

**Maine Revised Statute Title 22, Chapter 1683: MAINE HEALTH DATA
ORGANIZATION**

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Subtitle 6. FACILITIES FOR CHILDREN AND ADULTS

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22 §8701. DECLARATION OF PURPOSE

It is the intent of the Legislature that uniform systems of reporting health care information be established; that all providers and payors who are required to file reports do so in a manner consistent with these systems; and that, using the least restrictive means practicable for the protection of privileged health care information, public access to those reports be ensured. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF).

22 §8702. DEFINITIONS

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

1. Board. "Board" means the Board of Directors of the Maine Health Data Organization established pursuant to section 8703.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

1-A. Carrier. "Carrier" means an insurance company licensed in accordance with Title 24-A, including a health maintenance organization, a multiple employer welfare arrangement licensed pursuant to Title 24-A, chapter 81, a preferred provider organization, a fraternal benefit society or a nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24. An employer exempted from the applicability of Title 24-A, chapter 56-A under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.

[2001, c. 457, §1 (NEW) .]

2. Clinical data. "Clinical data" includes but is not limited to the data required to be submitted by providers and payors pursuant to sections 8708 and 8711.

[2007, c. 136, §1 (AMD) .]

3. Financial data. "Financial data" includes but is not limited to financial information required to be submitted pursuant to section 8709.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

4. Health care facility. "Health care facility" means a public or private, proprietary or not-for-profit entity or institution providing health services, including, but not limited to, a radiological facility licensed under chapter 160, a health care facility licensed under chapter 405, an independent radiological service center, a federally qualified health center certified by the United States Department of Health and Human Services, Health Resources and Services Administration, a rural health clinic or rehabilitation agency certified or otherwise approved by the Division of Licensing and Regulatory Services within the Department of Health and Human Services, a home health care provider licensed under chapter 419, an assisted living program or a residential care facility licensed under chapter 1663, a hospice provider licensed under chapter 1681, a state institution as defined under Title 34-B, chapter 1 and a mental health facility licensed under Title 34-B, chapter 1. For the purposes of this chapter, "health care facility" does not include retail pharmacies.

[2011, c. 233, §1 (AMD) .]

4-A. Health care practitioner. "Health care practitioner" has the meaning provided in Title 24, section

2502, subsection 1-A.

[2003, c. 469, Pt. C, §18 (NEW) .]

5. Managed care organization. "Managed care organization" means an organization that manages and controls medical services, including but not limited to a health maintenance organization, a preferred provider organization, a competitive medical plan, a managed indemnity insurance program and a nonprofit hospital and medical service organization, licensed in the State.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

5-A. Medicare health plan sponsor. "Medicare health plan sponsor" means a health insurance carrier or other private company authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services to administer Medicare Part C and Part D benefits under a health plan or prescription drug plan.

[2009, c. 71, §4 (AMD) .]

5-B. Nonlicensed carrier. "Nonlicensed carrier" means a health insurance carrier that is not required to obtain a license in accordance with Title 24-A and pays health care claims on behalf of residents of this State.

[2007, c. 136, §1 (NEW) .]

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

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

7. Outpatient services. "Outpatient services" means all therapeutic or diagnostic health care services rendered to a person who has not been admitted to a hospital as an inpatient.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

8. Payor. "Payor" means a 3rd-party payor, 3rd-party administrator, Medicare health plan sponsor, pharmacy benefits manager or nonlicensed carrier.

[2009, c. 71, §5 (AMD) .]

8-A. Plan sponsor. "Plan sponsor" means any person, other than an insurer, who establishes or maintains a plan covering residents of this State, including, but not limited to, plans established or maintained by 2 or more employers or jointly by one or more employers and one or more employee organizations or the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the plan.

[2001, c. 457, §3 (NEW) .]

8-B. Pharmacy benefits manager. "Pharmacy benefits manager" has the same meaning as in Title 24-A, section 1913, subsection 1, paragraph A.

[2011, c. 443, §3 (AMD) .]

9. Provider. "Provider" means a health care facility, health care practitioner, health product manufacturer or health product vendor but does not include a retail pharmacy.

[2011, c. 233, §2 (AMD) .]

9-A. Quality data. "Quality data" means information on health care quality required to be submitted

pursuant to section 8708-A.

[2003, c. 469, Pt. C, §20 (NEW) .]

