CHAPTER 401

GENERAL PROVISIONS

§1701. Program of health services

The department, through its Bureau of Health, is authorized to administer a program to extend and improve its services for promoting the general public health.

The department is authorized to:

1. Apply for federal aid. Apply for federal aid under the Public Health Service Act (Public Law No. 410, 78th Congress Second Session as heretofore or hereafter amended);

2. Cooperate with Federal Government. Cooperate with the Federal Government through the United States Public Health Service in matters of mutual concern pertaining to general public health, including such methods of administration as are found to be necessary for the efficient operation of the plan for the aid; and
[PL 1981, c. 470, Pt. A, §70 (AMD).]

3. Reports. Make such reports in such form and containing such information as the Surgeon General of the United States Public Health Service may require, and comply with such provisions as said Surgeon General may find necessary to assure the correctness and verification of such reports.

The Treasurer of State shall be the appropriate fiscal officer of the State to receive federal grants on account of general public health services as contemplated by Public Health Service Act, as heretofore or hereafter amended, and the State Controller shall authorize expenditures therefrom as approved by the department.

SECTION HISTORY

PL 1981, c. 470, §A70 (AMD).

§1702. Hospital surveys

(REPEALED)

SECTION HISTORY

PL 1965, c. 231, §1 (RP).

§1703. Acceptance of federal and other funds

The department shall have authority to accept any federal law now in effect or hereafter enacted which makes federal funds available for public health services of all kinds and to meet such federal requirements with respect to the administration of such funds as are required as conditions precedent to receiving federal funds. The department, subject to the approval of the Governor, shall have authority to accept funds from other sources for the same purposes. [PL 1975, c. 771, §215 (AMD).]

SECTION HISTORY

PL 1965, c. 231, §2 (AMD). PL 1975, c. 771, §215 (AMD).

§1704. Advisory Hospital Council

(REPEALED)

SECTION HISTORY

PL 1965, c. 231, §1 (RP).

§1705. Individuals may select own physician

This Title may not be construed to empower or authorize the department or its representative to interfere in any manner with the right of an individual to select the physician or mode of treatment of the individual's choice, as long as sanitary laws, rules and regulations are complied with. [RR 2021, c. 2, Pt. B, §105 (COR).]

SECTION HISTORY

RR 2021, c. 2, Pt. B, §105 (COR).

§1706. Distribution of antitoxins in emergency

The department, with the approval of the Governor, may, for the purpose of aiding in national defense in case of war or in any state emergency declared by the Governor under Title 37-B, section 742, procure and distribute inside the State and sell or give away, in its discretion, antitoxins, serums, vaccines, viruses and analogous products applicable to the prevention or cure of disease. [PL 2013, c. 462, §2 (AMD).]

SECTION HISTORY

PL 1975, c. 771, §216 (AMD). PL 2013, c. 462, §2 (AMD).

§1707. Responsible relatives; duty of hospitals

(REPEALED)

SECTION HISTORY

PL 1973, c. 163 (RP).

§1708. Appropriations for aid of public and private hospitals and nursing homes

1. Compensation for hospitals. Such sums of money as may be appropriated by the Legislature in aid of public and private hospitals shall be expended under the direction of the department, and the expense of administration shall be charged to the appropriation of that department for general administration. The department is authorized to compensate hospitals located in the State of New Hampshire within 15 miles from the Maine - New Hampshire state line or hospitals located in the Provinces of Quebec or New Brunswick, Canada, within 5 miles of the international boundary, for cases where the hospital care is for persons resident in the State of Maine and, in the judgment of the commissioner, adequate local hospital facilities are not available. The department may compensate hospitals at such rates as it may establish for hospital care of persons whose resources or the resources of whose responsible relatives are insufficient therefor, except as provided in subsection 2. Bills itemizing the expenses of such hospital care, when approved by the department and audited by the State Controller, shall be paid by the Treasurer of State.
[PL 1975, c. 365, §1 (RPR).]

2. Compensation for nursing homes.
[PL 1991, c. 528, Pt. E, §17 (RP); PL 1991, c. 528, Pt. E, §18 (AFF); PL 1991, c. 528, Pt. RRR (AFF); PL 1991, c. 591, Pt. E, §17 (RP); PL 1991, c. 591, Pt. E, §18 (AFF).]

2-A. Base-year revisions.
[PL 1991, c. 528, Pt. E, §19 (RP); PL 1991, c. 528, Pt. E, §20 (AFF); PL 1991, c. 528, Pt. RRR (AFF); PL 1991, c. 591, Pt. E, §19 (RP); PL 1991, c. 591, Pt. E, §20 (AFF).]

3. Compensation for nursing homes. A nursing home, as defined under section 1812-A, or any portion of a hospital or institution operated as a nursing home, when the State is liable for payment for care, must be reimbursed at a rate established by the Department of Health and Human Services pursuant to this subsection. The department may not establish a so-called "flat rate." This subsection applies to all funds, including federal funds, paid by any agency of the State to a nursing home for patient care. The department shall establish rules concerning reimbursement that:

A. Take into account the costs of providing care and services in conformity with applicable state and federal laws, rules, regulations and quality and safety standards; [PL 1991, c. 528, Pt. E, §21 (NEW); PL 1991, c. 528, Pt. E, §22 (AFF); PL 1991, c. 528, Pt. RRR (AFF); PL 1991, c. 591, Pt. E, §21 (NEW); PL 1991, c. 591, Pt. E, §22 (AFF).]

A-1. [PL 2001, c. 666, Pt. A, §1 (RP); PL 2001, c. 666, Pt. E, §1 (AFF).]

