility fee" and consider how best to define "facility fee", including whether charges billed by ambulatory care facilities or other independent non-hospital-based facilities should be included in the scope of any legislation limiting the charging of a facility fee**

The task force recommends that the Legislature review current definitions of "facility fee" and consider how best to define "facility fee", including whether charges billed by ambulatory care facilities or other independent non-hospital-based facilities should be included in the scope of any legislation limiting the charging of a facility fee. Under current law (as enacted in Public Law 2023, chapter 410) for the purposes of the annual reporting on facility fee payments by the Maine Health Data Organization, a facility fee is defined as "any fee charged or billed by a health care provider for outpatient services provided in a hospital-based facility or freestanding emergency facility that is intended to compensate the health care provider for the operational expenses of the health care provider, separate and distinct from a professional fee, and charged or billed regardless of how a health care service is provided." The task force members note that the scope of this definition and definitions used in laws enacted in other states is limited to hospital-based facilities and freestanding emergency care facilities. During its meetings, the task force heard about the charging of facility fees to some patients by independent ambulatory surgical care centers or other independent providers. The task force suggests that the Legislature consider whether the scope of the definition of facility fee should be broadened to include ambulatory care centers or other non-hospital-based facilities. Before making any substantive recommendation to limit or prohibit facility fees, the task force believes the Legislature should have a comprehensive understanding of how to define "facility fee" and consider if a facility fee is appropriate to account for the operating and administrative expenses of a health care provider, what type of providers or facilities are entitled to a facility fees and for what type of services a facility fee may be imposed.

2. Data collection and reporting associated with facility fees

- **Recommend that the Maine Health Data Organization and the Office of Affordable Health Care be directed to review the available data reported by MHDO related to facility fees pursuant to the annual reporting requirement established by Public Law**

2023, chapter 410; identify any gaps in the data being reported and collected related to facility fees; and make recommendations for any additional data reporting requirements related to facility fees to the Legislature no later than December 31, 2024

The task force recommends that the Maine Health Data Organization and the Office of Affordable Health Care be directed to review the available data reported by MHDO related to facility fees pursuant to the annual reporting requirement established by Public Law 2023, chapter 410; identify any gaps in the data being reported and collected related to facility fees; and make recommendations for any additional data reporting requirements related to facility fees to the Legislature no later than December 31, 2024. Pursuant to Public Law 2023, chapter 410, in January 2024, the Maine Health Data Organization will be required to begin reporting on facility fee payments on an annual basis. At its first meeting, the task force members were briefed by MHDO on its progress in collecting data for the report and on the methodology being used to extract data from the existing MHDO all-payer claims database. During its discussion, the task force learned that a facility fee is billed using the UB-4 standard claim form for institutional providers and professional services rendered by physicians and other health care practitioners are billed using a different claim form, the CMS 1500. However, task force members believe that differentiating facility fee payments based on the type of claim form may not provide the most accurate picture of how "overhead" costs, including facility fees, are accounted for in the data currently available. The task force recommends that the Office of Affordable Health Care and the Maine Health Data Organization work in conjunction to review the first report carefully to identify any needs for additional data reporting requirements related to facility fees.

3. Notice or transparency requirements related to facility fees

- **Recommend that the Legislature consider the introduction of legislation to require health care providers that charge a facility fee post notice on their website and on signs in common areas of the facility, including information on how to access the Maine Health Data Organization website for more information about facility fees and under what circumstances facility fees may be charged depending on the payor for a service and the setting in which a service is provided to patient**

The task force recommends that the Legislature consider the introduction of legislation to require health care providers that charge a facility fee post notice on their website and on signs in common areas of the facility, including information on how to access the Maine Health Data Organization website for more information about facility fees and under what circumstances facility fees may be charged depending on the payor for a service and the setting in which a service is provided to patient. The task force believes that patients lack a complete understanding if and when facility fees may be charged. Testimony provided at the public hearing on LD 1795 and input provided by Consumers for Affordable Health Care in a presentation to the task force indicates that patients are surprised and confused when facility fees are charged, particularly for services provided in an office setting. The task force supports additional transparency measures related to facility fees and urges the Legislature to consider requirements for health care providers to post notice about facility fees in their facilities and on their websites so patients are more aware of facility fees and under what circumstances facility

fees may be charged depending on the payor for a service and the setting in which a service is provided to patient.

- **Recommend that the Maine Health Data Organization be directed to develop information on its publicly accessible website designed to educate patients about facility fees and whether and in what circumstances depending on payor and type of service a facility fee may be charged**

The task force recommends that the Maine Health Data Organization be directed to develop information on its publicly accessible website designed to educate patients about facility fees and whether and in what circumstances depending on payor and type of service a facility fee may be charged. In order to provide a single, trusted and uniform source of information, the task force believes that MHDO is the appropriate entity to develop information about facility fees to educate patients and the general public.

- **Recommend that the Legislature consider the introduction of legislation to require health care providers to notify patients prior to a scheduled service if they will be charged a facility fee associated with their scheduled service**

Six members of the task force recommend that the Legislature consider the introduction of legislation to require health care providers to notify patients prior to a scheduled service if they will be charged a facility fee associated with their scheduled service. In the interest of transparency, the members supporting the recommendation believe that the Legislature should consider legislation requiring providers to notify patients individually if they will be charged a facility prior to receiving a scheduled service.

The task force members opposed to the recommendation (Jeff Austin and Mark Souders) note that posting general notices about facility fees on a provider's website and in their offices would provide adequate notice to a patient and an additional written notice to a patient is not necessary.

- **Recommend that the Legislature consider the introduction of legislation to require that, if a health care provider charges a patient a facility fee, a health care provider and any health care payor must identify any facility fee separately in an itemized manner on any bill or explanation of benefits sent to a patient, to the extent possible**

Six members of the task force recommend that the Legislature consider the introduction of legislation to require that, if a health care provider charges a patient a facility fee, a health care provider and any health care payor must identify any facility fee separately in an itemized manner on any bill or explanation of benefits sent to a patient, to the extent possible. In the interest of transparency, the members supporting the recommendation believe that it is reasonable to require providers to itemize any facility fee separately on any bill or explanation of benefits sent to a patient.

The task force members opposed to the recommendation (Jeff Austin and Mark Souders) reiterate that posting general notices about facility fees on a provider's website and in their

offices would provide adequate notice to a patient and an itemized bill would add an unnecessary administrative burden on a provider.

4. Limitations on facility fees associated with telehealth services

- **Recommend that the Legislature consider the introduction of legislation to prohibit a health care provider from charging a facility fee for telehealth services when a patient is not in a facility**

Six members of the task force recommend that the Legislature consider the introduction of legislation to prohibit a health care provider from charging a facility fee for telehealth services when a patient is not in a facility. As a matter of policy, the members supporting the recommendation do not believe a facility fee is an appropriate charge in association with a telehealth visit when the patient receiving those telehealth services is not present in a facility.

The task force members opposed to the recommendation (Jeff Austin and Mark Souders) believe that the data available to the task force is limited and does not appear to demonstrate that facility fees are being charged inappropriately for telehealth visits on a widespread basis in the State.

5. Limitations on facility fees based on location or type of service

- **Recommend that the Maine Health Data Organization be directed to review its available data to determine if any health care providers have charged more than one facility fee per medical encounter on the same date of service and report back to the Legislature on its findings**

The task force recommends that the Maine Health Data Organization be directed to review its available data to determine if any health care providers have charged more than one facility fee per medical encounter on the same date of service and report back to the Legislature on its findings. One of the anecdotal examples provided to the task force about the impact of facility fees on patients related to a patient who was charged three separate facility fees in the same amount associated with three separately-coded services provided to that patient during one encounter for eye surgery in an ambulatory surgical center. On its face, this is the type of circumstance that task force members believe the charging of more than one facility fee for the same medical encounter is inappropriate. However, members want to determine if this is an example of a billing error or an example of a larger issue with how facility fees are being billed. Before making any substantive recommendation, the task force want the Maine Health Data Organization to review its data to determine if there are other examples of multiple facility fees being charged for the same medical encounter.

- **Recommend that the Office of Affordable Health Care be directed to review other state laws that impose limitations or prohibitions on facility fees to determine if similar limitations or prohibitions would reduce the cost of care for consumers in Maine and report back to the Legislature on its findings**

The task force recommends that the Office of Affordable Health Care be directed to review other state laws that impose limitations or prohibitions on facility fees to determine if similar limitations or prohibitions would reduce the cost of care for consumers in Maine and report back to the Legislature on its findings. While the task force reviewed the laws enacted in other states that limit facility fees and received a presentation on the impact of such a law on costs in Connecticut, the task force did not have enough time to research and understand the potential impact a limitation on facility fees might have on patients here in Maine. Task force members want to understand the impact a limitation on facility fees may have on the cost of care for patients, but did not have enough time to do so. The task force believes the more information is needed and that the Office of Affordable Health Care should be directed to review and analyze the limitations adopted in other state laws to help determine if one or more of the limitations imposed in other states would reduce the cost of care for Maine patients.

- **Recommend that the Legislature consider the introduction of legislation to require hospitals to bill uninsured patients using a single invoice that itemizes any facility fees and professional fees on the invoice in order to eliminate any confusion for patients who may have previously received separate bills for facility fees and professional fees associated with the same service**

The task force recommends that the Legislature consider the introduction of legislation to require hospitals to bill uninsured patients using a single invoice that itemizes any facility fees and professional fees on the invoice in order to eliminate any confusion for patients who may have previously received separate bills for facility fees and professional fees associated with the same service. The task force believes that the current practice of health care providers to bill for health care services rendered in a hospital-based facility using two separate invoices – one that bills for the facility fee or "overhead" costs of receiving services in that facility and another invoice that bills for the professional services of physicians or other health care practitioners – may be contributing to a patient's confusion about facility fees and whether they are appropriately being charged. Members suggest that, if a patient received one invoice that separately identified the charges for the use of the facility and the charges for the services of health care professionals during one medical encounter, a patient may better understand the necessary billing components for the patient's medical encounter.

- **Recommend that the Legislature consider the introduction of legislation to regulate facility fees charged, billed or collected by a health care provider, except for the charging, billing or collection of facility fees from MaineCare, by imposing the limitations on facility fees included in the NASHP model legislation as follows:**
  - **Prohibit facility fees charged by hospital-affiliated providers except for services provided on a hospital's campus (all buildings within 250 yards of main building); at a facility that includes a licensed hospital emergency department; or emergency services provided at a licensed freestanding emergency facility; and**
  - **Prohibit facility fees for outpatient evaluation and management services regardless of where the services are provided.**

Five members of the task force recommend that the Legislature consider the introduction of legislation to regulate facility fees charged, billed or collected by a health care provider, except for the charging, billing or collection of facility fees from MaineCare, by imposing the limitations on facility fees included in the NASHP model legislation. The Legislature should evaluate the two limitations proposed in the NAHP model legislation separately: (1) the first component of the model proposes to prohibit facility fees charged by hospital-affiliated or hospital-owned providers except for services provided on a hospital's campus (all buildings within 250 yards of main building); at a facility that includes a licensed hospital emergency department; or emergency services provided at a licensed freestanding emergency facility; and (2) the second component proposes to prohibit facility fees for outpatient evaluation and management services regardless of where the services are provided.

The task force members supporting the recommendation acknowledge that there was limited time to discuss and understand the potential consequences of such a proposal but felt it was important that such a proposal be brought forward to the Legislature to consider given the reasons why the original bill, LD 1795, was proposed. Policymakers in other states have enacted similar laws to limit the charging of facility fees based on the components of the NASHP model legislation. These task force members suggest that the Legislature should consider whether to limit or restrict the charging of facility fees associated with the delivery of health care services, particularly in a setting away from a hospital campus or for certain evaluation and management services traditionally delivered in an office setting. The task force members also urge the Legislature to consider and discuss the impact of such a limitation on facility fees on different payors for health care services, including Medicare and self-insured health plans, and the potential that federal law or regulations may preempt state action.

The task force members opposed to the recommendation (Sen. Bailey, Jeff Austin and Mark Souders) felt strongly that such a proposal would have a devastating financial impact on hospitals, including the potential closure of some facilities and the loss of patient access to health care services.

Following the task force's final meeting, task force co-chair, Rep. Arford, who voted in support of making the recommendation shared additional comments expressing her view that the Legislature's consideration, at least initially, should focus on the regulation of facility fees charged in association with outpatient office visits for evaluation and management services regardless of where the services are provided. In offering this suggestion, Rep. Arford believes that more research and study needs to take place to avoid unintended and possibly harmful consequences before a broader recommendation to limit the charging of facility fees by hospital-affiliated providers or independent providers moves forward. Concerns were expressed that such a limitation could result in harmful financial consequences to these facilities. Until further study determines the potential consequences on access to care and the cost of care for patients, Rep. Arford has indicated she can no longer support a recommendation related to the first component of the NASHP model legislation.

6. Assistance to patients experiencing general billing issues, including billing of facility fees

- **Recommend that the Legislature consider the introduction of legislation to establish a complaint mechanism for patients experiencing billing issues with health care providers, including facility fees**

The task force recommends that the Legislature consider the introduction of legislation to establish a complaint mechanism for patients experiencing billing issues with health care providers, including facility fees. The task force recognizes that patients with health insurance coverage are able to make complaints about billing or claims issues with their health insurance carrier to the Bureau of Insurance, but there is no State regulatory entity to assist patients in resolving billing issues with health care providers, such as hospitals. While patients may be able to resolve issues directly with a health care provider in certain instances, the task force suggests that patients may be better served if there is a mechanism to make complaints about billing issues with providers in a similar manner to the mechanism available for complaints about health insurance carriers.