10. Restructuring data. "Restructuring data" means reports, charts and information required to be submitted pursuant to section 8710.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

10-A. Third-party administrator. "Third-party administrator" means any person who, on behalf of a plan sponsor, health care service plan, nonprofit hospital or medical service organization, health maintenance organization or insurer, receives or collects charges, contributions or premiums for, or adjusts or settles claims on, residents of this State.

[2001, c. 457, §3 (NEW) .]

11. Third-party payor. "Third-party payor" means a health insurer, carrier, including a carrier that provides only administrative services for plan sponsors, nonprofit hospital, medical services organization or managed care organization licensed in the State. "Third-party payor" does not include carriers licensed to issue limited benefit health policies or accident, specified disease, vision, disability, long-term care or nursing home care policies.

[2007, c. 695, Pt. A, §27 (RPR) .]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF). 1997, c. 525, §1 (AMD). 1999, c. 353, §1 (AMD). 2001, c. 457, §§1-3 (AMD). 2001, c. 596, §B21 (AMD). 2001, c. 596, §B25 (AFF). 2001, c. 677, §2 (AMD). 2003, c. 469, §§C17-21 (AMD). 2003, c. 689, §B6 (REV). RR 2005, c. 2, §18 (COR). 2005, c. 253, §2 (AMD). 2007, c. 136, §1 (AMD). 2007, c. 240, Pt. VV, §2 (AMD). 2007, c. 466, Pt. B, §18 (AMD). 2007, c. 695, Pt. A, §§26, 27 (AMD). 2009, c. 71, §§4, 5 (AMD). 2011, c. 233, §§1, 2 (AMD). 2011, c. 443, §3 (AMD).

22 §8703. MAINE HEALTH DATA ORGANIZATION ESTABLISHED

The Maine Health Data Organization is established as an independent executive agency. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

1. Objective. The purposes of the organization are to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens and to issue reports, as provided in section 8712. This database must be publicly accessible while protecting patient confidentiality and respecting providers of care. The organization shall collect, process, analyze and report clinical, financial, quality and restructuring data as defined in this chapter.

[2003, c. 469, Pt. C, §22 (AMD) .]

2. Board of directors. The organization operates under the supervision of a board of directors, which consists of 20 voting members and one nonvoting member.

A. The Governor shall appoint 18 board members in accordance with the following requirements. Appointments by the Governor are not subject to review or confirmation.

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

(2) Three members must represent employers. One member must be chosen from a list provided by a

health management coalition in this State. One member must be chosen from a list provided by a statewide chamber of commerce.

(3) Two members must represent 3rd-party payors chosen from a list provided by a statewide organization representing 3rd-party payors.

(4) Nine members must represent providers. Two provider members must represent hospitals chosen from a list provided by the Maine Hospital Association. Two provider members must be physicians or representatives of physicians, one chosen from a list provided by the Maine Medical Association and one chosen from a list provided by the Maine Osteopathic Association. One provider member must be a doctor of chiropractic chosen from a list provided by a statewide chiropractic association. One provider member must be a representative, chosen from a list provided by the Maine Primary Care Association, of a federally qualified health center. One provider member must be a pharmacist chosen from a list provided by the Maine Pharmacy Association. One provider member must be a mental health provider chosen from a list provided by the Maine Association of Mental Health Services. One provider member must represent a home health care company. [2007, c. 136, §2 (AMD).]

B. The commissioner shall appoint one member who is an employee of the department to represent the State's interest in maintaining health data and to ensure that information collected is available for determining public health policy. [2009, c. 71, §6 (AMD).]

C. [1999, c. 353, §4 (RP).]

D. The Executive Director of Dirigo Health, or a designee of the executive director who is an employee of Dirigo Health, shall serve as a voting member. [2009, c. 71, §6 (NEW).]

E. The Commissioner of Professional and Financial Regulation, or the commissioner's designee who is an employee of the Department of Professional and Financial Regulation, shall serve in a nonvoting, consultative capacity. [2009, c. 71, §6 (NEW).]

[2009, c. 71, §6 (AMD).]

3. Terms of office. The terms of office of board members are determined under this subsection.

A. The terms of board members appointed by the Governor are determined as follows.

(1) Initial terms are staggered. One consumer, one employer, one 3rd-party payor and 3 providers shall serve one-year terms. Two consumers, one employer, one 3rd-party payor and 3 providers shall serve 2-year terms.

(2) After the initial terms, members appointed by the Governor shall serve full 3-year terms and shall continue to serve until their successors have been appointed.