B. Are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities; [PL 1995, c. 696, Pt. A, §32 (AMD).]

C. Are consistent with federal requirements relative to limits on reimbursement under the federal Social Security Act, Title XIX; [PL 2001, c. 666, Pt. A, §1 (AMD); PL 2001, c. 666, Pt. E, §1 (AFF).]

D. Ensure that any calculation of an occupancy percentage or other basis for adjusting the rate of reimbursement for nursing facility services to reduce the amount paid in response to a decrease in the number of residents in the facility or the percentage of the facility's occupied beds excludes all beds that the facility has removed from service for all or part of the relevant fiscal period in accordance with section 333. If the excluded beds are converted to residential care beds or another program for which the department provides reimbursement, nothing in this paragraph precludes the department from including those beds for purposes of any occupancy standard applicable to the residential care or other program pursuant to duly adopted rules of the department; [PL 2013, c. 594, §1 (AMD).]

E. Contain an annual inflation adjustment that:

(1) Recognizes regional variations in labor costs and the rates of increase in labor costs determined pursuant to the principles of reimbursement and establishes at least 4 regions for purposes of annual inflation adjustments; and

(2) Uses the applicable regional inflation factor as established by a national economic research organization selected by the department to adjust costs other than labor costs or fixed costs; and [PL 2013, c. 594, §1 (AMD).]

F. Establish a nursing facility's base year every 2 years and increase the rate of reimbursement beginning July 1, 2014 and every year thereafter until June 30, 2018. For the state fiscal year beginning July 1, 2018, the base year for each facility is its fiscal year that ended in the calendar year 2016. For state fiscal years beginning on or after July 1, 2019, subsequent rebasing must be based on the most recent cost report filings available. The department may provide a mechanism for subsequent adjustments to base year costs to reflect any material difference between as-filed cost reports used in rebasing and subsequent determinations of audited, allowable costs for the same fiscal period. The department's rules must provide that, beginning in the state fiscal year beginning July 1, 2018, the rates set for each rebasing year must include an inflation adjustment for a cost-of-living percentage change in nursing facility reimbursement each year in accordance with the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index nursing homes and adult day care services index.

Any rebasing done pursuant to this paragraph may not result in a nursing facility receiving a reimbursement rate that is lower than the rate in effect on June 30, 2018. [PL 2021, c. 29, Pt. R, §1 (AMD).]

Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 29, Pt. R, §1 (AMD).]

4. Medicaid savings.
[PL 2011, c. 655, Pt. T, §1 (RP).]

SECTION HISTORY

PL 1975, c. 293, §4 (AMD). PL 1975, c. 365, §1 (RPR). PL 1989, c. 567 (AMD). PL 1989, c. 886, §1 (AMD). PL 1991, c. 528, §§E17,19,21 (AMD). PL 1991, c. 528, §§E18,20,22, RRR (AFF). PL 1991, c. 591, §§E17,19,21 (AMD). PL 1991, c. 591, §§E18,20,22 (AFF). PL 1991, c. 622, §M8 (AMD). PL 1991, c. 622, §M9 (AFF). PL 1993, c. 410, §YY1 (AMD). PL 1995, c. 696, §§A32,33 (AMD). RR 2001, c. 2, §A33 (COR). PL 2001, c. 666, §A1 (AMD). PL 2001, c. 666, §E1 (AFF). PL 2003, c. 689, §B6 (REV). PL 2011, c. 655, Pt. T, §1 (AMD). PL 2013, c. 594, §1 (AMD). PL 2017, c. 460, Pt. B, §1 (AMD). PL 2021, c. 29, Pt. R, §1 (AMD).

§1709. State-wide plan; advisory council; duties

(REPEALED)

SECTION HISTORY

PL 1965, c. 231, §3 (NEW). PL 2003, c. 469, §B4 (RP).

§1710. Deferred revenue payments

The Department of Health and Human Services may make a payment to each general hospital in the State which is certified for participation in the Medical Assistance Program under Title 19 of the Social Security Act, not to exceed the average amount paid to that hospital by the department during a 30-day period in the next preceding fiscal year. Such payment shall constitute a deferred revenue obligation for the hospital. Any unliquidated balance of such obligation shall be repaid to the department upon demand. [PL 1973, c. 175 (NEW); PL 1975, c. 293, §4 (AMD); PL 2003, c. 689, Pt. B, §6 (REV).]

SECTION HISTORY

PL 1973, c. 175 (NEW). PL 1975, c. 293, §4 (AMD). PL 2003, c. 689, §B6 (REV).

§1711. Patient access to hospital medical records

If a patient of an institution licensed as a hospital by the State, after discharge from such institution, makes written request for copies of the patient's medical records, the copies must, if available, be made available to the patient in accordance with the requirements of 45 Code of Federal Regulations, Section 164.524 (2019) or for a hospital not subject to the requirements of 45 Code of Federal Regulations, Section 164.524 (2019) within a reasonable time unless, in the opinion of the hospital, it would be detrimental to the health of the patient to obtain the records. If the hospital is of the opinion that release of the records to the patient would be detrimental to the health of the patient, the hospital shall advise the patient that copies of the records will be made available to the patient's authorized representative upon presentation of a proper authorization signed by the patient. The hospital may exclude from the copies of medical records released any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. [PL 2019, c. 503, Pt. F, §1 (AMD).]

If an authorized representative for a patient requests, in writing, that a hospital provide the authorized representative with a copy of the patient's medical records and presents a proper authorization from the patient for the release of the information, copies must be provided to the authorized representative in accordance with the requirements of 45 Code of Federal Regulations, Section 164.524 (2019) or for a hospital not subject to the requirements of 45 Code of Federal Regulations, Section 164.524 (2019) within a reasonable time. [PL 2019, c. 503, Pt. F, §1 (AMD).]