7. Financial impact on patients for services depending on the setting or site of service

- **Does not recommend any action related to this issue as cost sharing obligations are applied by health insurance carriers in a consistent manner according to the terms and benefits of a patient's health plans**

The task force discussed whether the financial impact on patients might be different in terms of patient's cost sharing obligations depending on the setting of a health care service and on any facility fee charges. Based on information provided by the Maine Association of Health Plans, task force members noted that cost sharing obligations may differ when services are provided in an inpatient, outpatient or office setting. If services are provided in an office setting, regardless of where the office is located, health insurance carriers do not accept any claims for facility fees in part due to the application of the standardized claim form requirements in Title 24-A, sections 2753, 2823-B and 4235. If services are provided in a hospital facility, then facility fees may be imposed and the amounts may differ depending on whether inpatient, outpatient or emergency services are provided. The cost sharing obligation of the patient is determined under the terms and benefits of the patient's specific health plan based on the total overall cost and is not tied in any way to the amount of any facility fee. In light of the information that cost sharing obligations are applied in a consistent manner according to the terms and benefits of a patient's health plans, the task force did not make any recommendation related to this topic.

V. Conclusion

The task force believes it is important that policymakers understand how facility fees charged by health care facilities and health care providers impact Maine patients and Maine's health care system; determine how facility fees should be communicated to patients in a transparent manner; and take steps to minimize the burden to patients that result from imposing facility fees. With

these considerations in mind, the task force has made the recommendations included in this report. In the limited time available, however, it was not possible for the task force to consider and understand all of implications and consequences of its recommendations. The task force encourages the Legislature to carefully consider its recommendations and engage task force members and other stakeholders in further discussions before moving forward with these recommendations.

APPENDIX A

Authorizing Legislation: Public Law 2023, chapter 410

APPROVED
JULY 10, 2023
BY GOVERNOR

CHAPTER
410
PUBLIC LAW

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

S.P. 720 - L.D. 1795

An Act to Create Greater Transparency for Facility Fees Charged by Health Care Providers and to Establish the Task Force to Evaluate the Impact of Facility Fees on Patients

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

Sec. 1. 22 MRSA §8712, sub-§2-A is enacted to read:

2-A. Facility fees charged by health care providers. By January 1, 2024, and annually thereafter, the organization shall produce and post on its publicly accessible website a report on the payments for facility fees made by payors to the extent that payment information is already reported to the organization. The organization shall submit the report required by this subsection to the Office of Affordable Health Care established in Title 5, section 3122 and the joint standing committee of the Legislature having jurisdiction over health data reporting and health insurance matters. The joint standing committee may report out legislation based on the report to a first regular or second regular session of the Legislature, depending on the year in which the report is submitted.

For the purposes of this subsection, unless the context otherwise indicates, the following terms have the following meanings.

A. "Facility fee" means any fee charged or billed by a health care provider for outpatient services provided in a hospital-based facility or freestanding emergency facility that is intended to compensate the health care provider for the operational expenses of the health care provider, separate and distinct from a professional fee, and charged or billed regardless of how a health care service is provided.

B. "Health care provider" means a person, whether for profit or nonprofit, that furnishes bills or is paid for health care service delivery in the normal course of business. "Health care provider" includes, but is not limited to, a health system, hospital, hospital-based facility, freestanding emergency facility or urgent care clinic.

Sec. 2. Task force established. The Task Force to Evaluate the Impact of Facility Fees on Patients, referred to in this section as "the task force," is established as follows.

1. Appointments; composition. Notwithstanding Joint Rule 353, the task force consists of 8 voting members and 2 ex officio nonvoting members as follows:

A. Four members must be appointed by the President of the Senate as follows:

(1) One member of the Senate;

(2) One member representing a statewide organization supporting the interests of health care consumers;

(3) One member representing the interests of health insurance carriers; and

(4) One member with expertise, knowledge and background in health care policy;

B. Four members must be appointed by the Speaker of the House of Representatives as follows:

(1) One member of the House of Representatives;

(2) One member representing a statewide organization of retired persons;

(3) One member representing a statewide organization of hospitals; and

(4) One member representing a hospital in the State; and

C. Two ex officio nonvoting members as follows:

(1) The Director of the Office of MaineCare Services within the Department of Health and Human Services or the director's designee; and

(2) The Director of the Office of Affordable Health Care or the director's designee.

2. Chairs. The member of the Senate is the Senate chair and the member of the House of Representatives is the House chair of the task force. Notwithstanding Joint Rule 353, the chairs may appoint, as nonvoting members, individuals with expertise in health care policy, health care financing or health care delivery. Any additional members appointed pursuant to this subsection are not entitled to compensation or reimbursement under subsection 5.

3. Appointments; convening. All appointments must be made no later than 30 days following the effective date of this Act. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members, the chairs shall call and convene the first meeting of the task force. If 30 days or more after the effective date of this Act a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the task force to meet and conduct its business.

4. Duties. The task force shall:

A. Review the industry practices for charging facility fees, uses of the funds received as facility fees and impacts on patients of paying facility fees charged by health care providers;

B. Review federal transparency requirements for hospitals and health insurance carriers regarding cost of treatment, identify any gaps or redundancies between state laws and federal laws and identify any problems with enforcement of those laws;

C. Consider efforts in other states and by national organizations related to regulation of, or minimization of, facility fees and the potential effects such efforts might have on health care costs in this State; and

D. Make recommendations for changes in laws or rules regarding facility fees and medical cost transparency based on the information examined under this subsection.

5. Compensation. The legislative members of the task force are entitled to receive the legislative per diem, as set out in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses related to their attendance at authorized meetings of the task force. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the task force.

6. Quorum. A quorum is a majority of the voting members of the task force, including those members invited to participate who have accepted the invitation to participate.

7. Staffing. The Legislative Council shall provide staff support for the task force. To the extent needed when the Legislature is in session, the Legislative Council may contract for such staff support if sufficient funding is available.

8. Consultants; additional staff assistance. The task force may solicit the services of one or more outside consultants to assist the task force to the extent resources are available. Upon request, the Office of Affordable Health Care, the Department of Health and Human Services, the Department of Professional and Financial Regulation, Bureau of Insurance and the Maine Health Data Organization shall provide additional staffing assistance to the task force to ensure the task force has the information necessary to fulfill their duties under this section.

9. Reports. The task force shall submit a report no later than December 6, 2023 that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Health Coverage, Insurance and Financial Services and the committee may report out a bill based on the report to the Second Regular Session of the 131st Legislature.

10. Additional funding; sources. The task force may apply for and receive funds, grants or contracts from public and private sources to support its activities under this section.

11. Definition. For purposes of this section, "facility fees" and "healthcare provider" have the same meanings as in the Maine Revised Statutes, Title 22, section 8712, subsection 2-A.

APPENDIX B

Membership list: Task Force to Evaluate the Impact of Facility Fees on Patients

TASK FORCE TO EVALUATE THE IMPACT OF FACILITY FEES ON PATIENTS

Membership List

Name	Representation
Sen. Donna Bailey	Senate Chair, appointed by the President of the Senate
Rep. Poppy Arford	House Chair, appointed by the Speaker of the House
Kate Ende	Representing a statewide organization supporting the interests of health care consumers, appointed by the President of the Senate
Maureen Hensley-Quinn	Member with expertise, knowledge and background in health care policy, appointed by the President of the Senate
Kristine Ossenfort	Representing the interests of health insurance carriers, appointed by the President of the Senate
Jessica Maurer	Representing a statewide organization of retired persons, appointed by the Speaker of the House
Jeff Austin	Representing a statewide organization of hospitals, appointed by the Speaker of the House
Mark Souders	Representing a hospital in the State, appointed by the Speaker of the House
Michelle Probert	The Director of the Office of MaineCare Services within the Department of Health and Human Services or the director's designee
Meg Garratt-Reed	The Director of the Office of Affordable Health Care or the director's designee

APPENDIX C

Overview of Other State Laws Related to Regulation of Facility Fees

OVERVIEW OF OTHER STATE LAWS RELATED TO REGULATION OF FACILITY FEES

State	Statutory Citations	Summary of Provisions
Connecticut	Conn. Gen. Stat. § 19a-906; Conn. Gen. Stat. § 19a-508c; Conn. H.B. 6669 (2023)	• Prohibits a hospital or health system from charging a facility fee on telehealth services or specific health care evaluation and management (E/M) services provided on a hospital campus outside of an emergency department. • Requires providers/health systems to give patients notice at the time the appointment is made if/when they do charge facility fees and post signs in their common areas outlining that in plain language. • Requires a health care provider to provide a standardized bill to patients that lists any facility fee and include contact information for filing an appeal. • Requires each hospital and health system to submit annual to the State reports on facility fees collected. • Prohibits telehealth providers and hospitals from charging facility fees for telehealth services.
Colorado	Colo. Rev. Stat. § 6-20-102; Colo. Rev. Stat. § 25.5-4-216	• Prohibits the collection of a facility fee from a patient for preventive services that are not covered by a patient's insurance • Requires providers/health systems to give patients notice at the time the appointment is made that they charge facility fees and post signs in their common areas • Requires a health care provider to issue a standardized bill to patients that lists any facility fee and include contact information for filing an appeal. • Authorizes a report on facility fees to be completed by October 2024.
Florida	Fla. Stat. § 395.1041; Fla. Stat. § 395.301	• Requires hospital owned outpatient emergency departments to post signs in their common areas that they charge facility fees.

OVERVIEW OF OTHER STATE LAWS RELATED TO REGULATION OF FACILITY FEES

State	Statutory Citations	Summary of Provisions
		• Requires facility fees to be included in good faith estimates provided to patients.
Georgia	Ga. Code Ann. § 33-20E-24	• Prohibits insurers from being required to pay a facility fee to a hospital for telehealth services unless the hospital is the originating site.
Indiana	Ind. Code Ann. § 16-51-1-11; Ind. Code Ann. §§ 16-21-6-3; Ind. Code Ann. §§ 25-1-9.8-11; Ind. Code Ann. §§16-21-17-1; 16-21-17-2	• Bans facility fees by prohibiting an insurer or other person responsible for the payment of the cost services from accepting a bill submitted on an "institutional provider form", which is what hospitals use to bill for facility fees, for services provided in an office setting • Limits the restrictions in this bill to non-profit health systems with more than $2 billion in patient service revenue in 2021. • Requires providers to supply, upon request, a good faith estimate of the amount the provider intends to charge for services, including any charge for use of the provider facility, at least five days before a scheduled appointment. • Requires ambulatory outpatient surgical centers to post on their website the standard charge per item or service, including facility fees. • Requires each hospital to file an annual report to the state including information on facility fees collected.
Maryland	Md. Ins. Code § 19-349.2; Md. Ins. Code § 15-139	• Requires providers/health systems to give patients notice at the time the appointment is made that they charge facility fees, including expected amounts and how a patient can file a complaint about a facility fee. • Requires each hospital to file an annual report to the Health Services Cost Review Commission including information on outpatient facility fees collected. • Prohibits providers from charging facility fees for telehealth services unless they are not authorized to bill a professional fee separately for the service.

OVERVIEW OF OTHER STATE LAWS RELATED TO REGULATION OF FACILITY FEES

State	Statutory Citations	Summary of Provisions
		• Prohibits hospitals from charging facility fees for administering COVID-19 vaccines and monoclonal antibody infusions and injections.
Massachusetts	Mass. Ann. Laws ch. 111, §§ 228; Mass. Ann. Laws ch. 176O, §§ 6, 23	• Requires providers/health systems to give patients notice at the time the appointment is made that they charge facility fees, including expected amounts. • Requires insurers explain any facility fee a consumer may be responsible to pay in its evidence of coverage and allow opportunity for enrollees to request and obtain facility fee estimates.
Minnesota	Minn. Stat. Ann. § 62J.824 (2022)	• Requires providers/health systems to give patients notice prior to the delivery of non-emergency services that they may charge facility fees, including for telehealth services
New York	N.Y. Public. Health Law § 2830-2	• Prohibits the collection of a facility fee from a patient for preventive services, or any service not covered by the patient's insurance, unless the patient received prior notification that a facility fee would be charged. • Requires providers/health systems to give patients notice in advance that they charge facility fees and post signs in their common areas outlining that.
Ohio	Ohio Rev. Code § 4743.09	• Prohibits a health care professional from charging a patient or a health plan issuer a facility fee when providing telehealth services.
Texas	Tex. Health and Safety Code §241.222; §254.1555; §254.156	• Requires facilities to notify patients that they may be charged a facility fee, including median amounts of fees charged. • Prohibits freestanding emergency departments from charging facility fees on drive-thru services, and requires freestanding emergency departments to notify patients that they may be charged a facility fee, including the amount.
Washington	Wash. Rev. Code § 70.01.040; Rev. Code Wash. § 4.43.735	• Requires providers/health systems to give patients notice prior to the delivery of non-emergency services that they may charge facility fees.

OVERVIEW OF OTHER STATE LAWS RELATED TO REGULATION OF FACILITY FEES

State	Statutory Citations	Summary of Provisions
		• Prohibits a telehealth distant site or a hospital that is an originating site for audio-only telemedicine from charging a facility fee.

Sources: National Conference of State Legislatures;

"State Laws to Promote Fair Billing" November 2023 Issue Brief, United States of Care, https://unitedstatesofcare.org/new-resource-state-successes-passing-laws-to-promote-fair-billing/

"Regulating Outpatient Facility Fees: States Are Leading the Way to Protect Consumers" July 2023 Issue Brief, Georgetown University Center on Health Insurance Reforms, https://georgetown.app.box.com/v/statefacilityfeeissuebrief

National Academy of State Health Policy Legislative Tracker: State Legislative Action to Lower Health System Costs, https://nashp.org/state-legislative-action-to-lower-health-system-costs/

State of Maine
131st Legislature, First Regular and First Special Session

Gagetown Harmful Chemical Study Commission

January 2024

Office of Policy and Legal Analysis

STATE OF MAINE
131st LEGISLATURE
FIRST REGULAR AND FIRST SPECIAL SESSION

Gagetown Harmful Chemical Study Commission

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Appendices

Executive Summary

The 131st Legislature established the Gagetown Harmful Chemical Study Commission, referred to in this report as the "commission" with the passage of Resolve 2023, chapter 95 (Appendix A). Pursuant to the resolve, ten members were appointed to the commission: two members of the Senate appointed by the President of the Senate, including a member from each of the two parties holding the largest number of seats in the Legislature; two members of the House of Representatives appointed by the Speaker of the House, including a member from each of the two parties holding the largest number of seats in the Legislature; two members who represent veterans' advocacy organizations; one member who is a family member of a veteran who served at the Canadian military support base in Gagetown, New Brunswick, Canada; one member with expertise processing veterans' claims for benefits related to harmful chemicals; and two members who served at Gagetown and were exposed to harmful chemicals during their service.