(3) Board members may serve 3 full terms consecutively. [2005, c. 253, §4 (AMD).]

B. State agency board members may serve an unlimited number of terms. [2009, c. 71, §7 (AMD).]

[2009, c. 71, §7 (AMD).]

4. Meetings; officers. Board members shall elect a chair and a vice-chair from among the membership to serve 2-year terms. All meetings of the board are public proceedings within the meaning of the Freedom of Access Law, Title 1, chapter 13, subchapter I.

[1999, c. 353, §5 (AMD).]

5. Legal counsel. The Attorney General, when requested, shall furnish any legal assistance, counsel or advice the organization requires in the discharge of its duties.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

6. Compensation. Board members are entitled to reimbursement for necessary expenses according to the

provisions of Title 5, chapter 379.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF). 1997, c. 53, §1 (AMD). 1997, c. 568, §1 (AMD). 1999, c. 353, §§2-5 (AMD). 2001, c. 457, §§4-6 (AMD). 2003, c. 264, §1 (AMD). 2003, c. 469, §C22 (AMD). 2005, c. 253, §§3,4 (AMD). 2007, c. 136, §2 (AMD). 2009, c. 71, §§6, 7 (AMD).

22 §8704. POWERS AND DUTIES OF THE BOARD

The board has the following powers and duties. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

1. Uniform reporting systems. The board shall establish uniform reporting systems.

A. The board shall develop and implement policies and procedures for the collection, processing, storage and analysis of clinical, financial, quality and restructuring data in accordance with this subsection for the following purposes:

- (1) To use, build and improve upon and coordinate existing data sources and measurement efforts through the integration of data systems and standardization of concepts;
- (2) To coordinate the development of a linked public and private sector information system;
- (3) To emphasize data that is useful, relevant and not duplicative of existing data;
- (4) To minimize the burden on those providing data; and
- (5) To preserve the reliability, accuracy and integrity of collected data while ensuring that the data is available in the public domain. [2003, c. 469, Pt. C, §23 (AMD).]

B. Information and data required to be filed pursuant to this chapter must be filed annually or more frequently as specified by the organization. The organization shall establish a schedule for compliance with the required uniform reporting systems. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

C. The organization may modify the uniform reporting systems for clinical, financial, quality and restructuring data to allow for differences in the scope or type of services and in financial structure among health care facilities, providers or payors subject to this chapter. [2003, c. 469, Pt. C, §24 (AMD).]

D. The board may provide analysis of data upon request. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

E. The board shall exempt from reporting by a provider data regarding a person who informs the provider of the person's objection, or the objection of a parent of a minor, to inclusion in data collection based on a sincerely held religious belief. [1999, c. 353, §7 (NEW).]

[2003, c. 469, Pt. C, §§23, 24 (AMD) .]

2. Contracts for data collection; processing. The board may contract with one or more qualified, nongovernmental, independent 3rd parties for services necessary to carry out the data collection, processing and storage activities required under this chapter. For purposes of this subsection, a group or organization affiliated with the University of Maine System is not considered a governmental entity. Unless permission is specifically granted by the board, a 3rd party hired by the organization may not release, publish or otherwise use any information to which the 3rd party has access under its contract and shall otherwise comply with the requirements of this chapter.

[2001, c. 457, §8 (AMD) .]

3. Contracts generally. The board may enter into all other contracts necessary or proper to carry out the powers and duties of this chapter, including contracts allowing organization staff to provide technical assistance to other public or private entities, with the proceeds used to offset the operational costs of the organization.

[2007, c. 136, §3 (AMD) .]

4. Rulemaking. The board shall adopt rules necessary for the proper administration and enforcement of the requirements of this chapter. All rules must be adopted in accordance with Title 5, chapter 375 and unless otherwise provided are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2011, c. 494, §7 (AMD) .]

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

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

6. Staff. The board shall appoint staff as needed to carry out the duties and responsibilities of the board under this chapter. The appointment and compensation of the staff are subject to Civil Service Law.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

7. Annual report. The board shall prepare and submit an annual report on the operation of the organization and the Maine Health Data Processing Center as authorized in Title 10, section 681, including any activity contracted for by the organization or contracted services provided by the center, with resulting net earnings, to the Governor and the joint standing committee of the Legislature having jurisdiction over health and human services matters no later than February 1st of each year. The report must include an annual accounting of all revenue received and expenditures incurred in the previous year and all revenue and expenditures planned for the next year. The report must include a list of persons or entities that requested data from the organization in the preceding year with a brief summary of the stated purpose of the request.