A written request or authorization for release of medical records under this section satisfies the requirements of section 1711-C, subsection 3. [PL 1997, c. 793, Pt. A, §1 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a

hospital health care information that corrects or clarifies the patient's treatment record, which must be retained with the medical record by the hospital. If the hospital adds to the medical record a statement in response to the submitted correction or clarification, the hospital shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem. [PL 1999, c. 512, Pt. A, §1 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

Reasonable costs incurred by the hospital in making and providing paper copies of medical records and additions to medical records may be assessed as charges to the requesting person and the hospital may require payment prior to responding to the request. The charge for paper copies of records may not exceed $5 for the first page and 45¢ for each additional page, up to a maximum of $250 for the entire medical record. [PL 2013, c. 158, §1 (AMD).]

If a medical record exists in a digital or electronic format, the hospital shall provide an electronic copy of the medical record if an electronic copy is requested and it is reasonably possible to provide it. The hospital may assess as charges reasonable actual costs of staff time to create or copy the medical record and the costs of necessary supplies and postage. Actual costs may not include a retrieval fee or the costs of new technology, maintenance of the electronic record system, data access or storage infrastructure. Charges assessed under this paragraph may not exceed $150. [PL 2013, c. 158, §2 (NEW).]

Release of a patient's medical records to a person other than the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem is governed by section 1711-C. [PL 1999, c. 512, Pt. A, §2 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

SECTION HISTORY

PL 1977, c. 122 (NEW). PL 1997, c. 793, Pt. A, §1 (AMD). PL 1997, c. 793, Pt. A, §10 (AFF). PL 1999, c. 3, §§3, 5 (AFF). PL 1999, c. 512, Pt. A, §§1, 2 (AMD). PL 1999, c. 512, Pt. A, §6 (AFF). PL 1999, c. 790, Pt. A, §§58, 60 (AFF). PL 2003, c. 418, §1 (AMD). PL 2013, c. 32, §1 (AMD). PL 2013, c. 158, §§1, 2 (AMD). PL 2019, c. 503, Pt. F, §1 (AMD).

§1711-A. Fees charged for records

Whenever a health care practitioner defined in section 1711-B furnishes in paper form requested copies of a patient's treatment record or a medical report or an addition to a treatment record or medical report to the patient or the patient's authorized representative, the charge for the copies or the report may not exceed the reasonable costs incurred by the health care practitioner in making and providing the copies or the report. The charge for the copies or the report may not exceed $5 for the first page and 45¢ for each additional page, up to a maximum of $250 for the entire treatment record or medical report. [PL 2013, c. 158, §3 (AMD).]

If a treatment record or medical report exists in a digital or electronic format, the health care practitioner shall provide an electronic copy of the treatment record or medical report if an electronic copy is requested and it is reasonably possible to provide it. The health care practitioner may assess as charges reasonable actual costs of staff time to create or copy the treatment record or medical report and the costs of necessary supplies and postage. Actual costs may not include a retrieval fee or the costs of new technology, maintenance of the electronic record system, data access or storage infrastructure. Charges assessed under this paragraph may not exceed $150. [PL 2013, c. 158, §3 (NEW).]

SECTION HISTORY

PL 1989, c. 666 (NEW). PL 1991, c. 142, §1 (AMD). PL 1997, c. 793, §A2 (AMD). PL 1997, c. 793, §A10 (AFF). PL 1999, c. 3, §§3,5 (AFF). PL 1999, c. 512, §A6 (AFF). PL 2003, c. 418, §2 (AMD). PL 2013, c. 32, §2 (AMD). PL 2013, c. 158, §3 (AMD).

§1711-B. Patient access to treatment records; health care practitioners

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

A. "Health care practitioner" has the same meaning as in section 1711-C, subsection 1, paragraph F. [PL 1997, c. 793, Pt. A, §3 (AMD); PL 1997, c. 793, Pt. A, §10 (AFF).]

B. "Treatment records" means all records relating to a patient's diagnosis, treatment and care, including x rays, performed by a health care practitioner. [PL 1997, c. 793, Pt. A, §3 (AMD); PL 1997, c. 793, Pt. A, §10 (AFF).]

[PL 1997, c. 793, Pt. A, §3 (AMD); PL 1997, c. 793, Pt. A, §10 (AFF); PL 1999, c. 512, Pt. A, §6 (AFF).]

2. Access. Upon written authorization executed in accordance with section 1711-C, subsection 3, a health care practitioner shall release copies of all treatment records of a patient or a narrative containing all relevant information in the treatment records to the patient. The health care practitioner may exclude from the copies of treatment records released any personal notes that are not directly related to the patient's past or future treatment and any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. The copies or narrative must be released to the designated person in accordance with the requirements of 45 Code of Federal Regulations, Section 164.524 (2019) or for a health care practitioner not subject to the requirements of 45 Code of Federal Regulations, Section 164.524 (2019) within a reasonable time.

If the practitioner believes that release of the records to the patient is detrimental to the health of the patient, the practitioner shall advise the patient that copies of the treatment records or a narrative containing all relevant information in the treatment records will be made available to the patient's authorized representative upon presentation of a written authorization signed by the patient. The copies or narrative must be released to the authorized representative in accordance with the requirements of 45 Code of Federal Regulations, Section 164.524 (2019) or for a health care practitioner not subject to the requirements of 45 Code of Federal Regulations, Section 164.524 (2019) within a reasonable time.

Except as provided in subsection 3, release of a patient's treatment records to a person other than the patient is governed by section 1711-C.

[PL 2019, c. 503, Pt. F, §2 (AMD).]