A list of commission members may be found in Appendix B.

The duty of the commission is set forth in Resolve 2023, chapter 95 (Appendix A) and charges the commission with studying the impacts of exposure to harmful chemicals on veterans who served at the Canadian military support base in Gagetown, New Brunswick, Canada.

Over the course of four meetings, the commission developed the following recommendations:

Recommendation #1. To request that the United States Department of Veterans Affairs provide access to medical care and assistance to members of the National Guard who have trained at the Canadian military support base in Gagetown, New Brunswick, Canada and who have been diagnosed with a condition or illness associated with exposure to tactical herbicides or exposure to other dioxins.

Recommendation #2. The Veterans and Legal Affairs committee should invite individuals with relevant expertise to review and discuss the existing reports and underlying data that comprise the *Canadian Forces Base Gagetown Herbicide Spray Program 1952-2004 Fact-Finders' Report*, as well as other related content, in order to evaluate the reports' processes, methods, data and analysis and to determine what steps and resources would be required in order to either reanalyze the existing data or to conduct new studies.

Recommendation #3. The Department of Defense, Veterans and Emergency Management, Bureau of Veterans' Services should reestablish and expand the registry of individuals who served/serve in the Maine National Guard who have trained at the Canadian military support base in Gagetown, New Brunswick, Canada.

Recommendation #4. The Legislature should reestablish the Gagetown Harmful Chemical Study Commission.

I. Introduction

The Gagetown Harmful Chemical Study Commission, referred to in this report as the "commission" was established by Resolve 2023, chapter 95 to study the impacts of exposure to harmful chemicals on veterans who served at the Canadian military support base in Gagetown, New Brunswick, Canada. The resolve directs the commission to submit a report that includes its findings and recommendations to the Legislature no later than December 6, 2023. An extension of that deadline was requested and granted on November 14, 2023 creating a new report submission deadline of December 15, 2023.[1]

Pursuant to the resolve, the commission has ten members:[2] four legislative members and six non-legislative members representing individuals directly or indirectly affected by the spraying of chemicals at the Canadian military support base in Gagetown, New Brunswick, Canada. Those members include:

- Five members appointed by the President of the Senate as follows:
    - Two members of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature;
    - One member who represents veterans' advocacy organizations;
    - One member who is a family member of a veteran who served at the Canadian military support base in Gagetown, New Brunswick, Canada; and
    - One member who served at Gagetown and was exposed to harmful chemicals during their service.
- Five members appointed by the Speaker of the House as follows:
    - Two members of the House of Representatives, including members from each of the 2 parties holding the largest number of seats in the Legislature;
    - One member who represents veterans' advocacy organizations;
    - One member with expertise processing veterans' claims for benefits related to harmful chemicals; and
    - One member who served at Gagetown and was exposed to harmful chemicals during their service.

Senate President Troy Jackson was named Senate chair and Representative Ronald Russell was named House chair.

II. Background

Agent Orange is a blend of tactical herbicides sprayed by the U.S. military from 1962 to 1971 during the Vietnam War to remove trees and dense tropical foliage that provided enemy cover. Agent Orange was the most used tactical herbicide combination of the so-called "rainbow"

[1] A copy of the commission's authorizing legislation is included as Appendix A.
[2] The complete membership list of the commission is included as Appendix B.

herbicide combinations – which also include pink, blue, white, green and purple. The two active ingredients in the Agent Orange herbicide combination were equal amounts of 2,4-dichlorophenoxyacetic acid (2,4-D) and 2,4,5-trichlorophenoxyacetic acid (2,4,5-T), which contained traces of 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD), an unwanted byproduct of herbicide production. TCDD is the most toxic of the dioxins, and is classified as a human carcinogen by the Environmental Protection Agency. The U.S. Department of Defense developed these tactical herbicides to be used in combat operations. These tactical herbicides were also used, tested and stored in areas outside of Vietnam, including in the United States and Canada.[3] With the permission of the Canadian government, the U.S. military conducted small-scale testing of tactical herbicides, including Agent Orange and Agent Purple, at 5th Canadian Division Support Base Gagetown (Base Gagetown), in New Brunswick, Canada, on June 14-16, 1966 and June 21-24, 1967 to test their effectiveness for vegetation management.[4] [5]

In addition to the use, testing, and storage of tactical herbicides, the U.S. Department of Defense and the Canadian Department of National Defence both deploy commercial grade herbicides for installation vegetation management, including an annual vegetation management program at Base Gagetown. Many commercial grade herbicides also contain dioxins or other impurities.[6]

In 2005, the Canadian Department of National Defence, along with Veterans Affairs Canada, Health Canada and various other departments and agencies, began a fact-finding project to understand the health and environmental risks associated with the past use of herbicides at Base Gagetown. The investigation included several enumerated tasks, including: compiling a list of individuals and military units who were present at Base Gagetown during the testing of herbicides in 1966 and 1967; an historical records review of past herbicide use at Base Gagetown between 1952 and 2005, including water and soil sampling; consulting with current and former Canadian Armed Forces/Department of Defence personnel, contractors, local community members and members of the public about areas to investigate; barrel investigations, excavation and analysis of former disposal sites; human health risk assessments, including how individuals may have been exposed to herbicides, and how the herbicides may have migrated through the air and groundwater/surface water at specific sites; an epidemiological literature review to understand the relationship between herbicides and human health; and testing the tissue of fish and freshwater clams from Base Gagetown for dioxin concentrations.[7]

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[3] U.S. Department of Veterans Affairs. (2015, June 3). *Facts About Herbicides*. Public Health. https://www.publichealth.va.gov/exposures/agentorange/basics.asp

[4] Government of Canada. (2019, January 30). *Agent Orange Investigations at Base Gagetown*. National Defence. https://www.canada.ca/en/department-national-defence/corporate/reports-publications/agent-orange.html

[5] Maine Bureau of Veterans' Services, CFB Gagetown & Agents Orange/Purple Information Paper as of 28 June 2005 (2005). Retrieved December 13, 2023, from https://www.maine.gov/veterans/docs/CFB%20Gagetown%20Agent%20Orange%20Information%20Paper.pdf.

[6] Furlong, D. (2007). CFB Gagetown Herbicide Spray Programs 1952-2004 Fact-Finders' Report (D. Furlong, Ed.) [Review of CFB Gagetown Herbicide Spray Programs 1952-2004 Fact-Finders' Report]. *Note:* Commission staff was unable to locate a complete set of the reports that comprise the Fact-Finders' Report. Meg Sears, Ph.D., an invited speaker, indicated she retained copies of most of the original reports downloaded from the publicly accessible website maintained by the Canadian government at the time the reports were issued. The reports she was able to locate and share can be found at https://preventcancernow.ca/canadian-forces-base-gagetown-fact-finding-project-reports-re-herbicide-spraying-1952-2004/.

[7] Government of Canada. (2019, January 30). *Agent Orange Investigations at Base Gagetown*. National Defence. https://www.canada.ca/en/department-national-defence/corporate/reports-publications/agent-orange.html

The Fact-Finding Project concluded that most people who lived near or worked at Base Gagetown were not at risk for long-term health effects from the herbicides applied there and that only specific populations, including those directly involved with herbicide applications and brush clearings soon after application were at a greater risk for developing adverse health outcomes.[8] On September 12, 2007 the Government of Canada provided eligible individuals with a one-time, tax free ex gratia payment of $20,000 as compensation for the possible exposure to tactical herbicides sprayed by the U.S. military in 1966 and 1967.[9]

The United States Department of Veterans Affairs (Veterans Affairs) has statutory authority to presumptively recognize a number of diseases for veterans of the Vietnam War as connected to exposure to herbicides used in the Vietnam War, but these presumptions only apply to veterans who were on active duty in Vietnam during the war[10] or in limited other locations during specific time periods as determined by Veterans Affairs.[11] Veterans Affairs currently maintains an active Agent Orange Registry and provides medical treatment or disability compensation to Vietnam War veterans.

The Maine National Guard began training at Base Gagetown in 1971 and continues to use the base as a training site, as do National Guard units from other states, including Massachusetts and Connecticut. As investigations in Canada uncovered testing of tactical herbicides at Base Gagetown and allegations of significant harm to human health as a result of the chemical spraying conducted there increased, concerns from National Guard members in Maine who had trained at Base Gagetown regarding their health also emerged.

As the Canadian Fact-Finding Project began, the Maine Bureau of Veterans' Services (MBVS) established an internet website and contact list to provide updates regarding the issue of Agent Orange and other herbicides sprayed at Base Gagetown in order to share information as it became available.[12] Of concern is not just the exposure to tactical herbicides, but also the continued exposure to all the herbicides used at Base Gagetown since 1956, which includes over 40 different herbicides made up of 24 active ingredients that have two known manufacturing impurities: dioxin and hexachlorobenzene.[13] MBVS also began a registry of self-reported individuals who served at Base Gagetown, which totaled 413, and published a questionnaire that individuals who trained at Base Gagetown could submit, for which MBVS received 108 responses.[14]

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[8] Ibid.

[9] Order amending the Testing of Unregistered US Military Herbicides, including Agent Orange, at CFB Gagetown Ex Gratia Payments Order, P.C. 2010-1607, 09 December, 2010, SI/2010-0096.

[10] Maine Bureau of Veterans' Services, & Ogden, P. W., Update #3 to Information Paper Agent Orange/Agent Purple and Canadian Forces Base Gagetown (2007). Retrieved December 13, 2023, from https://www.maine.gov/veterans/benefits/healthcare/agent-orange-purple.html.

[11] *See:* https://www.publichealth.va.gov/exposures/agentorange/index.asp and https://www.va.gov/disability/eligibility/hazardous-materials-exposure/agent-orange/

[12] *See:* https://www.maine.gov/veterans/benefits/healthcare/agent-orange-purple.html

[13] Maine Bureau of Veterans' Services, & Ogden, P. W., Update #2 to Information Paper Agent Orange/Agent Purple and Canadian Forces Base Gagetown (2006). Retrieved December 13, 2023, from https://www.maine.gov/veterans/benefits/healthcare/agent-orange-purple.html.

[14] Presentation by Director Richmond, Maine Bureau of Veterans' Services, Department of Defense, Veterans and Emergency Management at the November 15, 2023 commission meeting.

Unlike Vietnam War veterans, members of the Maine National Guard who trained at Base Gagetown do not have the same presumption of exposure because the use of Base Gagetown as an official training site for the Maine National Guard did not begin until 1971, four years after the last documented instance of tactical herbicide spraying, and because National Guard members conducting training and who have not served on active duty are not considered veterans. Additionally, it was determined, through the Canadian Fact-Finding Project's reports, that the exposure to commercial grade herbicides does not represent a public health hazard. Given these three elements, no path toward recognition and assistance currently exists for members of the Maine National Guard who trained at Base Gagetown and who have an illness or condition attributable to exposure to harmful chemicals sprayed at Base Gagetown.

In the spring and summer of 2012, U.S. Representative Michael Michaud and U.S. Senator Susan Collins sent letters to Veterans Affairs, the Environmental Protection Agency (EPA), and the Centers for Disease Control and Prevention (CDC). Representative Michaud requested more information from Veterans Affairs about their handling of benefit claims related to service at Base Gagetown and the reason for the denials of these claims, as well as information on how the claimed incident rate of Agent Orange-associated diseases and illnesses for this cohort compares to a similar population that did not train at Base Gagetown. He also requested that the EPA provide more information on the standards of use for commercial herbicides used at Base Gagetown and whether amounts sprayed during the training periods and the Reservists' interaction with their surroundings meets those standards and whether the rainbow agents and the chemical impurities present at Base Gagetown during the Reservists' training posed a health risk, specifically when they were breathing in contaminated soil disturbed by digging.[15] Senator Collins requested that the Director of the Agency for Toxic Substances and Disease Registry (ATSDR) review the report "Environmental Site Assessment of CFB Gagetown," completed on behalf of the Canadian Department of National Defence concerning the use of Agent Orange and other commercial herbicides at Base Gagetown as a part of the Fact-Finding Project. Senator Collins specifically asked ATSDR to assess whether concentrations and quantity of TCDD and other herbicides used as Base Gagetown could lead to health problems among those who were exposed to it over time and to evaluate whether the concentrations of contaminants at Base Gagetown could be considered a past public health hazard, according to EPA guidelines.[16]

ATSDR completed its review on January 30, 2013. The review concluded that the methodology used in the report was consistent with CDC guidelines, but noted the limitations of its own conclusions, which relied on the assumptions and uncertainties included in the original report. The review by ATSDR reiterated the following statement from the original report:

> "The level of uncertainty resulting from… activities, some of which occurred more than 50 years ago, coupled with the uncertainties inherent in standard forward-looking risk assessment, is very large. As a result, the expectations regarding the

[15] Michael, M. H. (2012, July 19). Letter from Representative Michael Michaud to General Allison A. Hickey, Under Secretary for Benefits. *Maine Department of Defense, Veterans and Emergency Management, Bureau of Veterans' Services*. Retrieved from https://www.maine.gov/veterans/benefits/healthcare/agent-orange-purple.html.
[16] Agency for Toxic Substances and Disease Registry. (2013, January 30). *ATSDR Review of Gagetown Herbicide Spray Programs, Canadian Forces Base Gagetown, New Brunswick, Canada*. Retrieved December 13, 2023, from https://www.maine.gov/veterans/benefits/healthcare/agent-orange-purple.html.

level of precision that this risk assessment exercise can produce should be limited."[17]

Given these noted limitations and the considerable degree of dispute as to the potential harm that exposure to the chemical herbicides sprayed at Base Gagetown may have on service members who trained there, Senator Collins requested that Veterans Affairs commission an independent study to examine potential health risks to veterans, including Maine National Guard members, who may have been exposed to harmful toxins while training at Base Gagetown. In addition, Senator Collins requested that Veterans Affairs establish a registry to track individuals who may have been exposed to harmful substances at Base Gagetown and who have previously or subsequently applied for Veterans Affairs healthcare services, filed claims for compensation on the basis of any disability which may be associated with such service, had claims filed by survivors of such veterans, or requested a health examination for inclusion in the Registry.[18]

In 2014, during the Second Regular Session of the 126th Maine Legislature, two bills were considered and then enacted related to the potential health risks and disabilities connected to members of the Maine National Guard who trained at Base Gagetown. Resolve 2013, chapter 100 (LD 1632),[19] directed the Commissioner of the Department of Defense, Veterans and Emergency Management (DVEM) to request Veterans Affairs to recognize the environmental hazards present at Base Gagetown and the resulting potential health risks and disabilities to veterans who, as members of the Maine National Guard, trained at the base. It also directed the Commissioner of DVEM to report no later than January 10, 2015 to the joint standing committee of the Legislature having jurisdiction over veterans and legal affairs on the status of that request and to include a summary of any correspondence regarding these issues to and from the State's congressional delegation. Public Law 2013, chapter 569 (LD 1612), [20] added a requirement to include information on the status of communications with Veterans Affairs regarding the potential health risks to and the potential disabilities of veterans who, as members of the Maine National Guard, were exposed to environmental hazards at the Base Gagetown.

