LAWS

OF THE

STATE OF MAINE

AS PASSED BY THE

ONE HUNDRED AND TWENTIETH LEGISLATURE

FIRST REGULAR SESSION
December 6, 2000 to June 22, 2001

THE GENERAL EFFECTIVE DATE FOR
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PUBLISHED BY THE REVISOR OF STATUTES
IN ACCORDANCE WITH MAINE REVISED STATUTES ANNOTATED,
TITLE 3, SECTION 163-A, SUBSECTION 4.

J.S. McCarthy Company
Augusta, Maine
2001

2. Dissolution of center. Upon dissolution of the center, the board of directors shall, after paying or making provision for the payment of all liabilities of the center, cause all of the remaining assets of the center to be transferred to the Maine Health Data Organization and the Maine Health Information Center in shares proportionate to the total revenue transferred to the center by each entity.

§690. Liberal construction

This chapter must be liberally construed and broadly interpreted to effect the interest and purposes of the center for an improved health care data collection and processing effort in the State.

§691. Repeal

This chapter is repealed September 1, 2005.

Sec. 2. Allocation. The following funds are allocated from Other Special Revenue funds to carry out the purposes of this Act.

	2001-02	2002-03
MAINE HEALTH DATA ORGANIZATION		
Maine Health Data Organization		
Positions - Legislative Count	(3.000)	(3.000)
Personal Services	$175,796	$181,109
All Other	138,823	286,000
Allocates funds for 2 Programmer Analyst positions and one Planning and Research Associate II position and related operating costs to increase access to and improve the utility of health care information and to provide funds for the establishment of the Maine Health Data Processing Center.		
MAINE HEALTH DATA ORGANIZATION TOTAL	$314,619	$467,109

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

Effective June 28, 2001.

CHAPTER 457

S.P. 395 - L.D. 1310

An Act to Amend the Maine Health Data Organization Laws

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

Whereas, the Maine Health Data Organization will be required to proceed with rulemaking in order to achieve the purposes of this Act, and action to begin the rulemaking is required promptly; and

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

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

Sec. 1. 22 MRSA §8702, sub-§1-A is enacted to read:

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.

Sec. 2. 22 MRSA §8702, sub-§2, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

2. Clinical data. "Clinical data" includes but is not limited to the data required to be submitted by providers, payors, 3rd-party administrators and carriers that provide only administrative services for a plan sponsor pursuant to sections 8708 and 8711.

Sec. 3. 22 MRSA §8702, sub-§§8-A and 10-A are enacted to read:

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.

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.

Sec. 4. 22 MRSA §8703, sub-§1, as amended by PL 1999, c. 353, §2, is further amended to read:

1. Objective. The purpose of the organization is to ~~improve the health of Maine citizens through the creation and maintenance of~~ create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens. This database must be publicly accessible while protecting patient confidentiality and respecting providers of care. The organization shall collect, process and analyze clinical and financial data as defined in this chapter.

Sec. 5. 22 MRSA §8703, sub-§2, as amended by PL 1999, c. 353, §§3 and 4, is further amended to read:

2. Board of directors. The organization operates under the supervision of a board of directors, which consists of ~~18~~ 20 voting members.

A. The Governor shall appoint ~~16~~ 18 board members in accordance with the following requirements. Appointments by the Governor are not subject to review or confirmation.

(1) ~~Three~~ 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.

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

(4) ~~Eight~~ Nine members must represent providers. Two provider members must represent hospitals chosen from a list of at least 5 current hospital representatives provided by the Maine Hospital Association. Two provider members must be physicians or representatives of physicians chosen from a list of at least 5 nominees provided jointly by the Maine Medical Association and the Maine Osteopathic Association. One provider member must be a chiropractor 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 Ambulatory Care Coalition, of a federally qualified health center. One provider member must be a pharmacist chosen from a list provided by the Maine Pharmacy Association. Two provider members must be representatives of other health care providers, at least one of whom is a current representative of a home health care company.

B. The commissioner shall appoint 2 members who are employees 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.

Sec. 6. 22 MRSA §8703, sub-§3, ¶B, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

B. The terms of departmental board members are 2-year terms. Departmental board members may serve ~~3 full terms consecutively~~ an unlimited number of terms.

Sec. 7. 22 MRSA §8704, sub-§1, ¶A, as amended by PL 1999, c. 353, §6, is further amended to read:

A. The board shall develop and implement data collection policies and procedures for the collection, processing, storage and analysis of clinical, financial 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 is not duplicative of existing data;

(4) To minimize the burden on those providing data;

(5) To preserve the reliability, accuracy and integrity of collected data while ensuring that the data is available in the public domain; and

(6) To collect information from providers who were required to file data with the Maine Health Care Finance Commission. The organization may collect information from additional providers ~~and payors~~ only when a linked information system for the electronic transmission, collection and storage of data is reasonably available to providers.