3. Person receiving the records. Except as otherwise provided in this section, the copies or narrative specified in subsection 2 must be released to:

A. The person who is the subject of the treatment record, if that person is 18 years of age or older and mentally competent; [PL 1991, c. 142, §2 (NEW).]

B. The parent, guardian ad litem or legal guardian of the person who is the subject of the record if the person is a minor, or the legal guardian if the person who is the subject of the record is mentally incompetent; [PL 1997, c. 793, Pt. A, §5 (AMD); PL 1997, c. 793, Pt. A, §10 (AFF).]

C. The designee of a durable health care power of attorney executed by the person who is the subject of the record, at such time as the power of attorney is in effect; [PL 2015, c. 370, §1 (AMD).]

D. The agent, guardian or surrogate pursuant to the Uniform Health Care Decisions Act; or [PL 2017, c. 402, Pt. C, §43 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

E. The lay caregiver designated pursuant to section 1711-G by the person who is the subject of the record. [PL 2015, c. 370, §3 (NEW).]

[PL 2017, c. 402, Pt. C, §43 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

3-A. Corrections and clarifications of treatment records. A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's

parent, legal guardian or guardian ad litem may submit to a health care practitioner health care information that corrects or clarifies the patient's treatment record, which must be retained with the treatment record by the health care practitioner. If the health care practitioner adds to the treatment record a statement in response to the submitted correction or clarification, the health care practitioner shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem.
[PL 1999, c. 512, Pt. A, §3 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

4. Minors. This section does not affect the right of minors to have their treatment records treated confidentially pursuant to the provisions of, chapter 260.
[PL 1995, c. 694, Pt. D, §28 (AMD); PL 1995, c. 694, Pt. E, §2 (AFF).]

5. HIV test. Release of information regarding the HIV infection status of a patient is governed by Title 5, section 19203-D.
[PL 1999, c. 512, Pt. A, §4 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

6. Hospital records. Release of treatment records in a hospital is governed by the provisions of section 1711.
[RR 1993, c. 2, §11 (COR).]

7. Retention of records. This section does not alter the existing law or ethical obligations of a health care practitioner with respect to retaining treatment records.
[PL 1991, c. 142, §2 (NEW).]

8. Violation. A person who willfully violates this section commits a civil violation for which a forfeiture of not more than $25 may be adjudged. Each day that the treatment records or narrative is not released after the reasonable time specified in subsection 2 constitutes a separate violation, up to a maximum forfeiture of $100.
[PL 1991, c. 142, §2 (NEW).]

SECTION HISTORY

PL 1991, c. 142, §2 (NEW). RR 1993, c. 2, §11 (COR). PL 1995, c. 694, Pt. D, §28 (AMD). PL 1995, c. 694, Pt. E, §2 (AFF). PL 1997, c. 793, Pt. A, §§3-7 (AMD). PL 1997, c. 793, Pt. A, §10 (AFF). PL 1997, c. 793, Pt. B, §5 (AMD). PL 1997, c. 793, Pt. B, §6 (AFF). PL 1999, c. 3, §§3-5 (AFF). PL 1999, c. 512, Pt. A, §§3, 4 (AMD). PL 1999, c. 512, Pt. A, §6 (AFF). PL 1999, c. 512, Pt. B, §5 (AFF). PL 1999, c. 790, Pt. A, §§58, 60 (AFF). PL 2015, c. 370, §§1-3 (AMD). PL 2017, c. 402, Pt. C, §43 (AMD). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2019, c. 503, Pt. F, §2 (AMD). PL 2019, c. 417, Pt. B, §14 (AFF).

§1711-C. Confidentiality of health care information

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

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

A. "Authorized representative of an individual" or "authorized representative" means an individual's legal guardian; agent pursuant to Title 18-C, section 5-803; agent pursuant to Title 18-C, Article 5, Part 9; or other authorized representative or, after death, that person's personal representative or a person identified in subsection 3-B. For a minor who has not consented to health care treatment in accordance with the provisions of state law, "authorized representative" means the minor's parent, legal guardian or guardian ad litem. [PL 2017, c. 402, Pt. C, §44 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

A-1. "Authorization to disclose" means authorization to disclose health care information in accordance with subsection 3, 3-A or 3-B. [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF).]

A-2. "Aiding and assisting legally protected health care activity" has the same meaning as in Title 14, section 9002, subsection 1. [PL 2023, c. 648, Pt. F, §1 (NEW).]

B. "Disclosure" means the release, transfer of or provision of access to health care information in any manner obtained as a result of a professional health care relationship between the individual and the health care practitioner or facility to a person or entity other than the individual. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B-1. "Gender-affirming health care services" has the same meaning as in Title 14, section 9002, subsection 4. [PL 2023, c. 648, Pt. F, §2 (NEW).]

C. "Health care" means preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, treatment, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that affects an individual's physical, mental or behavioral condition, including individual cells or their components or genetic information, or the structure or function of the human body or any part of the human body. Health care includes prescribing, dispensing or furnishing to an individual drugs, biologicals, medical devices or health care equipment and supplies; providing hospice services to an individual; and the banking of blood, sperm, organs or any other tissue. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. "Health care facility" or "facility" means a facility, institution or entity licensed pursuant to this Title that offers health care to persons in this State, including a home health care provider, hospice program and a pharmacy licensed pursuant to Title 32. For the purposes of this section, "health care facility" does not include a state mental health institute, the Elizabeth Levinson Center, the Aroostook Residential Center or Freeport Towne Square. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