With no progress made as a result of these previous actions, the 131st Legislature enacted Resolve 2023, chapter 95 (LD 1597),[21] which established the Gagetown Harmful Chemical Study Commission to study the impacts of exposure to harmful chemicals on veterans who served at Base Gagetown.

[17] Collins, S. M. (2013, March 29). Letter from Senator Susan Collins to Hon. Eric Shinseki, Secretary, U.S. Department of Veterans Affairs. *Maine Department of Defense, Veterans and Emergency Management, Bureau of Veterans' Services*. Retrieved from https://www.maine.gov/veterans/benefits/healthcare/agent-orange-purple.html.
[18] Ibid.
[19] A copy of Resolve 2013, c. 100 can be found at: https://legislature.maine.gov/legis/bills/getPDF.asp?paper=SP0623&item=3&snum=126
[20] A copy of P.L. 2013, c. 569 can be found at: https://legislature.maine.gov/legis/bills/getPDF.asp?paper=HP1184&item=5&snum=126
[21] Appendix A.

III. Commission Process

The commission held four public meetings at the State House on November 15, November 30, December 6 and December 14.[22]

A. First Meeting – November 15, 2023

The commission held its first meeting on November 15, 2023. The meeting began with opening remarks by the chairs and introductions by commission members. Staff then provided an overview of the commission's authorizing legislation, including duties, the study process and the projected timeline for completion of the commission's work.[23]

The commission received a presentation from David Richmond, Director of the Maine Bureau of Veterans' Services, who presented on the history of the use of harmful chemicals at Base Gagetown and the bureau's involvement with the issue. Director Richmond described the facts as they are known to the bureau and outlined steps that the bureau has taken, such as establishing a list of members of the National Guard who have trained at Base Gagetown. Director Richmond also offered suggestions for the commission on what components are necessary for a member of the National Guard to make a claim for disability compensation and other benefits with Veterans Affairs. Throughout the presentation, commission members asked clarifying questions. Commission members acknowledged the good work that veterans service officers do, but expressed frustration at the onerous path towards recognition and the complete lack of success from any claims related to Base Gagetown.

The meeting closed with a discussion of the information that commission members had individually collected, as well as information that the commission should seek to acquire or have presented at future meetings. Some of the information requested included a presentation from Barret Fisher, a Veterans' Services Supervisor, on claims made by former members of the Maine National Guard in Aroostook County, a presentation by a subject matter expert on harmful chemicals, and verification of information provided to commission members by various parties interested in the commission's work.

B. Second Meeting – November 30, 2023

The second commission meeting was held on November 30, 2023 and consisted primarily of presentations covering various elements relevant to the commission's duties and which were requested by the commission at their first meeting.[24]

The commission received brief remarks from individuals representing three members of Maine's federal Congressional delegation: U.S. Senator Susan Collins, U.S. Senator Angus King and U.S. Representative Jared Golden. The representative from Senator Collins' office specifically provided information on the previous work conducted by her office in 2012 and 2013.

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[22] Materials distributed and reviewed at the meetings are available at https://legislature.maine.gov/gagetown-harmful-chemical-study-commission.

[23] The archived video of the first meeting is available at the following link: https://legislature.maine.gov/Audio/#437?event=89738&startDate=2023-11-15T12:00:00-05:00

[24] The archived video of the second meeting is available at the following link: https://legislature.maine.gov/Audio/#437?event=89825&startDate=2023-11-30T12:00:00-05:00

Representatives of the federal delegation agreed that there is not a lot of information regarding the progress of examining the potential health risks to individuals who may have been exposed to harmful toxins while training at Base Gagetown and that there has not been any significant activity since prior to 2014. The representatives also indicated that they have not seen any initial filing of claims, nor resubmission of claims related to harmful chemical use at Gagetown, despite the expanded coverage and messaging related to the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022. The representatives all indicated their offices' willingness to use their resources to help acquire the information the commission is seeking or may seek in the future.

The commission next heard from Barrett Fisher, Supervisor Veterans' Services, who answered questions regarding the process for, and the challenges of, filing disability compensation claims with Veterans Affairs. Mr. Fisher highlighted that one of the major issues with preparing claims, even before the filing process, is the access to and availability of records of service. Most required records, such as the DD-214, are in paper form due to their age and some may have been lost to fire[25] or other unintended damages. Additionally, Mr. Fisher explained that there have been no successful claims for harm from chemical spraying at Base Gagetown, as the recognized dates and locations at Base Gagetown are only for those days that tactical herbicides were sprayed in 1966 and 1967. He explained that individuals who have only served in the National Guard are not eligible for Veterans Affairs benefits unless they have a service-connected injury, which are most often determined through a line-of-duty investigation. For such an investigation to be successful, Veterans Affairs would, among other things, need to acknowledge the harmful effects of the chemicals sprayed and recognize specific "injuries" associated with that exposure. An individual making a claim would need to prove exposure at a significant enough amount to cause harm and that the exposure occurred while training with the National Guard and that the "injury" is "at least as likely as not" to be as a result of that exposure while training and not a result of something else. Exposure could also occur over time, rather than from a specific incident, as is frequently seen with tinnitus claims, for example. This would not necessarily require a line-of-duty investigation, but would still require acknowledgement of the harmful effects of the chemicals sprayed and recognition of specific "injuries" associated with that exposure. He also acknowledged that, over the years, Veterans Affairs has expanded the geographic areas in which recognized spraying or storage occurred.

The commission then heard from Meg Sears, who has a Ph.D. in biochemical engineering and is the chair of Prevent Cancer Now, a Canadian organization working to eliminate preventable contributors to cancer through research, awareness, education and advocacy.[26] Ms. Sears presented on her experience with the Fact-Finding Project and with harmful chemicals such as those sprayed at Base Gagetown. Ms. Sears was critical of the methods and processes used in the Fact-Finding Project studies. Specifically, Ms. Sears addressed Task 4 of the project, testing the tissue of fish and freshwater clams from Base Gagetown for dioxin concentrations, which she

[25] In 1973, a fire at the National Personnel Records Center (NPRC) in St. Louis destroyed records held for Veterans who were discharged from the Army and Air Force during certain periods of time. If your records were destroyed in this fire, the Department of Veterans Affairs can help you in reconstructing them. *See:* https://www.va.gov/disability/how-to-file-claim/evidence-needed/

[26] Prevent Cancer Now. (2022, October 4). *About Us*. Prevent Cancer Now. https://preventcancernow.ca/about-us/

described as an after-thought to the project, based on criticism from many interested parties, including herself. She described the methods for testing used in Task 4 of the project as scientifically faulty and purposely manipulated to result in a conclusion that aligned with the overall project's conclusions that most people who lived near or worked at Base Gagetown were not at risk for long-term health effects from the herbicides applied there. Ms. Sears explained that dioxins accumulate in fatty tissue, but that in conducting the study, the fat layer was removed from fish samples before being tested for dioxin levels, resulting in inaccurate results. She noted that the underlying data collected as a part of Task 4, which was included in the appendix of the Task 4 report, was good – the issue was the analysis. She also noted concerns with the methodology in the medical study. Commission members discussed with Ms. Sears the methods and feasibility in collecting new data or in reanalyzing the data that has already been collected. The process for collecting similar data in humans was also discussed. Ms. Sears offered some advice on the benefits and hurdles of conducting both another environmental study and a health study connected to the spraying of chemicals at Base Gagetown. Ms. Sears praised the work of the commission and indicated her willingness to continue to assist in any future work recommended by the commission.

The commission next heard from Gary Goode, chair of Brats In The Battlefield Association, Inc., whose mission is to demand the convening of a public inquiry relating to the Pesticide Applications Program carried out at Base Gagetown and adjacent communities beginning in the mid-1950s until the present.[27] Mr. Goode spoke about his work advocating for a public inquiry into the history of chemical use at Base Gagetown. Mr. Goode described information that he and others have collected related to the spraying of chemicals at Base Gagetown, including information on the number of barrels of herbicide sprayed on the training areas and that there are documents that show chemicals were sprayed that were not registered, and therefore would not be accounted for in the official records. He also explained that dioxins can remain in the environment for a long time, up to 100 years or more, seeping deeply into soil and sediments. Mr. Goode indicated that a significant percentage of those members of the Black Watch (Royal Highland Regiment) of Canada stationed at Base Gagetown and believed to have been exposed to tactical herbicides have died. He also noted that few people have actually been successfully compensated for their exposure, either through the ex gratia payment, which he believes went to mostly civilians, or through a Canadian Veterans Affairs pension. Mr. Goode explained to the commission how he acquired his information, which was largely through Access to Information Act requests, akin to Freedom of Information Act requests in the United States, made by himself or by others whom he was associated with during his time with the Agent Orange Association of Canada. He also spoke about the significant concerns held by many that the groups involved in the Fact-Finding Project were biased and, in some cases, outright corrupt. He also discussed his connections to experts in the field, such as Dr. Wayne Dwernychuk, who served as Chief Scientist for Hatfield Consultants' comprehensive studies in Vietnam from 1994 through 2006 involving the impact of dioxins on the environment and humans.[28]

Finally, the commission heard from Kelly Porter Franklin, who presented on his personal and family experience growing up at Base Gagetown. Mr. Franklin shared with commission

[27] *Mission Statement*. Brats In The Battlefield. https://www.bratsinthebattlefield.ca/
[28] Dwernychuk, W. (2023, November). *Curriculum Vitae*. Hatfield Group. https://hatfieldgroup.com/wp-content/uploads/2023/04/dr-wayne-dwernychuk-cv-2023-april.pdf

members his story and described seeing firsthand the medical hardships that his father suffered, as well as his own. He described the many birth defects that his father's other child had, who was born in the Base Gagetown community. Mr. Franklin answered questions regarding his father's position at Base Gagetown, how long he has been researching chemical spraying at Base Gagetown and spoke of the other connections to individuals and information he has established over his 18 years of research, including his visit to Vietnam as a part of the Agent Orange Association of Canada. Mr. Franklin described the issue as being bigger than the capacity of either the United States government or the government of Canada to resolve and suggested that the commission, or others, contact the United Nations.

The second meeting ended with a discussion between commission members and commission staff regarding next steps. During this discussion, preliminary recommendations that the commission should consider were offered and it was determined that commission members would work between the second and third meetings to solidify these proposed recommendations.

C. Third Meeting – December 6, 2023

The third commission meeting was held on December 6, 2023.[29] Commission members were instructed to come to the meeting with proposed recommendations for discussion. During the meeting, members were invited to bring forward recommendations that they wished the commission to discuss and ultimately vote on. The commission engaged in a lengthy and deliberate discussion of each of the presented recommendations, including posing clarifying questions to commission staff and chairs and ultimately weighed the merits of each recommendation before taking a vote. As described in Section IV of this report, the commission voted unanimously in favor of four recommendations to be included in the final study report. The meeting concluded with additional discussion regarding the distribution of a draft report and the review of that report at the fourth and final commission meeting.

D. Fourth Meeting – December 14, 2023

The fourth and final commission meeting was held on December 14, 2023.[30] Based on discussion and the initial voting on recommendations at the third meeting, commission staff prepared and distributed to commission members a draft report for review and discussion at this meeting. The meeting began with commission chairs directing members to discuss their thoughts and comments on the draft report. Commission members posed clarifying questions regarding the report and made additional technical suggestions for changes to the report and its recommendations, which were discussed and, without objection, agreed to be included in the final report. After a final discussion regarding the process for finalization and distribution of the report, as well as what steps come after the report is submitted to the Legislature, the commission adjourned its fourth and final meeting.

[29] The archived video of the third meeting is available at the following link: https://legislature.maine.gov/Audio/#437?event=89900&startDate=2023-12-06T12:00:00-05:00

[30] The archived video of the fourth meeting is available at the following link: https://legislature.maine.gov/Audio/#437?event=89921&startDate=2023-12-14T12:00:00-05:00

IV. Findings and Recommendations

Although the commission would have liked more time to fully study the impacts of exposure to harmful chemicals on veterans who served at the Canadian military support base in Gagetown, New Brunswick, Canada, as tasked by its authorizing legislation, the commission focused its very limited time on identifying obstacles and determining logical next steps for National Guard members securing recognition of and support for the recognition of harmful impacts of chemical exposure at Base Gagetown. The commission is mindful that the recognition and support sought must ultimately come from the federal government, through Veterans Affairs. Therefore, the following recommendations are put forward as necessary steps towards achieving that recognition.[31]

- **Recommendation 1: To request that the United States Department of Veterans Affairs provide access to medical care and assistance to members of the National Guard who have trained at the Canadian military support base in Gagetown, New Brunswick, Canada and who have been diagnosed with a condition or illness associated with exposure to tactical herbicides or exposure to other dioxins.**

The federal government is failing to support those members of the National Guard who, through their commitment to and willingness to serve their country, have been exposed to dangerous and harmful chemicals that have directly impacted their health, including directly leading to premature death in some cases. This includes those individuals who trained at Base Gagetown during the Vietnam War era through those who continue to train there today and into the future. It is ultimately within the power of the U.S. Department of Veterans Affairs to recognize the health hazards associated with exposure to tactical herbicides and to products containing other dioxins and to recognize those locations and groups exposed, which include National Guard members who have trained at Base Gagetown in the past and those who continue to train there. It is also within the department's control to provide access to medical care and assistance to those members of the National Guard who have trained at Base Gagetown and who have been diagnosed with a condition or illness associated with such exposure.