[2011, c. 494, §8 (AMD) .]

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

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

9. Cooperation; advice. The board may cooperate with and advise the department and any other person or entity on behavioral risk factor surveys, work site health and safety, and health work force research.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

10. Quality improvement foundations.

[2003, c. 469, Pt. C, §26 (RP) .]

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

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF). 1997, c. 525, §2 (AMD). 1999, c. 127, §B8 (AMD). 1999, c. 353, §§6-8 (AMD). 2001, c. 457, §§7-10

(AMD). 2003, c. 469, §§C23-26 (AMD). 2005, c. 253, §5 (AMD). 2005, c. 565, §5 (AMD). 2007, c. 136, §3 (AMD). 2007, c. 460, §§2, 3 (AMD). 2011, c. 494, §§7, 8 (AMD).

22 §8705. ENFORCEMENT

(REPEALED)

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF). 1999, c. 353, §9 (AMD). 2001, c. 457, §§11,12 (AMD). 2003, c. 452, §§K28,29 (AMD). 2003, c. 452, §X2 (AFF). 2003, c. 659, §1 (RP).

22 §8705-A. ENFORCEMENT

The board shall adopt rules to ensure that payors and providers file data as required by section 8704, subsection 1; that users that obtain health data and information from the organization safeguard the identification of patients and health care practitioners as required by section 8707, subsections 1 and 3; and that payors and providers pay all assessments as required by section 8706, subsection 2. [2003, c. 659, §2 (NEW).]

1. Definitions. As used in this section, unless the context otherwise indicates, the following definitions of "intentionally" and "knowingly" apply to this section.

A. A person acts intentionally with respect to a result of that person's conduct when it is that person's conscious object to produce such a result. [2003, c. 659, §2 (NEW).]

B. A person acts knowingly with respect to a result of that person's conduct when the person is aware that it is practically certain that that person's conduct will cause such a result. [2003, c. 659, §2 (NEW).]

[2003, c. 659, §2 (NEW).]

2. Rulemaking. The board shall adopt rules to implement this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A. The rules may contain procedures for monitoring compliance with this chapter. Rules adopted pursuant to this subsection must include a schedule of fines for:

A. Failure to file data; [2003, c. 659, §2 (NEW).]

B. Failure to pay assessments; and [2003, c. 659, §2 (NEW).]

C. Intentionally or knowingly and without authorization using or disseminating health care information that directly or indirectly identifies patients or health care practitioners performing abortions as defined in section 1596. [2003, c. 659, §2 (NEW).]

[2003, c. 659, §2 (NEW).]

3. Fines. The following provisions apply to enforcement actions under this section except for circumstances beyond a person's or entity's control.

A. When a person or entity that is a health care facility or payor violates the requirements of this chapter, except for section 8707, that person or entity commits a civil violation for which a fine of not more than \$1,000 per day may be adjudged. A fine imposed under this paragraph may not exceed \$25,000 for any one occurrence. [2007, c. 136, §4 (AMD).]

B. A person or entity that receives data or information under the terms and conditions of section 8707 and intentionally or knowingly uses, sells or transfers the data in violation of the board's rules for commercial

advantage, pecuniary gain, personal gain or malicious harm commits a civil violation for which a fine not to exceed \$500,000 may be adjudged. [2005, c. 565, §6 (AMD).]

C. A person or entity not covered by paragraph A or B that violates the requirements of this chapter, except for section 8707, commits a civil violation for which a fine of not more than \$100 per day may be adjudged. A fine imposed under this paragraph may not exceed \$2,500 for any one occurrence. [2003, c. 659, §2 (NEW).]

[2007, c. 136, §4 (AMD).]

4. Enforcement action. Upon a finding that a person or entity has failed to comply with the requirements of this chapter, including the payment of a fine determined under this section, the board may undertake any or all of the following.

A. The board may refer the matter to the department or board that issued a license to the provider for such action as the department or board considers appropriate. [2003, c. 659, §2 (NEW).]

B. The board may refer the matter to the Department of Professional and Financial Regulation, Bureau of Insurance for such action against the payor as the bureau considers appropriate. [2003, c. 659, §2 (NEW).]