E. "Health care information" means information that directly identifies the individual and that relates to an individual's physical, mental or behavioral condition, personal or family medical history or medical treatment or the health care provided to that individual. "Health care information" does not include information that protects the anonymity of the individual by means of encryption or encoding of individual identifiers or information pertaining to or derived from federally sponsored, authorized or regulated research governed by 21 Code of Federal Regulations, Parts 50 and 56 and 45 Code of Federal Regulations, Part 46, to the extent that such information is used in a manner that protects the identification of individuals. The Board of Directors of the Maine Health Data Organization shall adopt rules to define health care information that directly identifies an individual. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

"Health care information" does not include information that is created or received by a member of the clergy or other person using spiritual means alone for healing as provided in Title 32, sections 2103 and 3270. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F. "Health care practitioner" means a person licensed by this State to provide or otherwise lawfully providing health care or a partnership or corporation made up of those persons or an officer, employee, agent or contractor of that person acting in the course and scope of employment, agency or contract related to or supportive of the provision of health care to individuals. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

G. "Individual" means a natural person who is the subject of the health care information under consideration and, in the context of disclosure of health care information, includes the individual's authorized representative. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

G-1. "Legally protected health care activity" has the same meaning as in Title 14, section 9002, subsection 8. [PL 2023, c. 648, Pt. F, §3 (NEW).]

G-2. "Reproductive health care services" has the same meaning as in Title 14, section 9002, subsection 9. [PL 2023, c. 648, Pt. F, §4 (NEW).]

H. "Third party" or "3rd party" means a person other than the individual to whom the health care information relates. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).] [PL 2023, c. 648, Pt. F, §§1-4 (AMD).]

2. Confidentiality of health information; disclosure. An individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility except as provided in subsection 3, 3-A, 3-B, 6 or 11. Nothing in this section prohibits a health care practitioner or health care facility from adhering to applicable ethical or professional standards provided that these standards do not decrease the protection of confidentiality granted by this section. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

3. Written authorization to disclose. A health care practitioner or facility may disclose health care information pursuant to a written authorization signed by an individual for the specific purpose stated in the authorization. A written authorization to disclose health care information must be retained with the individual's health care information. A written authorization to disclose is valid whether it is in an original, facsimile or electronic form. A written authorization to disclose must contain the following elements:

A. The name and signature of the individual and the date of signature. If the authorization is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

B. The types of persons authorized to disclose health care information and the nature of the health care information to be disclosed; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

C. The identity or description of the 3rd party to whom the information is to be disclosed; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

D. The specific purpose or purposes of the disclosure and whether any subsequent disclosures may be made pursuant to the same authorization. An authorization to disclose health care information related to substance use disorder treatment or care subject to the requirements of 42 United States Code, Section 290dd-2 (Supplement 1998) is governed by the provisions of that law; [PL 2017, c. 407, Pt. A, §72 (AMD).]

E. The duration of the authorization; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

F. A statement that the individual may refuse authorization to disclose all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

G. A statement that the authorization may be revoked at any time by the individual by executing a written revocation, subject to the right of any person who acted in reliance on the authorization

prior to receiving notice of revocation, instructions on how to revoke an authorization and a statement that revocation may be the basis for denial of health benefits or other insurance coverage or benefits; and [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

H. A statement that the individual is entitled to a copy of the authorization form. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

[PL 2017, c. 407, Pt. A, §72 (AMD).]

3-A. Oral authorization to disclose. When it is not practical to obtain written authorization under subsection 3 from an individual or person acting pursuant to subsection 3-B or when a person chooses to give oral authorization to disclose, a health care practitioner or facility may disclose health care information pursuant to oral authorization. A health care practitioner or facility shall record with the individual's health care information receipt of oral authorization to disclose, including the name of the authorizing person, the date, the information and purposes for which disclosure is authorized and the identity or description of the 3rd party to whom the information is to be disclosed.
[PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

3-B. Authorization to disclose provided by a 3rd party. When an individual or an authorized representative is unable to provide authorization to disclose under subsection 3 or 3-A, a health care practitioner or facility may disclose health care information pursuant to authorization to disclose that meets the requirements of subsection 3 or 3-A given by a 3rd party listed in this subsection. A health care practitioner or facility may determine not to obtain authorization from a person listed in this subsection when the practitioner or facility determines it would not be in the best interest of the individual to do so. In making this decision, the health care practitioner or facility shall respect the safety of the individual and shall consider any indicators, suspicion or substantiation of abuse. Persons who may authorize disclosure under this subsection include:

A. The spouse of the individual; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. A parent of the individual; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. An adult who is a child, grandchild or sibling of the individual; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. An adult who is a sibling of the individual's parent or that sibling's spouse or a child of a sibling of the individual or a child of a sibling of the individual's spouse, related by blood or adoption; [RR 2021, c. 2, Pt. B, §106 (COR).]

E. An adult related to the individual, by blood or adoption, who is familiar with the individual's personal values; and [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F. An adult who has exhibited special concern for the individual and who is familiar with the individual's personal values. [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[RR 2021, c. 2, Pt. B, §106 (COR).]

4. Duration of authorization to disclose. An authorization to disclose may not extend longer than 30 months, except that the duration of an authorization for the purposes of insurance coverage under Title 24, 24-A or 39-A is governed by the provisions of Title 24, 24-A or 39-A, respectively.
[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

5. Revocation of authorization to disclose. A person who may authorize disclosure may revoke authorization to disclose at any time, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation. A written revocation of authorization must be signed and dated. If the revocation is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature. A health care practitioner or facility shall record receipt of oral revocation of authorization, including the name of the person revoking authorization and the date. A revocation of authorization must be retained with the authorization and the individual's health care information.

[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

6. Disclosure without authorization to disclose. A health care practitioner or facility may disclose, or when required by law must disclose, health care information without authorization to disclose under the circumstances stated in this subsection or as provided in subsection 11. Disclosure may be made without authorization as follows:

A. To another health care practitioner or facility for diagnosis, treatment or care of individuals or to complete the responsibilities of a health care practitioner or facility that provided diagnosis, treatment or care of individuals, as provided in this paragraph.