In even the brief time allowed for the commission to meet, it became clear that the underlying data and analysis, provided as a part of the Canadian government's Fact-Finding Project reports and used as evidence to support the claim that individuals living, working and training at Base Gagetown are not at higher risk to health hazards from exposure to these herbicides, are flawed. It is the belief of the commission that a reevaluation of the body of evidence linking exposure to tactical herbicides and other herbicides containing dioxins to harmful effects on human health would demonstrate a connection similar to those Veterans Affairs has made for Vietnam War veterans exposed to Agent Orange and other tactical herbicides and for other service members exposed to burn pits and other specific environmental hazards recognized in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022. This reevaluation would prove the necessity for Veterans Affairs to provide access to medical care and assistance for these individuals.

[31] All recommendations were supported unanimously by commission members.

Therefore, the commission has mailed letters to each member of Maine's federal congressional delegation urging them to request Veterans Affairs to provide access to medical care and assistance for members of the National Guard who have trained at Base Gagetown and who have been diagnosed with a condition or illness associated with exposure to tactical herbicides or exposure to other dioxins, and to take any other steps necessary to recognize the harm they have caused. The commission has also sent a letter directly to the Honorable Denis Richard McDonough, Secretary of Veterans Affairs.[32]

- **Recommendation 2: The Veterans and Legal Affairs committee should invite individuals with relevant expertise to review and discuss the existing reports and underlying data that comprise the *Canadian Forces Base Gagetown Herbicide Spray Program 1952-2004 Fact-Finders' Report*,[33] as well as other related content, in order to evaluate the reports' processes, methods, data and analysis and to determine what steps and resources would be required in order to either reanalyze the existing data or to conduct new studies.**

Due to the very limited time frame for the commission to complete its work, as well as the highly technical nature of the information, the commission was not able to hear from all of the experts and review all of the materials necessary to gain a complete picture of the *Canadian Forces Base Gagetown Herbicide Spray Program 1952-2004 Fact-Finders' Report*, including all of the underlying task reports, the existing criticisms and critiques of those reports, current and ongoing work related to these types of chemical herbicides and dioxins, or the necessary steps, resources, and costs in conducting either a reanalysis of existing data or entirely new environmental or health outcome studies.

Therefore, the commission recommends that the Veterans and Legal Affairs Committee invite individuals with relevant expertise to review the existing data and analysis related to herbicide spraying at Base Gagetown and to provide insight into the study methods and processes, underlying data collection, analysis of data, and report conclusions. In considering individuals to conduct such a review, the commission would recommend reaching out to Hatfield Consultants,[34] one of western Canada's leading environmental consultancies, the University of Maine[35] and the Muskie School of Public Health at the University of Southern Maine. Additionally, the commission recommends that the committee inquire of these groups whether it would be advisable to conduct a new analysis of existing data or to conduct a new set of studies and if so, what would it take to design and implement such studies, the costs, and potential groups capable of contracting to perform such work. These groups could also consult with MBVS on what information might be useful for them to collect as a part of their registry,[36] given

[32] Copies of the letters are provided in Appendix C.
[33] Furlong, D. (2007). CFB Gagetown Herbicide Spray Programs 1952-2004 Fact-Finders' Report (D. Furlong, Ed.) [Review of CFB Gagetown Herbicide Spray Programs 1952-2004 Fact-Finders' Report].
[34] The commission reached out to Hatfield Consultants regarding a presentation to the commission, but due to time restraints, was not able to finalize the presentation.
[35] President Jackson, chair of the commission, spoke with representatives at UMaine regarding their possible involvement, but due to time restraints, no further action was possible.
[36] See recommendation #3.

that one goal of the registry is to identify health outcome patterns and provide data that could be used to conduct a health outcomes study of affected individuals.

The commission feels that this information is crucial. In order for an individual to be successful in applying for disability compensation and associated benefits with Veterans Affairs, there must be a significant, recognized body of evidence to support the claim that the chemicals sprayed at Base Gagetown are harmful to human health and are known to be associated with specific health conditions or illnesses. The current narrative, as supported by the *Canadian Forces Base Gagetown Herbicide Spray Program 1952-2004 Fact-Finders' Report* is that the levels of toxins as a result of chemical herbicide spraying are below the levels that would cause harm to human health. The commission, as a result of presentations by individuals who are connected to Base Gagetown and to the work of the Fact-Finding Project, find that the data and analysis within those reports is incorrect, biased, and based on, in some cases, incomplete data and poor study design – at times exacerbated by the rapid period in which these reports were required to be conducted and issued. Additionally, the reports and their underlying data are not widely available and accessible, which undermines their scientific credibility and usability, and the reports were issued over 15 years ago; significant new knowledge about these chemicals, scientific methods and the health of those connected to Base Gagetown have since emerged and been developed.

Finally, conducting this further analysis and study mirrors the process Veterans Affairs has gone through in the decades following the Vietnam War regarding Agent Orange exposure, and more recently in the PACT Act of 2022, regarding burn pits and other associated hazards: claims by those affected, multiple studies, scientific advancements, acceptance. Providing trustworthy evidence of the harmful effects of spraying is vital to securing the recognition and help these members of the National Guard deserve.

- **Recommendation 3: The Department of Defense, Veterans and Emergency Management, Bureau of Veterans' Services should reestablish and expand the registry of individuals who served/serve in the Maine National Guard who have trained at the Canadian military support base in Gagetown, New Brunswick, Canada.**

In July of 2005, the Department of Defense, Veterans and Emergency Management, Bureau of Veterans' Services (MBVS) began a registry of individuals who trained at Base Gagetown and self-reported to MBVS. The total list size reached 413 individuals. In addition, MBVS published a questionnaire that members of the National Guard who trained at Gagetown could submit to MBVS, which resulted in 108 responses.[37] The commission strongly believes that data collection is a core component of assisting members of the National Guard in receiving the support they deserve. Therefore, the commission recommends that MBVS reestablish and expand the registry in order to collect data to support future health outcome studies or analyses, to support the record collection and verification process of service and training records for Veterans Affairs claims, and for education and outreach campaigns related to on-going and future work. Maine Bureau of Veterans' Services should submit an annual report to the Veterans and Legal Affairs Committee regarding the status of the registry, outreach methods, emerging trends and patterns based on the

[37] The questionnaire can be found at:
https://www.maine.gov/veterans/docs/CFB%20Gagetown_Questionnaire%202013%20APRIL.pdf

data collected, obstacles to data collection or verification, and recommended next steps for the registry or for the data collected as a part of the registry.

Maine Bureau of Veterans' Services acknowledged that many individuals on the registry from 2005 are now deceased. The bureau should begin by verifying and updating existing information and contacting those individuals on the list who are still living and contacting surviving family members of those who are now deceased. The registry should contain information for both living and deceased individuals. It should also list members of the National Guard who are currently serving and train or have trained in the past at Base Gagetown and former members of the National Guard who have trained at the Base. Along with the names of these individuals, the registry should also contain, at a minimum, the following associated information: date of birth, dates of service, units, military occupational specialty, dates of training at Base Gagetown, self-reported health conditions/diagnoses, and cause of death, if applicable.[38]

In order to compile the most complete registry possible, MBVS should undertake an education and outreach campaign to identify individuals who qualify for the registry, but are not currently on it, and to update existing information. The bureau should make it well known that both individuals who currently serve or have served in the past in the National Guard and family members of those individuals can report information, especially if that individual is now deceased. Maine Bureau of Veterans' Services should also work with existing veterans' organizations to conduct this outreach and education campaign. Additionally, as a part of the registry work, MBVS should reach out to other states' National Guard units in order to gather general information regarding those units' involvement with training exercises at Base Gagetown, including timeframes, frequency, duration, estimated numbers of individuals involved, and any health outcome patterns. Maine Bureau of Veterans' Services should encourage these other states to develop their own registries.[39]

- **Recommendation 4: The Legislature should reestablish the Gagetown Harmful Chemical Study Commission.**

Due to the very abbreviated timeframe for authorized legislative studies to complete their work this interim, the Gagetown Harmful Chemical Study Commission was unable to review all the necessary materials and to speak with the experts in the field that would have allowed the commission to put forward more concrete recommendations. As a result, the commission's recommendations request that the Veterans and Legal Affairs Committee and MBVS continue the work started by this commission. The commission should have the opportunity to examine the information collected by the bureau and the committee and to determine the proper next steps. Too often this issue has come before the Legislature and failed to achieve any forward progress. Reestablishing the commission would ensure a continuity of purpose and action. In reflecting on what the commission has learned to date, it may also be helpful to consider expanding commission membership by two members, in order to include individuals with

[38] Pursuant to recommendation #2, MBVS could consult with experts in the field of data collection and human health studies to guide them in determining what types of information would be most beneficial to collect and what kinds of patterns in human health data for which they could monitor.

[39] Director Richmond, MBVS, indicated at the third meeting, during the discussion and voting on recommendations, that this work can be completed using existing resources. He also indicated his support for this recommendation.

expertise in chemical engineering, environmental science, or human health as they relate to exposure to hazardous chemicals.

V. Conclusion

The commission's work and publication of its report represent the most recent effort to bring necessary attention to an issue that is threatening the lives of former members of the Maine National Guard and has resulted in the untimely death of other members - and will continue to do so into the future for members who have more recently trained at Gagetown and for members who may do so presently. The United States Department of Veterans Affairs must recognize the harmful effects of chemical spraying on members of the National Guard who have trained or continue to train at the Canadian military support base in Gagetown, New Brunswick, Canada. The State must do everything in its power to gather, generate, and present the necessary data to force this recognition. This report presents a path forward for the State to begin that process and a plea to Veterans Affairs to take care of its people. This report represents not only the hopes of the commission, but also the hopes of all those affected - this work is not just an expression of passion to finally appropriately address the problem, it is also an expression of compassion. The commission is hopeful that with support from the Veterans and Legal Affairs Committee of these recommendations, progress towards recognition and medical care and assistance can be achieved. Commissioners look forward to working with the committee and the Legislature on the recommended proposals and next steps.

Finally, the commission would like to thank all of its members and presenters for generously offering their time, expertise, and advice on this emotional and complicated issue. Their knowledge and perspectives were invaluable in developing the recommendations of the commission.

APPENDIX A

Authorizing Legislation: Resolve 2023, c. 95

APPROVED
JULY 7, 2023
BY GOVERNOR

CHAPTER
95
RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD

TWO THOUSAND TWENTY-THREE

S.P. 628 - L.D. 1597

Resolve, to Establish the Gagetown Harmful Chemical Study Commission

Sec. 1. Study commission established. Resolved: That the Gagetown Harmful Chemical Study Commission, referred to in this resolve as "the study commission," is established.

Sec. 2. Study commission membership. Resolved: That, notwithstanding Joint Rule 353, the study commission consists of 10 members appointed as follows:

1. Two members of the Senate appointed by the President of the Senate, including members from each of the 2 parties holding the largest number of seats in the Legislature;

2. Two members of the House of Representatives appointed by the Speaker of the House, including members from each of the 2 parties holding the largest number of seats in the Legislature;

3. Two members who represent veterans' advocacy organizations, one appointed by the President of the Senate and one appointed by the Speaker of the House;

4. One member who is a family member of a veteran who served at the Canadian military support base in Gagetown, New Brunswick, Canada, appointed by the President of the Senate;

5. One member with expertise processing veterans' claims for benefits related to harmful chemicals, appointed by the Speaker of the House; and

6. Two members who served at Gagetown and were exposed to harmful chemicals during their service, one appointed by the President of the Senate and one appointed by the Speaker of the House.

Sec. 3. Chairs. Resolved: That the first-named Senate member is the Senate chair and the first-named House of Representatives member is the House chair of the study commission.

Sec. 4. Appointments; convening of study commission. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. After appointment of all members,

the chairs shall call and convene the first meeting of the study commission. If 30 days or more after the effective date of this resolve a majority of but not all appointments have been made, the chairs may request authority and the Legislative Council may grant authority for the study commission to meet and conduct its business.

Sec. 5. Duties. Resolved: That the study commission shall study the impacts of exposure to harmful chemicals on veterans who served at the Canadian military support base in Gagetown, New Brunswick, Canada.

Sec. 6. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the study commission, except that Legislative Council staff support is not authorized when the Legislature is in regular or special session.

Sec. 7. Report. Resolved: That, no later than December 6, 2023, the study commission shall submit a report that includes its findings and recommendations, including suggested legislation, to the Joint Standing Committee on Veterans and Legal Affairs.