C. The board may file a complaint with the Superior Court in the county in which the person resides or the entity is located or in Kennebec County seeking an order to require that person or entity to comply with the requirements of this chapter, seeking enforcement of a fine determined under this section or seeking other relief from the court. [2003, c. 659, §2 (NEW).]

[2003, c. 659, §2 (NEW).]

5. Injunctive relief. In the event of any violation of this chapter or any rule adopted pursuant to this chapter, the Attorney General may seek to enjoin a further violation and seek any other appropriate remedy provided by this chapter.

[2003, c. 659, §2 (NEW).]

6. Exception.

[2009, c. 613, §7 (NEW); T. 22, §8705-A, sub-§6 (RP).]

SECTION HISTORY

2003, c. 659, §2 (NEW). 2005, c. 565, §6 (AMD). 2007, c. 136, §4 (AMD). 2009, c. 613, §7 (AMD). MRSA T. 22, §8705-A, sub-§6 (AMD).

22 §8706. REVENUES AND EXPENDITURES

1. Transition funding.

[1999, c. 353, §10 (RP).]

2. Permanent funding. Permanent funding for the organization is provided from reasonable costs, user fees and assessments according to this subsection and as provided by rules adopted by the board.

A. Fees may be charged for the reasonable costs of duplicating, mailing, publishing and supplies. [1997, c. 525, §3 (RPR).]

B. Reasonable user fees must be charged on a sliding scale for the right to access and use the health data and information available from the organization. Fees may be charged for services provided to the department on a contractual basis. Fees may be reduced or waived for users that demonstrate a plan to use the data or information in research of general value to the public health or inability to pay the scheduled

fees, as provided by rules adopted by the board. [2005 , c . 253 , §6 (AMD) .]

C. The operations of the organization must be supported from 3 sources as provided in this paragraph:

(1) Fees collected pursuant to paragraphs A and B;

(2) Annual assessments of not less than \$100 assessed against the following entities licensed under Titles 24 and 24-A: nonprofit hospital and medical service organizations, health insurance carriers and health maintenance organizations on the basis of the total annual health care premium; and 3rd-party administrators, carriers that provide only administrative services for a plan sponsor and pharmacy benefits managers that process and pay claims on the basis of claims processed or paid for each plan sponsor. The assessments are to be determined on an annual basis by the board. Health care policies issued for specified disease, accident, injury, hospital indemnity, disability, long-term care or other limited benefit health insurance policies are not subject to assessment under this subparagraph. For purposes of this subparagraph, policies issued for dental services are not considered to be limited benefit health insurance policies. The total dollar amount of assessments under this subparagraph must equal the assessments under subparagraph (3); and

(3) Annual assessments of not less than \$100 assessed by the organization against providers. The assessments are to be determined on an annual basis by the board. The total dollar amount of assessments under this subparagraph must equal the assessments under subparagraph (2).

The aggregate level of annual assessments under subparagraphs (2) and (3) must be an amount sufficient to meet the organization's expenditures authorized in the state budget established under Title 5, chapter 149. The annual assessment may not exceed \$1,346,904 in fiscal year 2002-03. In subsequent fiscal years, the annual assessment may increase above \$1,346,904 by an amount not to exceed 5% per fiscal year. The board may waive assessments otherwise due under subparagraphs (2) and (3) when a waiver is determined to be in the interests of the organization and the parties to be assessed. [2007 , c . 136 , §5 (AMD) .]

[2007 , c . 136 , §5 (AMD) .]

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

[1995 , c . 653 , Pt. A , §2 (NEW); 1995 , c . 653 , Pt. A , §7 (AFF) .]

4. Budget. The expenditures of the organization are subject to legislative approval in the biennial budget process.

[1995 , c . 653 , Pt. A , §2 (NEW); 1995 , c . 653 , Pt. A , §7 (AFF) .]

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

[1995 , c . 653 , Pt. A , §2 (NEW); 1995 , c . 653 , Pt. A , §7 (AFF) .]

6. Deposit with Treasurer of State. The organization shall deposit all payments made pursuant to this section with the Treasurer of State into a dedicated account. The deposits must be used for the sole purpose of paying the expenses of the organization.

[1995 , c . 653 , Pt. A , §2 (NEW); 1995 , c . 653 , Pt. A , §7 (AFF) .]