(1) For a disclosure within the office, practice or organizational affiliate of the health care practitioner or facility, no authorization is required.

(2) For a disclosure outside of the office, practice or organizational affiliate of the health care practitioner or facility, authorization is not required, except that in nonemergency circumstances authorization is required for health care information derived from mental health services provided by:

(a) A clinical nurse specialist licensed under the provisions of Title 32, chapter 31;

(b) A psychologist licensed under the provisions of Title 32, chapter 56;

(c) A social worker licensed under the provisions of Title 32, chapter 83;

(d) A counseling professional licensed under the provisions of Title 32, chapter 119; or

(e) A physician specializing in psychiatry licensed under the provisions of Title 32, chapter 36 or 48.

This subparagraph does not prohibit the disclosure of health care information between a licensed pharmacist and a health care practitioner or facility providing mental health services for the purpose of dispensing medication to an individual.

This subparagraph does not prohibit the disclosure without authorization of health care information covered under this section to a state-designated statewide health information exchange that satisfies the requirement in subsection 18, paragraph C of providing a general opt-out provision to an individual at all times and that provides and maintains an individual protection mechanism by which an individual may choose to opt in to allow the state-designated statewide health information exchange to disclose that individual's health care information covered under Title 34-B, section 1207.

This subparagraph does not prohibit the disclosure without authorization of health care information covered under this paragraph to a health care practitioner or health care facility, or to a payor or person engaged in payment for health care, for purposes of care management or coordination of care. Disclosure of psychotherapy notes is governed by 45 Code of Federal Regulations, Section 164.508(a)(2). A person who has made a disclosure under this

subparagraph shall make a reasonable effort to notify the individual or the authorized representative of the individual of the disclosure; [PL 2013, c. 326, §1 (AMD).]

B. To an agent, employee, independent contractor or successor in interest of the health care practitioner or facility including a state-designated statewide health information exchange that makes health care information available electronically to health care practitioners and facilities or to a member of a quality assurance, utilization review or peer review team to the extent necessary to carry out the usual and customary activities relating to the delivery of health care and for the practitioner's or facility's lawful purposes in diagnosing, treating or caring for individuals, including billing and collection, risk management, quality assurance, utilization review and peer review. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [PL 2011, c. 347, §7 (AMD).]

C. To a family or household member unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. To appropriate persons when a health care practitioner or facility that is providing or has provided diagnosis, treatment or care to the individual in good faith believes that disclosure is made to avert a serious threat to health or safety and meets the conditions, as applicable, described in 45 Code of Federal Regulations, Section 164.512(j) (2012). A disclosure pursuant to this paragraph must protect the confidentiality of the health care information consistent with sound professional judgment; [PL 2013, c. 289, §1 (AMD).]

E. To federal, state or local governmental entities in order to protect the public health and welfare when reporting is required or authorized by law, to report a suspected crime against the health care practitioner or facility or to report information that the health care facility's officials or health care practitioner in good faith believes constitutes evidence of criminal conduct that occurred on the premises of the health care facility or health care practitioner; [PL 2011, c. 572, §1 (AMD).]

E-1. To federal, state or local governmental entities if the health care practitioner or facility that is providing diagnosis, treatment or care to an individual has determined in the exercise of sound professional judgment that the following requirements, as applicable, are satisfied:

(1) With regard to a disclosure for public health activities, for law enforcement purposes or that pertains to victims of abuse, neglect or domestic violence, the provisions of 45 Code of Federal Regulations, Section 164.512(b), (c) or (f) (2012) must be met; and

(2) With regard to a disclosure that pertains to a victim of domestic violence or a victim of sexual assault, the provisions of 45 Code of Federal Regulations, Section 164.512(c)(1)(iii)(A) (2012) and Section 164.512(c)(1)(iii)(B) (2012) must be met. [PL 2013, c. 289, §2 (NEW).]

E-2. To federal, state or local governmental entities if the health care practitioner or facility that is providing diagnosis, treatment or care to an individual has determined in the exercise of sound professional judgment that the disclosure is required by section 1727; [RR 2015, c. 1, §17 (COR).]

F. [PL 1999, c. 512, Pt. A, §5 (RP); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-1. As directed by order of a court or as authorized or required by statute; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-2. To a governmental entity pursuant to a lawful subpoena requesting health care information to which the governmental entity is entitled according to statute or rules of court; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

F-3. **(TEXT EFFECTIVE ON CONTINGENCY: See PL 2013, c. 528, §12)** To the Maine Health Data Organization as required by and for use in accordance with chapter 1683. Health care information, including protected health information, as defined in 45 Code of Federal Regulations, Section 160.103 (2013), submitted to the Maine Health Data Organization must be protected by means of encryption; [PL 2013, c. 528, §1 (NEW); PL 2013, c. 528, §12 (AFF).]