APPENDIX B

Membership List: Gagetown Harmful Chemical Study Commission

Gagetown Harmful Chemical Study Commission

Resolve 2023, c. 95

Membership List

Name	Representation
President Troy D. Jackson - Chair	Senate member, appointed by the President of the Senate
Representative Ronald Russell - Chair	House member, appointed by the Speaker of the House
Senator Bradlee Farrin	Senate member, appointed by the President of the Senate
Representative Mark Babin	House member, appointed by the Speaker of the House
Jan McColm	A family member of a veteran who served at the Canadian military support base in Gagetown, New Brunswick, Canada, appointed by the President of the Senate
David Donovan	Representing veterans' advocacy organizations, appointed by the President of the Senate
Don Page	Who served at Gagetown and was exposed to harmful chemicals during their service, appointed by the President of the Senate
Karen St. Peter	Representing veterans' advocacy organizations appointed by the Speaker of the House
Dana Michaud	Who served at Gagetown and was exposed to harmful chemicals during their service, appointed by the Speaker of the House
Jim Gehring	With expertise processing veterans' claims for benefits related to harmful chemicals, appointed by the Speaker of the House

APPENDIX C

Commission Correspondence:

- Letter to Maine's Federal Congressional Delegation
- Letter to Secretary of Veterans Affairs, United States Department of Veterans Affairs

STATE OF MAINE
ONE HUNDRED AND THIRTY-FIRST LEGISLATURE
GAGETOWN HARMFUL CHEMICAL STUDY COMMISSION

January 10, 2024

Senator Susan Collins
413 Dirksen Senate Office Building
Washington, D.C. 20510

Senator Angus King
133 Hart Building
Washington, D.C. 20510

Representative Jared Golden
1710 Longworth House Office Building
Washington, D.C. 20515

Representative Chellie Pingree
2354 Rayburn House Office Building
Washington, D.C. 20515

Dear Senator Collins, Senator King, Representative Pingree and Representative Golden:

We are writing to you on behalf of the Gagetown Harmful Chemical Study Commission, which was established by the 131st Maine Legislature through Resolve 2023, chapter 95 "to study the impacts of exposure to harmful chemicals on veterans who served at the Canadian military support base in Gagetown, New Brunswick, Canada."

Throughout the course of our meetings, one obstacle has loomed large over our work – that the desperately needed recognition of the effects of exposure to harmful chemicals on members of the National Guard who have trained at Base Gagetown, and who continue to train there, as well as the access to medical care and assistance they deserve is ultimately within the power of the United States Department of Veterans Affairs. Our commission and the State can continue to take steps to prove these harmful effects and to demonstrate through scientific evidence the connection between exposure to these chemicals while training and the diagnosis of conditions or illnesses associated with such exposure, which this commission has recommended in our final report, but in the end, it is the responsibility of the Department of Veterans Affairs to make this determination and provide the requested care and assistance.

Therefore, we are urging you to advocate for the recognition of the effects of exposure to harmful chemicals, which include TCDD and other dioxins, on members of the National Guard who train at Base Gagetown and who are diagnosed with a condition or illness associated with such exposure, as already recognized by Veterans Affairs for Vietnam War veterans and others. We encourage you to request Veterans Affairs to review the most recent scientific reporting on the effects to human health of exposure to dioxins, to conduct independent environmental sampling and analysis at Base Gagetown related to dioxins and risks to human health, and to examine health outcomes for individuals who have trained there. We are confident that such a review would demonstrate a connection between the harmful chemicals applied and negative health outcomes similar to those Veterans Affairs has made for Vietnam War veterans exposed to tactical herbicides, including Agent Orange, which is known to have been tested

at Base Gagetown, and for other service members exposed to burn pits and other specific environmental hazards recognized more recently in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022. This comprehensive review would demonstrate the necessity for Veterans Affairs to provide access to medical care and assistance for these individuals.

We acknowledge that your offices have been involved in some of the work that has been done to address this issue over the past decade or more, but nothing has come of it yet, and time is running out for many of those affected. We thank you in advance for using all of your resources to address this issue and to champion the unanimous recommendation of the commission. We stand ready to discuss this issue further.

Sincerely,

President Troy Jackson
Senate Chair

Ronald Russell
House Chair

cc *(via email):* Members, Gagetown Harmful Chemical Study Commission

STATE OF MAINE
ONE HUNDRED AND THIRTY-FIRST LEGISLATURE
GAGETOWN HARMFUL CHEMICAL STUDY COMMISSION

January 10, 2024

The Honorable Denis Richard McDonough
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Secretary McDonough:

We are writing to you on behalf of the Gagetown Harmful Chemical Study Commission, which was established by the 131st Maine Legislature through Resolve 2023, chapter 95 "to study the impacts of exposure to harmful chemicals on veterans who served at the Canadian military support base in Gagetown, New Brunswick, Canada."

Throughout the course of our meetings, one obstacle has loomed large over our work – that the desperately needed recognition of the effects of exposure to harmful chemicals on members of the National Guard who have trained at Base Gagetown, and who continue to train there, as well as the access to medical care and assistance they deserve is ultimately within the power of the United States Department of Veterans Affairs. Our commission and the State can continue to take steps to prove these harmful effects and to demonstrate through scientific evidence the connection between exposure to these chemicals while training and the diagnosis of conditions or illnesses associated with such exposure, which this commission has recommended in our final report, but in the end, it is the responsibility of the Department of Veterans Affairs to make this determination and provide the requested care and assistance.

Therefore, we are urging you to recognize the effects of exposure to harmful chemicals, which include TCDD and other dioxins, on members of the National Guard who train at Base Gagetown and who are diagnosed with a condition or illness associated with such exposure, as you have already done for Vietnam War veterans and others. We implore you to review the most recent scientific reporting on the effects to human health of exposure to dioxins, to conduct independent environmental sampling and analysis at Base Gagetown related to dioxins and risks to human health, and to examine health outcomes for individuals who have trained there. We are confident that such a review would demonstrate a connection between the harmful chemicals and negative health outcomes similar to those your department has made for Vietnam War veterans exposed to tactical herbicides, including Agent Orange, which is known to have been tested at Base Gagetown, and for other service members exposed to burn pits and other specific environmental hazards recognized more recently in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022. This

comprehensive review would demonstrate the necessity for Veterans Affairs to provide access to medical care and assistance for these individuals.

Time is running out for many of those affected, so we thank you in advance for using all of your resources to address this issue in an expeditious manner. We stand ready to discuss this issue further.

Sincerely,

President Troy Jackson
Senate Chair

Ronald Russell
House Chair

cc *(via email):* Members, Gagetown Harmful Chemical Study Commission

Sunrise County Economic Council

January 22, 2024

Honorable Janet T. Mills
Governor
1 State House Station
Augusta, Me 04333-0001

Ms. Susanne Gresser
Executive Director of the Maine Legislature 115 State House Station
Augusta, ME 04333-0115

Honorable Chip Curry
Honorable Tiffany Roberts
Joint Committee of Innovation, Development, Economic Advancement and Business c/o
Legislative Information Office
100 State House Station

Dear Governor Mills, Ms. Gresser, Senator Curry and Representative Roberts,

Pursuant to MRSA Title 5, Chapter 383, Article 2-A, Section 13083-F, the Sunrise County Economic Council (SCEC) is pleased to submit the 2021-2022 Annual Report to the Legislature on behalf of the Washington County Development Authority (WCDA).

SCEC is a private, nonprofit, federally recognized economic development organization which works to create jobs and prosperity in Washington County. We provide staff support for the WCDA and are partnering with the Authority in its effort to redevelop the former U.S. Navy base in Cutler.

The WCDA continued its incremental work to restore the former Cutler Naval Base to productive use.

As indicated in the enclosed report, the WCDA procured GR Roofing LLC to replace the roof on the Base's Chapel Shop and Workshop. Seavee & Mahar Engineering were procured to take samples for hazardous materials, their findings revealed more hazardous materials than were anticipated through the tests. WCDA, EPA and the US Navy are now in discussions over cleanup of the contaminated area. WCDA did not make any significant contributions or changes to policies and procedures in the past year.

Please contact me with any questions or concerns. Thank you.

Sincerely,

Charles J. Rudelitch, Esq.
Executive Director
Enclosure: 2022-2023 Annual Report

Washington County
Development Authority

ANNUAL REPORT October 1, 2022- September 30, 2023

Introduction

Pursuant to the provisions of Title 5 of Maine Revised Statutes Annotated, Chapter 383, Subchapter 3, Article 2-A, the Washington County Development Authority is required to submit an annual report to the Governor, the Executive Director of the Legislative Council, and the joint standing committee of the Legislature having jurisdiction over business and economic development matters. The report must be submitted no later than 120 days after the close of the authority's fiscal year. The Authority's fiscal year ended on September 30, 2023.

Section 13083-F of 5 MRSA requires that the annual report of the Authority include:

A. A description of the authority's operations and activities;
B. An accounting of the authority's receipts and expenditures and assets and liabilities at the end of its fiscal year;
C. A listing of all property transactions pursuant to section 13083-D;
D. A statement of the authority's proposed and projected activities for the ensuing year; and
E. Recommendations regarding further actions that may be suitable for achieving the purposes of this article.

History of the Authority

The Washington County Development Authority was established by the Second Regular Session of the 120th Maine Legislature as Chapter 568 of the Laws of Maine 2001. The Authority was established in response to the need to create a state entity that could take title to the former Naval Computer and Telecommunications Station in Cutler, Maine from the United States Navy. Since that time, the legislation was amended to broaden the scope of the authority's mission to allow the authority to provide financial and technical assistance to any governmental entity and nonprofit located within Washington County in support of community and economic development projects. Representation was expanded to include all municipalities in Washington County, including the unorganized territories.

For the reporting period, the Authority was comprised of the following members: Elizabeth "Betsy" Fitzgerald (Machiasport), Renee Gray (Addison), Julie Jordan (Jonesport), Ron McAlpine (Crawford), Lewis Pinkham (Milbridge), Heron Weston (Eastport) and Lani Reynolds (Northfield). The DECO Appointee seat is currently vacant. Heron Weston and Lani Reynolds are no longer attending monthly board meetings.

For this time period, the following officers were elected: Betsy Fitzgerald (Chair), Lewis Pinkham (Vice Chair). The WCDA set monthly meetings on the third Monday of every month at 1:00 pm. During this period, all meetings were held virtually using the Zoom platform.

The Authority can have up to 13 voting members. At this point, there are 7 Trustees. The Authority would like to increase board membership and will work with Sunrise County Economic Council to provide a list of potential Trustees to the Governor.

Operations and Activities

The WCDA Trustees scheduled ten (10) regular meetings from October 2022 to September 2023, 5 of these meetings did not meet numbers to reach a quorum.

Major items of discussion during the course of the report period included the following subjects:

The Washington County Development Authority continues to contract with Sunrise County Economic Council to provide administrative and bookkeeping services.

An EPA Clean Up Grant was awarded to the Authority in 2021. The EPA required more testing on the Recreation Building in 2022. The Authority accepted a bid from Seavee and Mahar Engineering to conduct the required tests. More hazardous materials were found than were anticipated through the tests. At this time the cost of cleanup exceeds the amount of funds received through the Brownfields Grant. The Authority is now working on possible cleanup processes with the EPA, and the US Navy has been successfully contacted and will be assisting for the funding to help with the cleanup of the Rec Building.

The Authority is seeking additional funding for cleanup of the Administration Building, security is now an issue due to vandalism.

The Authority accepted the roofing bid from GR Roofing LLC to replace the roof of the Chapel shop and Workshop. The work was finished in a timely manner in late 2022.

New doors are still needed on the Warehouse and the Chapel. The Authority has put this project out to bid and has found the cost to be a barrier, $10,000 is the lowest bid that has been received. The Authority looked for a reasonable bid and the cost for the doors has increased. A revised bid from Machias Glass Works for $13,500 has been accepted and the doors will be put on in the new year.

During the year, the Authority had continued to manage the commercial buildings at the de- commissioned Cutler Base. The WCDA continues to lease space for several small Maine businesses and all of the space that can be leased on the Base at this time is full. The whole Public Works building has been rented and the Authority is also continuing to receive inquiries about when additional space will be finished.

Receipts and Expenditures

See attached Financial Statement

Property Transactions

The WCDA did not sell or buy real estate this year.

Proposed and Projected Activities

Sunrise County Economic Council and Washington County Government have provided what staff support they can, but the Authority's Trustees are handling much of the day-to-day management of the property as volunteers.

The Authority will continue to work with the EPA and the US Navy around the issue of cleaning up the contamination on the base, talks between the EPS and the US Navy have begun and will continue until the issue is resolved.

The Authority's sole source of income is rent, which has been entirely used for the maintenance and repair of the property.

The Authority will be seeking an extension on the current Brownfields Grant award in 2024 and applying for additional funding.

The Authority will continue to seek new tenants as the spaces receive additional repairs and cleanup as well as continue contact with perspective businesses.

Recommendations

1. The Authority requests the Governor, Honorable Janet T. Mills, to appoint additional Trustees to the Washington County Development Authority's Board.

Attachments:

Financial reports: WCDA Annual Income Statement

Respectfully Submitted,

Renée Gray

Renée Gray, WCDA Chair

Washington County Development Authority

Statement of Revenues and Expenditures - Detail - Unposted Transactions Included In Report

From 10/1/2022 Through 9/30/2023

	Current Period Actual
Operating Revenue	
Grant Revenue	
	60,952.51
Investment Income	
	11.96
Other Income	
	70,075.00
Total Operating Revenue	131,039.47
Total Revenue	131,039.47
Expenditures	
Program Expenses	
	11,471.63
Professional Fees	
	2,653.22
Postage & Shipping	
	66.00
Occupancy	
	4,094.62
Maintenance & Repairs	
	6,683.64
Miscellaneous	
	796.00
Total Expenditures	25,765.11
Net Revenue Over Expenditures	105,274.36

Washington County Development Authority
Balance Sheet
As of 9/30/2023

	Current Year	Prior Year	Current Year % Change
Assets			
Current Assets			
Cash & Cash Equivalents			
Checking Account	109,373.78	173,614.24	(37.00)
Camden CD	87,000.00	0.00	100.00
Total Cash & Cash Equivalents	196,373.78	173,614.24	13.11
Total Current Assets	196,373.78	173,614.24	13.11
Long-term Assets			
Property & Equipment	81,500.00	0.00	100.00
Total Property & Equipment	81,500.00	0.00	100.00
Total Long-term Assets	81,500.00	0.00	100.00
Total Assets	277,873.78	173,614.24	60.05
Liabilities			
Short-term Liabilities			
Accounts Payable			
Accounts Payable	0.00	1,014.82	(100.00)
Total Accounts Payable	0.00	1,014.82	(100.00)
Total Short-term Liabilities	0.00	1,014.82	(100.00)
Total Liabilities	0.00	1,014.82	(100.00)
Net Assets			
Beginning Net Assets			
Net Assets	188,279.76	188,279.76	0.00
Current YTD Net Income			
	89,594.02	(15,680.34)	(671.38)
Total Current YTD Net Income	89,594.02	(15,680.34)	(671.38)
Total Net Assets	277,873.78	172,599.42	60.99
Total Liabilities and Net Assets	277,873.78	173,614.24	60.05

MRRA
Midcoast Regional
Redevelopment Authority

January 18, 2024

The Honorable Janet T. Mills
Governor of the State of Maine
State House Station #1
Augusta, Maine 04330

Subject: Annual Report of MRRA for the year ending December 31, 2023

Dear Governor Mills:

Pursuant to 5 MRSA §13083-S, I am writing to update you on the activities of the Midcoast Regional Redevelopment Authority (MRRA) and the remarkable transformation of the former Naval Air Station Brunswick and its Topsham Annex.