Sec. 8. 22 MRSA §8704, sub-§2, as amended by PL 1999, c. 353, §8, is further amended to read:

2. Contracts for data collection; processing. The board ~~shall~~ 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. ~~If an appropriate contract can not be entered into or is terminated, data collection, processing and storage activities required under this chapter may be performed by the organization for a period of up to 12 months.~~

Sec. 9. 22 MRSA §8704, sub-§7, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

7. Annual report. The board shall prepare and submit an annual report on the operation of the organization, including any activity contracted for by the organization, and on health care trends 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.

Sec. 10. 22 MRSA §8704, sub-§10, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

10. Quality improvement foundations. In order to conduct quality improvement research, including, but not limited to, monitoring of health care utilization, analyses of population-based care, analyses of cost effectiveness and patient-oriented outcomes of care, continuous quality improvement initiatives and the development and implementation of practice guidelines, the board may designate ~~a~~ quality improvement ~~foundation~~ foundations if the board finds the following:

A. That the ~~foundation conducts~~ foundations conduct reliable and accurate research consistent with standards of health services and clinical effectiveness research; and

B. That the ~~foundation has~~ foundations have acceptable, established protocols to safeguard confidential and privileged information.

Sec. 11. 22 MRSA §8705, sub-§1, as amended by PL 1999, c. 353, §9, is further amended to read:

1. Rulemaking. The board shall adopt rules setting a schedule of forfeitures for failure to file data as required and failure to pay assessments, and willful or negligent failure to safeguard the identity of patients~~,~~ or providers~~, health care facilities or 3rd-party payors~~. The rules may contain procedures for monitoring compliance with this chapter.

Sec. 12. 22 MRSA §8705, sub-§2, as amended by PL 1999, c. 353, §9, is further amended to read:

2. Forfeitures. Except for circumstances beyond a person's or entity's control, a person or entity that violates the requirements of this chapter commits a civil violation for which a forfeiture may be adjudged not to exceed $1000 per day for a health care facility, payor, 3rd-party administrator or carrier that provides only administrative services for a plan sponsor or $100 per day for all other persons, entities and providers. A forfeiture imposed under this subsection may not exceed $25,000 for a health care facility, payor, 3rd-party administrator or carrier that provides only administrative services for a plan sponsor for any one occurrence or $2,500 for any other person or entity for any one occurrence.

Sec. 13. 22 MRSA §8706, sub-§2, ¶C, as amended by PL 1999, c. 353, §11, is further amended to read:

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 ~~on the basis of the total annual health care premium~~: 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 and carriers that provide only administrative services for a plan sponsor on the basis of ~~administration of health benefits plans administered for employers~~ 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, ~~Medicare supplement,~~ disability, long-term care or other limited benefit health insurance policies are not subject to assessment under this subparagraph. 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 ~~$760,000 in fiscal year 1999-00~~ $1,346,904 in fiscal year 2002-03. In subsequent fiscal years, the annual assessment may increase above ~~$760,000~~ $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.

Sec. 14. 22 MRSA §8707, sub-§1, as amended by PL 1999, c. 353, §12, is further amended to read:

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 ~~or health care practitioners~~ are not directly or indirectly identified through a reidentification process. ~~The board shall adopt rules governing public access in the least restrictive means possible to information that may indirectly identify a particular patient or health care practitioner.~~ 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.

Sec. 15. 22 MRSA §8707, sub-§3, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

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 ~~or health care practitioners~~ to the department and other researchers with established protocols that have been approved by the board for safeguarding confidential or privileged information.

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 ~~or health care practitioners~~ and to

maintain public confidence in the protection of confidential information.

C. The board may not grant approval under this subsection if the board finds that the proposed identification of or contact with patients ~~or health care practitioners~~ 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.

Sec. 16. 22 MRSA §8708, sub-§2, as amended by PL 1999, c. 353, §14, is further amended to read:

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~~, for each ambulatory service and surgery listed in rules adopted pursuant to subsection 4, occurring after January 1, 1990~~. This subsection may not be construed to require duplication of information required to be filed under subsection 1.

Sec. 17. 22 MRSA §8708, sub-§4, as amended by PL 1999, c. 353, §14, is repealed.

Sec. 18. 22 MRSA §8708, sub-§6-A, as enacted by PL 1999, c. 353, §14, is amended to read:

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, 3rd-party administrators and carriers that provide only administrative services for a plan sponsor. Data filed by payors, 3rd-party administrators or carriers that provide administrative services only for a plan sponsor must be provided in a format that does not directly identify the patient.

Sec. 19. 22 MRSA §8711, sub-§1, as enacted by PL 1995, c. 653, Pt. A, §2 and affected by §7, is amended to read:

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, 3rd-party administrators and carriers that provide only administrative services for a plan sponsor 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 ~~payors and~~ providers, payors, 3rd-party administrators and carriers that provide only administrative services for a plan sponsor.