G. To a person when necessary to conduct scientific research approved by an institutional review board or by the board of a nonprofit health research organization or when necessary for a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. A person conducting research or a clinical trial may not identify any individual patient in any report arising from the research or clinical trial. For the purposes of this paragraph, "institutional review board" means any board, committee or other group formally designated by a health care facility and authorized under federal law to review, approve or conduct periodic review of research programs. Health care information disclosed pursuant to this paragraph that identifies an individual must be returned to the health care practitioner or facility from which it was obtained or must be destroyed when it is no longer required for the research or clinical trial. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

H. To a person engaged in the assessment, evaluation or investigation of the provision of or payment for health care or the practices of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to statutory or professional standards or requirements. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

I. To a person engaged in the regulation, accreditation, licensure or certification of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to standards or requirements for regulation, accreditation, licensure or certification; [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

J. To a person engaged in the review of the provision of health care by a health care practitioner or facility or payment for such health care under Title 24, 24-A or 39-A or under a public program for the payment of health care or professional liability insurance for a health care practitioner or facility or to an agent, employee or contractor of such a person; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

K. To attorneys for the health care practitioner or facility that is disclosing the health care information or to a person as required in the context of legal proceedings or in disclosure to a court or governmental entity, as determined by the practitioner or facility to be required for the practitioner's or facility's own legal representation; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

L. To a person outside the office of the health care practitioner or facility engaged in payment activities, including but not limited to submission to payors for the purposes of billing, payment, claims management, medical data processing, determination of coverage or adjudication of health benefit or subrogation claims, review of health care services with respect to coverage or justification of charges or other administrative services. Payment activities also include but are not limited to:

(1) Activities necessary to determine responsibility for coverage;

(2) Activities undertaken to obtain payment for health care provided to an individual; and

(3) Quality assessment and utilization review activities, including precertification and preauthorization of services and operations or services audits relating to diagnosis, treatment or care rendered to individuals by the health care practitioner or facility and covered by a health

plan or other payor; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

M. To schools, educational institutions, youth camps licensed under section 2495, correctional facilities, health care practitioners and facilities, providers of emergency services or a branch of federal or state military forces, information regarding immunization of an individual; [PL 2009, c. 211, Pt. B, §17 (AMD).]

N. To a person when disclosure is needed to set or confirm the date and time of an appointment or test or to make arrangements for the individual to receive those services; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

O. To a person when disclosure is needed to obtain or convey information about prescription medication or supplies or to provide medication or supplies under a prescription; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

P. To a person representing emergency services, health care and relief agencies, corrections facilities or a branch of federal or state military forces, of brief confirmation of general health status; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

Q. To a member of the clergy, of information about the presence of an individual in a health care facility, including the person's room number, place of residence and religious affiliation unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

R. To a member of the media who asks a health care facility about an individual by name, of brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [PL 2015, c. 370, §4 (AMD).]

S. To a member of the public who asks a health care facility about an individual by name, of the room number of the individual and brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; [PL 2017, c. 203, §2 (AMD).]

T. To a lay caregiver designated by an individual pursuant to section 1711-G; [PL 2021, c. 398, Pt. MMMM, §3 (AMD).]

U. To a panel coordinator of the maternal, fetal and infant mortality review panel pursuant to section 261, subsection 4, paragraph B-1 for the purposes of reviewing health care information of a deceased person and a mother of a child who died within one year of birth, including fetal deaths after 28 weeks of gestation. For purposes of this paragraph, "panel coordinator" has the same meaning as in section 261, subsection 1, paragraph E and "deceased person" has the same meaning as in section 261, subsection 1, paragraph B; and [PL 2021, c. 398, Pt. MMMM, §4 (AMD).]

V. To a panel coordinator of the Aging and Disability Mortality Review Panel pursuant to section 264, subsection 5, paragraph B, subparagraph (4) for the purposes of reviewing health care information of an adult receiving services who is deceased, in accordance with section 264, subsection 5, paragraph A. For purposes of this paragraph, "panel coordinator" has the same meaning as in section 264, subsection 2, paragraph B. [PL 2021, c. 398, Pt. MMMM, §5 (NEW).]

[PL 2021, c. 398, Pt. MMMM, §§3-5 (AMD).]

7. Confidentiality policies. A health care practitioner, facility or state-designated statewide health information exchange shall develop and implement policies, standards and procedures to protect the confidentiality, security and integrity of health care information to ensure that information is not

negligently, inappropriately or unlawfully disclosed. The policies of health care facilities must provide that an individual being admitted for inpatient care be given notice of the right of the individual to control the disclosure of health care information. The policies must provide that routine admission forms include clear written notice of the individual's ability to direct that that individual's name be removed from the directory listing of persons cared for at the facility and notice that removal may result in the inability of the facility to direct visitors and telephone calls to the individual.
[PL 2011, c. 373, §1 (AMD).]

8. Prohibited disclosure. Disclosure of health care information is prohibited as follows.

A. A health care practitioner, facility or state-designated statewide health information exchange may not disclose health care information for the purpose of marketing or sales without written or oral authorization for the disclosure. [PL 2023, c. 648, Pt. F, §5 (NEW).]

B. Notwithstanding any provision of this section to the contrary and except as provided in paragraph C, a health care practitioner, facility or state-designated statewide health information exchange may not disclose any of the following in a civil or administrative action or proceeding or in response to a subpoena issued in a civil or administrative action or proceeding unless authorized in writing by the individual or the individual's authorized representative or pursuant to a court order issued by a court of competent jurisdiction in this State upon a showing of good cause, as long as the court order limits the use and disclosure of records and includes sanctions for misuse of records or sets forth other methods to ensure confidentiality:

(1) Any communication about reproductive health care services or gender-affirming health care services made to the health care practitioner, facility or state-designated statewide health information exchange from the individual or anyone acting on behalf of the individual, including an authorized representative of the individual; and

(2) Any information obtained through a personal examination of an individual relating to reproductive health care services or gender-affirming health care services. [PL 2023, c. 648, Pt. F, §5 (NEW).]