The Midcoast Regional Redevelopment Authority, a component unit of the State of Maine, is a municipal corporation created by Maine law, 5 MRSA §13083-G, and charged with the responsibility to acquire and manage property at the former Naval Air Station Brunswick (NAS Brunswick) and the Topsham Annex and to facilitate the rapid redevelopment of properties in order to recover from economic and employment loss as a result of base closure. The first meeting of the MRRA Board of Trustees was held on September 27, 2007.

As the following key performance indicators illustrate, the NAS Brunswick redevelopment effort is proceeding on the course originally envisioned by the Reuse Master Plan; at a much faster pace than originally projected. We have clearly established Brunswick Landing as *Maine's Center for Innovation* and an incredible asset for the growth of both the Mid-coast and Maine economy. Some of the key success metrics of the redevelopment effort since the base closure include:

- Over **132 public and private entities** now call Brunswick Landing and the Topsham Commerce Park home. Nearly 40% of these entities did not exist in Maine before.

- Over **2,405 new jobs** have been created to date. It should also be noted that there are 120 Maine Army National Guard members and 124 Marine Corps Reservists assigned to their units at Brunswick Landing bringing the **total employment to 2,529.**

- In a 2019 Beneficial Use Study of Brunswick Landing by the Environmental Protection Agency for Region 1, it was reported that the 1,800 individuals employed at Brunswick Landing earned an estimated $67 million in income and produced an estimated $683 million in state GDP. Using that ratio, the **estimated personal income at Brunswick is $97.6 million and close to $1 billion in state GDP.**

- TechPlace, our technology business incubator, is home to **38 early-stage technology businesses, with 107 current employees.** Resident businesses exist in all six target business sectors: aerospace, advanced materials, information technology, cleantech, and life sciences. To date, TechPlace has graduated 25 businesses nearly all of which have remained in Maine. Collectively those graduates have created 450 jobs.

- **$245,920,170 in new taxable property valuation** has been added to the property tax rolls in the Town of Brunswick and **$7,040,200 in Topsham**, generating new property tax revenues for FY 2023 in Brunswick of $5,334,008 and $95,605 in Topsham.

- Since the approval of the Public Benefit Conveyance (PBC) and the signing of the Economic Development Conveyance (EDC) Purchase and Sale Agreement in 2011, the Navy has transferred 1,959.38 of the 2,257.92 acres we are slated to receive through deed transfer or Lease in Furtherance of Conveyance. MRRA has now received 969.72 (77.25%) of the 1,255.32 acres of the non-airport property and 989.66 (98.71%) of the 1,002.6 acres of airport land. This year the Navy transferred 5.73 acres and four EDC buildings (buildings 29, 201, 221 and 226) on Neptune Drive and transferred 4.04 acres of PBC property and one building (building 9 scheduled to be demolished) on the corner of Admiral Fitch Avenue and Orion Street.

- Since 2011, MRRA has sold fifty-six buildings and 637.87 acres of land to twenty-two private sector developers and several individual businesses for active redevelopment purposes. This year MRRA sold three buildings on Neptune Drive (buildings 29, 221 and 226) and 1.76 acres (lot 60) to Sabattus Realty which will construct a new building on Allagash Drive for the dentist office of Dr. Peter Drewes.

- MRRA currently has ten direct tenants renting 144,366 square feet in eleven EDC acquired buildings and two buildings MRRA built.

- MRRA has another 534,481 square feet of building space under lease to 47 airport tenants in ten PBC acquired buildings and two other hangar buildings MRRA built and 4 other tenants leasing land area.

- In December **asylum-seeking families started moving into a new housing** development built at Brunswick Landing. A group of 23 families began settling into two 12-unit buildings that have been completed so far (each unit of 11,736 square feet). The other three 12-unit buildings in the development are expected to be completed in January of 2024. Portland-based Developers Collaborative is building the $13 million development. MaineHousing provided an $8 million loan package, while the Brunswick-based Genesis Community Loan Fund is providing a $4 million loan. MaineHousing is covering the families' rents for two years. Most of the 23 families are from Angola and the Democratic Republic of the Congo and have one or two children.

- Eighteen commercial and industrial buildings comprising 276,235 square feet have been constructed at Brunswick Landing.

- In 2022 Jones Street Investment Partners received $36 million in financing and approval from the Town of Brunswick to construct a 181 multifamily housing project (adding 159,408 square feet), Atlantic Point Apartments, at Brunswick Landing. Construction is well underway with four of nine four story apartment buildings currently housing tenants. Brunswick Landing Ventures also received approval to construct 85 single family homes on campus.

- In May Katahdin Property Management began construction on an $18 million apartment complex at Brunswick Landing. The 63-unit building off Admiral Fitch Avenue will have advanced heat pumps, electric-vehicle chargers, underground parking and solar panels. A total of 20% of the units will be reserved for affordable housing; rents are projected to range from $1,300-$2,500.

- This year's **flight operations have totaled right at 24,000.** FlightLevel Aviation the Fixed Base Operator (FBO) sold 450,000 gallons in up from 350,000 gallons in 2022. The Great State of Maine airshow will return in 2024, bringing with it an excitement and economic impact that will carry beyond the Brunswick area. The increase in flight operations and fuel sales have several contributing factors. Several flight schools located at BXM, increased corporate and private traffic, and the aircraft maintenance facilities to name a few. The large runways, ramps, and hangars make the airport an appealing place for aviation related companies to fly, work and train, the small town feel and welcoming accommodations make it a preferred destination for private travelers.

- This year, Brunswick Executive Airport hosted two Presidential visits which included Air Force One, Marine One, and four Osprey Tiltrotor Aircraft, the Presidential Limousine and support motorcade.

- **Over 1,200 acres of land has been reserved for conservation** and recreation purposes.

- Electric power provided to Brunswick Landing customers comes from **100% renewable energy sources.** The campus houses a 1.0-megawatt anaerobic digester which has the potential to burn methane to generate electricity. Its new owners are in the process of completing permitting and upgrades so operations can start up again. In January of 2019, a $3 million 1.5-megawatt solar farm owned by Diversified Communications began generating

electricity for the campus. The solar farm is currently generating about 12% of the energy needs of the campus. A planned 1-megawatt expansion of the digester will allow for nearly 100% of our power needs to be met by on campus renewable sources.

- MRRA inherited a significant bundle of utility and infrastructure systems from the Navy, including: 27 miles of roadways, streetlight and stormwater systems; 17 miles of water and wastewater pipes and multiple related pump stations; and over 15 miles of electric lines, poles and transformers. Since 2012, MRRA has invested more than $7.8 million in these utilities.

- In June of 2019, MRRA transferred the entire gravity sanitary sewer system to the Brunswick Sewer District. In December of 2021 MRRA finished the reconstruction of three sanitary sewer pump stations (Theater Lift Station, Public Works Lift Station and Hangar 6 Lift Station) at a cost of $1.47 million and transferred these new facilities and over 9,505 feet of sanitary sewer gravity mains over to the Brunswick Sewer District. This year, Brunswick Landing Ventures and the Brunswick Sewer District invested more than $1 million in the complete refurbishment of the Woodland Sanitary Sewer Pump Station which will be transferred to the Brunswick Sewer District early in 2024. Renovations to the Mariner Sanitary Sewer Pump Station began in December.

- MRRA, the Federal Aviation Administration, and MaineDOT have invested $14.5 million in the transition of a former military airfield into a general aviation airport and over $20.2 million in upgrading airport buildings to grow the aviation and aerospace industries in Maine including the construction of a ten-unit T-Hangar building and a 15,867 square foot box hangar.

- In February, the Brunswick Town Council approved a $1.12 million construction contract for the first phase of the Midcoast Athletic and Recreation Complex (MARC), a multi-million-dollar set of courts, fields and other recreation amenities at Brunswick Landing adjacent the Town's Community Recreational Facility.

A. *Description of the Authority's Operations*

The year 2023 was another busy, challenging and successful year for MRRA. MRRA continues to work hard to enhance the redevelopment of Brunswick Landing to be a catalyst for the State's economic growth. Our business development efforts continue to focus on quality job creation in our targeted industries: aviation/aerospace, clean technology, composites, information technology, biotechnology, and education.

The Midcoast Regional Redevelopment Authority reached a number of important milestones in 2023. Consistent with MRRA's adopted ***2023 Strategic Business Plan for Brunswick Landing and Topsham Commerce Park,*** this past year's performance on those objectives includes the following accomplishments:

In 2023, MRRA signed the following new leases:

New MRRA Tenants

- DiMillo's Boat Storage
- Fwego
- Northeastern University
- Roy's Driving School
- Squad 10 Medical Fitness
- Stratton Aviation
- Yarmouth Boat Yard

New leases signed this year in TechPlace include:

- Casco Bay Sewing and Fabrication
- Even Keel, Inc.
- Maine Space Grant Consortium
- Ocean Farm Supply, LLC
- Omission, Inc.
- Revert Technologies, Inc.
- R. E. Thomas Marine Hardware

TechPlace has been a valuable resource in growing Maine's economy having graduated the following twenty-five businesses since its creation:

- Altha Technology
- AO Cyber Security
- Arcadia Alliance
- Atayne
- BluShift Aerospace
- Captive Drone
- Fiddlehead Designs
- Go Babe
- Griffin LLC
- Harbor Technologies
- InSphero Manufacturing
- JMH Associates LLC
- Maritime Surveillance Associates
- Mobility Technologies
- Plant & Flask
- Running Tide
- Savoie Composite Solutions
- STARC Systems
- TanBark, LLC
- The Maine Extraction
- Thrivant Health
- VALT Enterprises, Inc.
- Village Green Ventures
- Vivid Cloud Development Services
- Wireless Sensors

Other accomplishments this year include:

- This fiscal year the Brunswick Executive Airport was awarded $997,000 from the Federal Aviation Administration and a state match of $55,400 from the Maine Department of Transportation along with MRRA's match of $55,400 to fund the following projects:

FAA MAP 046 Pavement Markings	$230,200
FAA MAP 047 Snow Removal Equipment	$695,600
FAA MAP 048 Customs Feasibility Study (CDS)	$71,200
	$997,000

- This year the Restoration Advisory Board prepared a Community Involvement Plan (CIP) in support of the ongoing cleanup being completed under the Department of the Navy Environmental Restoration Program (ERP) at former Naval Air Station (NAS) Brunswick. This CIP is designed to support effective two-way communication between former NAS Brunswick Navy representatives and local community members for the ERP. Effective communication and timely information exchange are essential for maintaining community understanding and support for former NAS Brunswick's property transfer activities and in continuing to implement a successful ERP. The outreach methods described in this CIP were developed based on the responses received through an online community survey conducted from November 2021 through January 2022.

- With a grant from the Maine Department of Transportation MRRA issued an RFP for design and engineering work on the planned Allagash bike/ped pathway. Gorrill Palmer will be issuing its final report in the first quarter of 2024.

- Remediation of the former Picnic Pond stormwater retention system by dredging contaminated soils containing chemical of concern in Ponds A and B and Picnic Pond by the United States Government Navy BRAC Office was completed this fall.

- New staff this year at MRRA, including Jake Levesque, hired as the Director of Innovation and Development replacing Jenna Muzzy. Jake brings a wealth of marketing and new social media relation skills to the position. Robin Saindon was brought on as the new Finance Officer, replacing Tushima Sims. Robin had previously worked in the Finance Office of Bowdoin College. Katherine Robison was hired as the Executive Administrative Assistant to the Executive Director. An engineer by training, she brings strong organizational skills to the MRRA operation. In November MRRA hired John Bolduc as the new TechShop Manager at *TechPlace* replacing Brian Mulligan who has retired from the part time position. John is a retired Professor and Department Chair of the Precision Machining and Manufacturing Department at Southern Maine Community College, having taught for over twenty years.

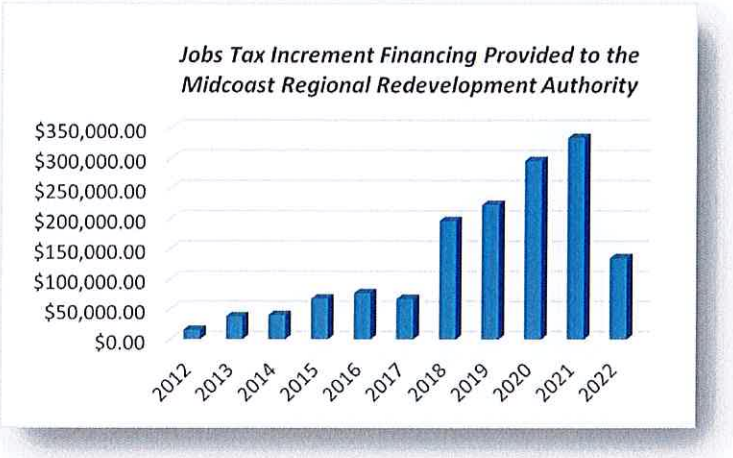
- On October 30, the Board elected the following officers: Chair – H. A. Nichols, Vice Chair – John Peters, Treasurer – Ann Marie Swenson and Secretary – Lois Skillings.

B. An accounting of the Authority's receipts and expenditures, assets and liabilities at the end of its fiscal year

Please find attached an Unaudited Financial Report for the period ending December 31, 2023. Also, please find attached a copy of the audited Financial Statements for the period ending June 30, 2023. The audit was conducted by Runyon Kersteen and Ouellette. These documents were presented to the Office of the State Controller for inclusion in the State financial statements for the period ending June 30, 2023. MRRA received an unmodified (clean audit) opinion letter for a sixteenth consecutive year.