SECTION HISTORY

1995 , c . 653 , §A2 (NEW). 1995 , c . 653 , §A7 (AFF). 1997 , c . 525 , §3 (AMD). 1999 , c . 353 , §§10,11 (AMD). 2001 , c . 457 , §13 (AMD). 2005 , c . 253 , §6 (AMD). 2005 , c . 565 , §7 (AMD). 2007 , c . 136 , §5 (AMD).

22 §8707. PUBLIC ACCESS TO DATA

The board shall adopt rules to provide for public access to data and to implement the requirements of this section. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

1. Public access; confidentiality. The board shall adopt rules making available to any person, upon request, information, except privileged medical information and confidential information, provided to the organization under this chapter as long as individual patients are not directly or indirectly identified through a reidentification process. The board shall adopt rules to protect the identity of certain health care practitioners, as it determines appropriate, except that the identity of practitioners performing abortions as defined in section 1596 must be designated as confidential and must be protected. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter II-A.

[2001, c. 457, §14 (AMD) .]

2. Notice and comment period. The rules must establish criteria for determining whether information is confidential clinical data, confidential financial data or privileged medical information and adopt procedures to give affected health care providers and payors notice and opportunity to comment in response to requests for information that may be considered confidential or privileged.

[2003, c. 469, Pt. C, §27 (AMD) .]

3. Public health studies. The rules may allow exceptions to the confidentiality requirements only to the extent authorized in this subsection.

A. The board may approve access to identifying information for patients to the department and other researchers with established protocols that have been approved by the board for safeguarding confidential or privileged information. [2001, c. 457, §15 (AMD).]

B. The rules must ensure that:

- (1) Identifying information is used only to gain access to medical records and other medical information pertaining to public health;
- (2) Medical information about any patient identified by name is not obtained without the consent of that patient except when the information sought pertains only to verification or comparison of health data and the board finds that confidentiality can be adequately protected without patient consent;
- (3) Those persons conducting the research or investigation do not disclose medical information about any patient identified by name to any other person without that patient's consent;
- (4) Those persons gaining access to medical information about an identified patient use that information to the minimum extent necessary to accomplish the purposes of the research for which approval was granted; and
- (5) The protocol for any research is designed to preserve the confidentiality of all health care information that can be associated with identified patients, to specify the manner in which contact is made with patients and to maintain public confidence in the protection of confidential information. [2001, c. 457, §15 (AMD).]

C. The board may not grant approval under this subsection if the board finds that the proposed identification of or contact with patients would violate any state or federal law or diminish the confidentiality of health care information or the public's confidence in the protection of that information in a manner that outweighs the expected benefit to the public of the proposed investigation. [2001, c. 457, §15 (AMD).]

[2001, c. 457, §15 (AMD) .]

4. Certain confidential information. The board may determine financial data submitted to the organization under section 8709 to be confidential information if the public disclosure of the data will directly

result in the provider of the data being placed in a competitive economic disadvantage. This section may not be construed to relieve the provider of the data of the requirement to disclose such information to the organization in accordance with this chapter and rules adopted by the board.

[2011, c. 524, §4 (AMD) .]

5. Rules for release, publication and use of data. The rules must govern the release, publication and use of analyses, reports or compilations derived from the health data made available by the organization.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF). 1999, c. 353, §§12,13 (AMD). 2001, c. 457, §§14,15 (AMD). 2003, c. 469, §C27 (AMD). 2007, c. 466, Pt. A, §44 (AMD). 2011, c. 524, §4 (AMD).

22 §8708. CLINICAL DATA

Clinical data must be filed, stored and managed as follows. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

1. Information required. Pursuant to rules adopted by the board for form, medium, content and time for filing, each health care facility shall file with the organization the following information:

A. [1999, c. 353, §14 (RP).]

B. A completed uniform hospital discharge data set, or comparable information, for each patient discharged from the facility after June 30, 1983 and for each hospital outpatient service occurring after June 30, 1996; and [1999, c. 353, §14 (AMD).]

C. In addition to any other requirements applicable to specific categories of health care facilities, the organization may require the filing of data as set forth in this chapter or in rules adopted pursuant to this chapter. [1999, c. 353, §14 (AMD).]

[1999, c. 353, §14 (AMD) .]

2. Additional information on ambulatory services and surgery. Pursuant to rules adopted by the board for form, medium, content and time for filing, each provider shall file with the organization a completed data set, comparable to data filed by health care facilities under subsection 1, paragraph B. This subsection may not be construed to require duplication of information required to be filed under subsection 1.

[2001, c. 457, §16 (AMD) .]