Sec. 20. 24-A MRSA §1906, sub-§4, as enacted by PL 1989, c. 846, Pt. D, §2 and affected by Pt. E, §4, is amended to read:

4. The administrator shall file with the superintendent the names and addresses of the insurers, health care service plans, health maintenance organizations and plan sponsors with whom the administrator has entered into written agreements. If an insurer, health care service plan, health maintenance organization or plan sponsor does not assume or bear the risk, the administrator must disclose the name and address of the ultimate risk bearer. In addition, at the time of a license renewal, the administrator shall also file with the superintendent for the most recent complete calendar year for all covered individuals in the State the total number of claims paid by the administrator by each plan sponsor and the total dollar amount of claims paid by each plan sponsor. This subsection applies to the initial application for an administrator's license and any renewal of a license.

Sec. 21. 24-A MRSA §2215, sub-§1, ¶¶O and P, as enacted by PL 1997, c. 677, §3 and affected by §5, are amended to read:

O. To a lienholder, mortgagee, assignee, lessor or other person shown on the records of a carrier or producer as having a legal or beneficial interest in a policy of insurance, only if:

(1) No health care information is disclosed unless the disclosure would otherwise be permitted by this section; and

(2) The information disclosed is limited to that which is reasonably necessary to permit that person to protect its interests in the policy; ~~or~~

P. To an affiliate whose only use of the information will be in connection with an audit of the regulated insurance entity or the marketing of a product or service of the affiliate, if the information disclosed for marketing purposes does not include health care information and if the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons~~.~~; or

Sec. 22. 24-A MRSA §2215, sub-§1, ¶Q is enacted to read:

Q. In order to protect the public health and welfare, to state governmental entities only insofar as necessary to enable those entities to perform their duties when reporting is required or authorized by law.

Sec. 23. 24-A MRSA §4302, sub-§4 is enacted to read:

4. Claims data. By February 1st of each year, a carrier that provides only administrative services for a plan sponsor shall annually file with the superintendent for the most recent complete calendar year for all covered individuals in the State the total number of claims paid for each plan sponsor and the total dollar amount of claims paid for each plan sponsor.

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

Effective June 28, 2001.

CHAPTER 458

S.P. 331 - L.D. 1099

An Act Regarding the Care and Treatment of Persons with Mental Illness Who Are Incarcerated

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

Whereas, persons with mental illness who are incarcerated in the county jails and state prisons need proper care and treatment that is safe and humane; and

Whereas, corrections officers and others in the jails and prisons who are responsible for persons with mental illness who are in their custody require proper training to care for these inmates; and

Whereas, the current corrections system does not provide adequate care for incarcerated persons with mental illness, nor does it provide those responsible for the care with the tools and training necessary to provide care; and

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

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

Sec. 1. 17-A MRSA §1258, as enacted by PL 1983, c. 673, §6, is amended to read:

§1258. Notification of commitments to the Department of Corrections

At the time of sentencing, the sheriff shall notify the Commissioner of Corrections or the commissioner's designee that a person has been committed to the Department of Corrections and shall inquire as to the correctional facility to which the sentenced person ~~shall~~ must be delivered by the sheriff or ~~his~~ the sheriff's deputies. The commissioner ~~shall have~~ or the commissioner's designee has complete discretion to determine the initial place of confinement. In making this determination, the commissioner or the commissioner's designee shall review all relevant information, including any available mental health information. The commissioner or the commissioner's designee shall immediately inform the sheriff and the court of the location of the correctional facility to which the sentenced person ~~shall~~ must be transported.

Sec. 2. 30-A MRSA §1656, sub-§5 is enacted to read:

5. Review of information prior to transfer. If a prisoner is transferred to the Department of Corrections, the Commissioner of Corrections or the commissioner's designee shall review all relevant information, including any available mental health information, prior to determining the prisoner's initial place of confinement.

Sec. 3. 34-A MRSA §1214 is enacted to read:

§1214. Accreditation

All adult correctional facilities and juvenile facilities operated by the department must be accredited by a nationally recognized correctional accrediting body by January 1, 2005 and must maintain accreditation thereafter.

Sec. 4. 34-A MRSA §3031, sub-§2, as amended by PL 1999, c. 583, §8, is further amended by amending the first paragraph to read:

2. Medical care. Adequate professional medical care and adequate professional mental health care, which ~~does~~ do not include medical treatment or mental health treatment requested by the client that the facility's treating physician or treating psychiatrist or psychologist determines unnecessary. The commissioner may establish medical and dental fees not to exceed $5 for the medical and dental services that are provided pursuant to this subsection and a fee not to exceed $5 for prescriptions, medication or prosthetic devices. Except as provided in paragraph A, every client may be charged a medical or dental services fee for each medical or dental visit, prescription, medica-