It should be noted that MRRA does not receive a direct state appropriation as part of the General Fund Budget. MRRA's funds come from revenues from property sales, leases, common area maintenance charges and utility customers.

In 2009 the Legislature amended our enabling statute and created the Brunswick Naval Air Station Job Increment Financing Fund. These funds have been an important resource in promoting the rapid and successful redevelopment of Brunswick Landing. A large portion of the funds collected from income taxes paid by employees of Brunswick Landing businesses for tax year 2022 were unexpectedly withheld from MRRA. The Maine Revenue Service and MaineDECD did not consider remote workers as eligible workers under the statute. This resulted in a substantial reduction in financial support. In 2022, the State of Maine provided $333,403.93; MRRA had projected and planned for a J-TIF revenue of $350,000 for 2023. Instead the State made a payment of $134,311.71, due to the exclusion of remote workers hired by Brunswick Landing employers.



Capital improvements projects are funded from a combination of aviation capital improvement funds from Maine DOT, the Federal Aviation Administration, tax increment financing revenue from the Town of Brunswick and revenues MRRA raises from property sales, leases, utility customers and public area maintenance charges.

C. A listing of all property transactions pursuant to Section 13083-K

On February 7, 2011, the Navy and MRRA signed the airport Public Benefit Conveyance (PBC) Agreement for 989.66 acres, including three large hangars, a number of aviation-related support buildings and revenue-producing facilities for the airport. Through subsequent amendments, the total expected PBC transfer is now 1,002.60 acres. The conveyance of title will come over time as properties that are determined to be "clean" through a Finding of Suitability to Transfer (FOST) and are then deeded from the Navy. Accordingly, not all the properties can be conveyed at the same time, but in phases as clean-up continues and FOSTs are issued. As of December 31, 2023, MRRA has received a total of 989.66 acres of airfield property and 19 buildings containing 627,516 square feet. As a condition of transfer from the Federal Aviation Administration and the Navy, land and buildings within the Airport property cannot be sold. MRRA built a 10,000-square foot ten-unit T-Hangar and a 15,867 square foot box hangar bringing the total square footage managed to 653,383. This year the Navy transferred AIR 15 and AIR 17 on July 28, 2023 comprising of 4.04 acres for two parcels on either side of Admiral Fitch Avenue at the intersection of Orion Street.

On September 14, 2011, the Navy signed a *Non-Binding Summary of the Acquisition Terms and Conditions for the Naval Air Station Brunswick, Maine by and between the United States of America and the Midcoast Regional Redevelopment Authority* (i.e., term sheet) for a total of 1,112 acres which would be transferred though an Economic Development Conveyance (EDC). Through subsequent amendments, the total expected EDC transfer is now 1,255.32 acres. MRRA has received through Quit Claim Deed or Lease in Furtherance of Conveyance 969.72 acres from the Navy.

As part of the EDC Agreement, MRRA agreed to share annually with the Navy 25% of gross revenues from the sale or lease of EDC property after the receipt of the first $7.0 million. The revenue share remains in place until gross revenues reach $37.4 million. There is no revenue sharing in excess of $37.4 million and less than $42.4 million. The Authority is required to pay the United States Government 50.0% of gross real estate proceeds in excess of $42.4 million until September 29, 2034. To date, MRRA has paid the United States Government $9,186,348.49.

This year, MRRA sold 1.94 acres and building 29, the former auto-hobby building to Priority Realty Group of Topsham, Maine. The building currently houses NorthEast Ambulance Service and Shoreline Auto Detailing. MRRA also sold the former SeaCadets building (building 221) and the former Thrift Store (building 226) and 1.6 acres to Jones Street Investment Partners for its leasing offices. In September MRRA sold 1.76 acres (lot 60) to Sabattus Realty which will construct a new building on Allagash Drive for the dentist office of Dr. Peter Drewes.

All the remaining properties at the former NASB and Topsham Annex will be conveyed from the United States Government to MRRA once appropriate environmental clearances are obtained.

D. An accounting of all activities of any special utility district formed under Section 13083-L

On September 30, 2011, the Navy transferred all utilities on the base, including the electrical distribution system, the potable water distribution system, the sewer collection and pump station assets, stormwater collection system to MRRA.

On June 30, 2019, MRRA transferred the operation and sanitary sewer gravity collection system to the Brunswick Sewer District. With the completion of the upgrade to three sanitary sewer pump stations, MRRA transferred those facilities and over 3,900 linear feet of force mains to the Brunswick Sewer District on December 31, 2021.

MRRA has been providing electrical distribution services at Brunswick Landing since 2011. In 2020, MRRA filed its Electrical Distribution Terms and Conditions to the Maine Public Utilities Commission to become a regulated municipal electric utility. The PUC approved our Terms and Conditions on July 21, 2021.

In 2021 MRRA became a Designated Operator of a Public Drinking Water System by the Department of Health and Human Service's Office of Drinking Water Division. On August 30, 2023, the Maine Public Utilities Commission initiated, pursuant to 35-A M.R.S. § 1303(2), a formal investigation into MRRA's water service operations at Brunswick Landing (Docket No. 2023-00209). This proceeding follows a summary investigation initiated in Docket No. 2023-00125,2 the scope of which was to determine whether there were grounds for further investigation into MRRA's water operations, particularly whether MRRA was operating its water system as a "public utility," as that term is defined under 35-A M.R.S. § 102(22). A final decision of the Commission had not been issued by December 31, 2023.

This year also marked MRRA's fourteenth year of operating a regional general aviation airport, which is becoming a great asset for the Midcoast region, with over 24,000 takeoffs and landings in 2023. Over a period of twelve years, MRRA received more than $33.4 million in grants from the Federal Aviation and MaineDOT to convert a military airfield into one of the state's largest general aviation

airports. Beginning in 2020, the airport was transferred into the FAA's competitive Discretionary Grant Program. This year the FAA approved the following grants:

FAA MAP 046 Pavement Markings	$230,200
FAA MAP 047 Snow Removal Equipment	$695,600
FAA MAP 048 Customs Feasibility Study (CDS)	$71,200
	$997,000

E. A listing of any property acquired by eminent domain under Sec. 13083-N

No property was acquired by MRRA through its powers of eminent domain.

F. A listing of any bonds issued during the fiscal year under Sec. 13083-I

MRRA did not issue any bonds during 2023. However, in 2020 entered into three debt instruments. MRRA was approached by two tenants requesting larger rental space; Starc Systems and Vivid Cloud Development Services (formerly Here Engineering). Starc Systems was interested in moving into the southern bay of Hangar 5, leasing approximately 50,000 square feet. MRRA and Starc came to an agreement that MRRA would borrow funds to provide tenant designed build to suit renovations of hangar 5. MRRA borrowed $350,000 on a five-year note from Mechanics Savings Bank at a rate of 4.72%. A loan agreement was signed in January of 2020 with an amortization schedule that began on April 16, 2020.

MRRA worked again with Mechanic Savings Bank to assist Vivid Cloud Development Services to expand its operations in Hangar 6 to a larger office area on the first floor. MRRA signed a ten-year Promissory Note on June 3, 2020, for $325,000 at an interest rate of 3.99%.

Both lease agreements state that if the tenant leaves, the tenant will be responsible for the balance of the principal due on the loan that MRRA signed.

On October 30, 2023, the MRRA Board of Trustees authorized the acceptance of the $831,368 of grant funding from Efficiency Maine Trust to purchase and install four direct current electric vehicle fast chargers at Brunswick Landing and authorize the leveraging of a loan up to $207,842 from Maine Community Bank to provide the local match for this project. MRRA had not closed on loan documents before December 31, 2023. The debt service would be retired through fees collected through credit card purchases at the point of sale.

On June 18, 2020, Brunswick Landing MHC USA, LLC, a partnership which is owned 99% by the Midcoast Regional Redevelopment Authority closed on the refinancing of debt with Bangor Savings Bank on the 79,600 square foot build to suit medical devise manufacturing facility for Molnlycke Healthcare USA with Norway Savings Bank following a request for bids from six Maine banks. Brunswick Landing MHC borrowed $7,714,311.17 on a note that will mature on March 18, 2033.

G. *A statement of the Authority's proposed and projected activities for the ensuing year*

Please find attached a copy of MRRA's current Business Plan. A new business plan for 2024 will be presented to the Board of Trustees at its February 28, 2024 meeting.

H. *Recommendations regarding further actions that may be suitable for achieving the purposes of this article.*

I would also like to express our concern and seek your support regarding a recent change in the revenue-sharing arrangement under the Job Tax Increment Financing program contained withing 5 MRSA 13083-S.1. Historically, MRRA has received 25% of income taxes paid by employees of businesses located at Brunswick Landing. This arrangement has been a crucial source of revenue for our organization, enabling us to carry out important community and economic development initiatives in the region. However, we were recently informed that the State of Maine has decided not to share this revenue with us for employees working from home for the businesses established at Brunswick Landing, resulting in a significant 66% reduction in our anticipated income.

We understand the need for fiscal responsibility and recognize that the state's priorities may shift over time. However, we believe it is essential to consider the broader economic impact of such decisions, especially in the context of the evolving nature of work, which increasingly involves remote and flexible arrangements.

The employees working from home continue to contribute to the economic vitality of Brunswick Landing, and their efforts have a positive impact on the community as a whole. These individuals are still an integral part of the Maine workforce, and we believe it is fair and equitable for the revenue-sharing agreement to encompass all employees, regardless of their physical work location.

We kindly request that the State of Maine reconsider its decision and reinstate the revenue-sharing arrangement for all employees, including those working from home. This adjustment is crucial for maintaining the financial stability of MRRA and ensuring that we can continue to support the economic growth and development of the Midcoast region.

One of the other areas that I intend on continuing to pursue is the development of a life science incubator center at Brunswick Landing and a partnership with the State of Maine will be critical to this effort. Life sciences are among the fastest-growing industries in Maine and play an increasingly important role in Maine's economy. This diverse industry contributes over 7,400 jobs to the state's economy, demands an average annual salary of $95,000, is responsible for over $1.5 billion to the state's GRP, and represents 5% of Maine's total exports. Over the last 5 years, life science job growth has shown a 14% increase, significantly outpacing the 4% job growth of all other industries in Maine combined and the data indicates these trends will continue in the years to come.

To assist in the growth of the life science industry, Maine needs to be able to support early stage and growth companies that are innovating in this sector. Companies focused on R&D and manufacturing need access to affordable lab space, equipment, funding, mentors, education, networking, and essential resources to allow them to commercialize life science discoveries.

Maine is geographically situated to be a prime location for life sciences, marine and ocean science research and development, and where the marine economy is ripe for expansion. Maine has an impressive concentration of world-class scientists producing cutting-edge bioscience discoveries at globally recognized research facilities including Jackson Laboratory, Mount Desert Island Biological Laboratory (MDIBL), Gulf of Maine Research Institute, Bigelow Laboratory for Ocean Sciences, Maine Health, the University of Maine, and the University of New England. With these companies as drivers, Maine is well positioned for continued growth and success in the life science sector.

The State of Maine will benefit from having a life science incubator center that can provide support and resources to bioscience companies looking to locate and grow in Maine. MRRA is in a unique position to help new biotech companies to the state.

The Master Reuse Plan for the Brunswick Landing calls for the development of centers of excellence for technology innovation, a live, work, play and educate environment, and to support smart growth principles. The Master Reuse Plan also identified the six predominant economic clusters (aviation, information technology, composite manufacturing, green and renewable technology, biotechnology and education) in the Midcoast which represented 45% of the total Midcoast economy. These clusters were shown to have higher location quotients than the state. Science, technology, and higher education was among the six economic clusters and a life science incubator aligns with MRRA's plan to work to support the growth of the science and technology sector.

Over the past year, MRRA has worked in concert with Maine Center for Entrepreneurs, Maine Bioscience Cluster Initiative, The Roux Institute, Maine DECD, Maine Technology Institute, SMRT, Consigli Construction, as well as several of our current bioscience and technology related tenants at TechPlace to begin to assemble a plan to design, fund, construct and operate a life science incubator center at Brunswick Landing. \ We look forward to working with the State of Maine as a critical partner in moving this project forward.

I. A description of the MRRA's progress toward achieving the goals set forth in Section 13083-G:

1. **Short-term goal.** Recover civilian job losses in the primary impact community resulting from the base closure; ***(Accomplished in 2015)***

2. **Intermediate goal.** Recover economic losses and total job losses in the primary impact community resulting from the base closure (estimated by the State Planning Office at $140 million);

   We have just started to review data this coming year and will evaluate how to best measure this metric against the State's impact analysis.

3. **Long-term goal.** Facilitate the maximum redevelopment of base properties (Reuse Master Plan estimated full build out potential of nearly 12,000 jobs).

Naval Air Station Brunswick employed 714 civilians at its Brunswick and Topsham sites at the time of the base closure announcement. After just 139 months from the official date of closing the base in May of 2011, there are over 2,405 individuals working at Brunswick Landing. The key to the success of the redevelopment effort is due, in large part, to the collaborative partnerships engaged in the effort, including, but certainly not limited to, you and the State of Maine, the Towns of Brunswick and

Topsham, multiple federal agencies, the U.S. Navy, the businesses and real estate community who have invested into the project, and many others.

Thank you for your continued interest and support of this important economic development project for the State of Maine, which has become a critical asset to growing our economy. I look forward to collaborating with you and your administration.

Sincerely,

Kristine M. Logan
Executive Director

cc. Heather Johnson, Commissioner, MaineDECD
Susan Gresser, Executive Director, Legislative Council
Joint Standing Committee on Labor, Commerce, Research and Economic Development
Brunswick Legislative Delegation
Brunswick Town Council
Topsham Board of Selectman
Julie Henze, Acting Brunswick Town Manager
Derek Scrapchansky, Topsham Town Manager
MRRA Board of Trustees
Jeffrey K. Jordan, Deputy Director, CFO, MRRA
Jamie Logan, *TechPlace* Director
Jake Levesque, Innovation and Development Director, MRRA