3. More than one licensed health care facility or location. When more than one licensed health care facility is operated by the reporting organization, the information required by this chapter must be reported for each health care facility separately. When a provider of health care operates in more than one location, the organization may require that information be reported separately for each location.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

4. Data lists.

[2001, c. 457, §17 (RP) .]

5. Medical record abstract data. In addition to the information required to be filed under subsections 1 and 2 and pursuant to rules adopted by the organization for form, medium, content and time of filing, each health care facility shall file with the organization such medical record abstract data as the organization may

require.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

6. Merged data. The board may require the discharge data submitted pursuant to subsection 1 and any medical record abstract data required pursuant to subsection 5 to be merged with associated billing data.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

6-A. Additional data. Subject to the limitations of section 8704, subsection 1, the board may adopt rules requiring the filing of additional clinical data from other providers and payors as long as the submission of data to the organization is consistent with federal law. Data filed by payors must be provided in a format that does not directly identify the patient.

[2007, c. 136, §6 (AMD) .]

7. Authority to obtain information. Nothing in this section may be construed to limit the board's authority to obtain information that it considers necessary to carry out its duties.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF). 1997, c. 525, §4 (AMD). 1999, c. 353, §14 (AMD). 2001, c. 457, §§16-18 (AMD). 2007, c. 136, §6 (AMD).

22 §8708-A. QUALITY DATA

The board shall adopt rules regarding the collection of quality data. The board shall work with the Maine Quality Forum and the Maine Quality Forum Advisory Council established in Title 24-A, chapter 87, subchapter 2 to develop the rules. The rules must be based on the quality measures adopted by the Maine Quality Forum pursuant to Title 24-A, section 6951, subsection 2. The rules must specify the content, form, medium and frequency of quality data to be submitted to the organization. In the collection of quality data, the organization must minimize duplication of effort, minimize the burden on those required to provide data and focus on data that may be retrieved in electronic format from within a health care practitioner's office or health care facility. As specified by the rules, health care practitioners and health care facilities shall submit quality data to the organization. Rules adopted pursuant to this section are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A. [2003, c. 469, Pt. C, §28 (NEW).]

SECTION HISTORY

2003, c. 469, §C28 (NEW).

22 §8709. FINANCIAL DATA; SCOPE OF SERVICE DATA

Financial data and scope of service data must be filed, stored and managed as follows. [1999, c. 353, §15 (AMD).]

1. Financial data. Each health care facility shall file with the organization, in a form specified by rule pursuant to section 8704, financial information including costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges and units of services, except to the extent that the board specifies by rule that portions of this information are unnecessary.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

1-A. Hospitals; standardized accounting template. When filing the financial information required under subsection 1, a hospital also shall file information using the standardized accounting template published

in the report of the Commission to Study Maine's Community Hospitals in February 2005. The hospital shall file this information using an electronic version of the template provided to the hospital by the organization. If in succeeding years the template needs to be modified, the board shall adopt rules specifying the filing requirements. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[2005, c. 394, §2 (NEW) .]

2. Certification required. The board may require certification of such financial reports and attestation from responsible officials of the health care facility that such reports have to the best of their knowledge and belief been prepared in accordance with the requirements of the board.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

3. Scope of service data. Each health care facility shall file with the organization scope of service information, including bed capacity by service provided, special services, ancillary services, physician profiles in the aggregate by clinical specialties, nursing services and such other scope of service information as the organization determines necessary for the performance of its duties.

[1999, c. 353, §15 (NEW) .]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF). 1999, c. 353, §15 (AMD). 2005, c. 394, §2 (AMD).

22 §8710. RESTRUCTURING DATA

Restructuring data must be filed, stored and managed as follows. [1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF).]

1. Major structural changes. The board may require providers and payors to report the occurrence of major structural changes relevant to the restructuring of the delivery and financing of health care in the State and to the potential effects of that restructuring upon consumers.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

2. Rulemaking. The board shall adopt rules to define the specific structural changes to be reported, consistent with subsection 1. The required report must be limited to the filing of a concise narrative description of those occurrences that are clearly defined by the rule as requiring a report, accompanied by a chart depicting the relationship among organizations affected by the structural change. The rule must allow a single report to be filed by all providers and payors participating in or affected by a structural change for which a report is required.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

3. Additional information. In addition to the reports required under subsections 1 and 2, the organization may collect, store and analyze additional information from published sources and information that a provider or payor has prepared voluntarily for nonconfidential distribution to persons other than employees, officers and the governing body of the provider or payor.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

4. Construction. Nothing in this section may be construed to require providers or payors to notify the organization prior to taking action to evaluate restructuring or to require providers or payors to generate, compile, analyze or submit information in addition to the concise narrative descriptions and chart required in subsection 2.

[1995, c. 653, Pt. A, §2 (NEW); 1995, c. 653, Pt. A, §7 (AFF) .]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF).

22 §8711. OTHER HEALTH CARE INFORMATION

1. Development of health care information systems. In addition to its authority to obtain information to carry out the specific provisions of this chapter, the organization may require providers and payors to furnish information with respect to the nature and quantity of services or coverage provided to the extent necessary to develop proposals for the modification, refinement or expansion of the systems of information disclosure established under this chapter. The organization's authority under this subsection includes the design and implementation of pilot information reporting systems affecting selected categories or representative samples of providers and payors.

[2007, c. 136, §7 (AMD) .]

2. Information on mandated services.

[2005, c. 253, §7 (RP) .]

SECTION HISTORY

1995, c. 653, §A2 (NEW). 1995, c. 653, §A7 (AFF). 1999, c. 353, §16 (AMD). 2001, c. 457, §19 (AMD). 2005, c. 253, §7 (AMD). 2007, c. 136, §7 (AMD).

22 §8712. REPORTS

The organization shall produce clearly labeled and easy-to-understand reports as follows. Unless otherwise specified, the organization shall distribute the reports on a publicly accessible site on the Internet or via mail or e-mail, through the creation of a list of interested parties. The organization shall make reports available to members of the public upon request. [2009, c. 613, §8 (AMD) .]

1. Quality. The organization shall promote public transparency of the quality and cost of health care in the State in conjunction with the Maine Quality Forum established in Title 24-A, section 6951 and shall collect, synthesize and publish information and reports on an annual basis that are easily understandable by the average consumer and in a format that allows the user to compare the information listed in this section to the extent practicable. The organization's publicly accessible websites and reports must, to the extent practicable, coordinate, link and compare information regarding health care services, their outcomes, the effectiveness of those services, the quality of those services by health care facility and by individual practitioner and the location of those services. The organization's health care costs website must provide a link in a publicly accessible format to provider-specific information regarding quality of services required to be reported to the Maine Quality Forum.

[2009, c. 2, §63 (COR) .]

2. Payments. The organization shall create a publicly accessible interactive website that presents reports related to payments for services rendered by health care facilities and practitioners to residents of the State. The services presented must include, but not be limited to, imaging, preventative health, radiology and surgical services and other services that are predominantly elective and may be provided to a large number of patients who do not have health insurance or are underinsured. The website must also be constructed to display prices paid by individual commercial health insurance companies, 3rd-party administrators and, unless prohibited by federal law, governmental payors. Beginning October 1, 2012, price information posted on the website must be posted semiannually, must display the date of posting and, when posted, must be current to within 12 months of the date of submission of the information.

[PL 2009, c. 613, § 8 (RP).]

A. [2009, c. 613, §8 (RP).]

[2011, c. 525, §1 (AMD) .]

3. Comparison report. At a minimum, the organization shall develop and produce an annual report that compares the 15 most common diagnosis-related groups and the 15 most common outpatient procedures for all hospitals in the State and the 15 most common procedures for nonhospital health care facilities in the State to similar data for medical care rendered in other states, when such data are available.

[2003, c. 469, Pt. C, §29 (NEW) .]

4. Physician services. The organization shall provide an annual report of the 10 services and procedures most often provided by osteopathic and allopathic physicians in the private office setting in this State. The organization shall distribute this report to all physician practices in the State. The first report must be produced by July 1, 2004.

[2003, c. 469, Pt. C, §29 (NEW) .]

SECTION HISTORY

2003, c. 469, §C29 (NEW). 2005, c. 391, §2 (AMD). RR 2009, c. 2, §63 (COR).
2009, c. 71, §8 (AMD). 2009, c. 350, Pt. A, §1 (AMD). 2009, c. 613, §8 (AMD).
2011, c. 525, §1 (AMD).

22 §8713. CONFIDENTIALITY PROTECTION FOR CERTAIN HEALTH CARE PRACTITIONERS

(REPEALED)

SECTION HISTORY

2007, c. 460, §4 (NEW). 2011, c. 494, §9 (RP).

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