C. Paragraph B does not apply if:

(1) The communication or information to be disclosed relates to an individual who is a plaintiff in a medical malpractice action and the health care practitioner, facility or state-designated statewide health information exchange from which the communication or information is requested is a defendant in the medical malpractice action;

(2) The communication or information to be disclosed is requested by a professional licensing board that licenses health care practitioners in this State and the request relates to and is made in connection with a complaint investigation. This subparagraph does not apply if the complaint is based solely on an allegation that a licensee of the board provided reproductive health care services or gender-affirming health care services that are legally protected health care activity or aiding and assisting legally protected health care activity within the licensee's scope of practice; or

(3) The communication or information to be disclosed is requested by the United States Department of Justice, a law enforcement agency of this State or a political subdivision of this State or any other federal agency or agency of this State that pursuant to statute is responsible for investigating abuse, neglect or exploitation and the request is made in connection with an investigation of abuse, neglect or exploitation of a child pursuant to the Child and Family Services and Child Protection Act or of an incapacitated or dependent adult pursuant to the Adult Protective Services Act. [PL 2023, c. 648, Pt. F, §5 (NEW).]

D. This subsection may not be construed to impede the lawful disclosure of information to another health care practitioner or facility for diagnosis, treatment or care of individuals or to complete the

responsibilities of a health care practitioner or facility that provides diagnosis, treatment or care of individuals or to impede the lawful disclosure of information to an insurer or payor related to the treatment provided by a health care practitioner or facility or to the payment or operations of a health care practitioner or facility. [PL 2023, c. 648, Pt. F, §5 (NEW).]

[PL 2023, c. 648, Pt. F, §5 (RPR).]

9. Disclosures of corrections or clarifications to health care information. A health care practitioner or facility shall provide to a 3rd party a copy of an addition submitted by an individual to the individual's health care information if:

A. The health care practitioner or facility provided a copy of the original health care record to the 3rd party on or after February 1, 2000; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. The correction or clarification was submitted by the individual pursuant to section 1711 or 1711-B and relates to diagnosis, treatment or care; [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. The individual requests that a copy be sent to the 3rd party and provides an authorization that meets the requirements of subsection 3, 3-A or 3-B; and [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. If requested by the health care practitioner or facility, the individual pays to the health care practitioner or facility all reasonable costs requested by that practitioner or facility. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

10. Requirements for disclosures. Except as otherwise provided by law, disclosures of health care information pursuant to this section are subject to the professional judgment of the health care practitioner and to the following requirements.

A. A health care practitioner or facility that discloses health care information pursuant to subsection 3, 3-A or 3-B may not disclose information in excess of the information requested in the authorization. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

B. A health care practitioner or facility that discloses health care information pursuant to subsections 3, 3-A, 3-B or 6 may not disclose information in excess of the information reasonably required for the purpose for which it is disclosed. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. If a health care practitioner or facility believes that release of health care information to the individual would be detrimental to the health of the individual, the health care practitioner or facility shall advise the individual and make copies of the records available to the individual's authorized representative upon receipt of a written authorization. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

D. If a health care practitioner or facility discloses partial or incomplete health care information, as compared to the request or directive to disclose under subsection 3, 3-A, 3-B or 6, the disclosure must expressly indicate that the information disclosed is partial or incomplete. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

11. Health care information subject to other laws, rules and regulations. Health care information that is subject to the provisions of 42 United States Code, Section 290dd-2 (Supplement

1998); chapters 710-B and 711; Title 5, section 200-E; Title 5, chapter 501; Title 24 or 24-A; Title 34-B, section 1207; Title 39-A; or other provisions of state or federal law, rule or regulation is governed solely by those provisions.
[PL 2009, c. 387, §2 (AMD).]

12. Minors. If a minor has consented to health care in accordance with the laws of this State, authorization to disclose health care information pursuant to this section must be given by the minor unless otherwise provided by law.
[PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

13. Enforcement. This section may be enforced within 2 years of the date a disclosure in violation of this section was or should reasonably have been discovered.

A. When the Attorney General has reason to believe that a person has intentionally violated a provision of this section, the Attorney General may bring an action to enjoin unlawful disclosure of health care information. [PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

B. An individual who is aggrieved by conduct in violation of this section may bring a civil action against a person who has intentionally unlawfully disclosed health care information in the Superior Court in the county in which the individual resides or the disclosure occurred. The action may seek to enjoin unlawful disclosure and may seek costs and a forfeiture or penalty under paragraph C. An applicant for injunctive relief under this paragraph may not be required to give security as a condition of the issuance of the injunction. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

C. A person who intentionally violates this section is subject to a civil penalty not to exceed $5,000, payable to the State, plus costs. If a court finds that intentional violations of this section have occurred after due notice of the violating conduct with sufficient frequency to constitute a general business practice, the person is subject to a civil penalty not to exceed $10,000 for health care practitioners and $50,000 for health care facilities, payable to the State. A civil penalty under this subsection is recoverable in a civil action. [PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

D. Nothing in this section may be construed to prohibit a person aggrieved by conduct in violation of this section from pursuing all available common law remedies, including but not limited to an action based on negligence. [PL 1999, c. 512, Pt. A, §5 (NEW); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

14. Waiver prohibited. Any agreement to waive the provisions of this section is against public policy and void.
[PL 1997, c. 793, Pt. A, §8 (NEW); PL 1997, c. 793, Pt. A, §10 (AFF).]

15. Immunity. A cause of action in the nature of defamation, invasion of privacy or negligence does not arise against any person for disclosing health care information in accordance with this section. This section provides no immunity for disclosing information with malice or willful intent to injure any person.
[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

16. Application. This section applies to all requests, directives and authorizations to disclose health care information executed on or after February 1, 2000. An authorization to disclose health care information executed prior to February 1, 2000 that does not meet the standards of this section is

deemed to comply with the requirements of this section until the next health care encounter between the individual and the health care practitioner or facility.
[PL 1999, c. 512, Pt. A, §5 (AMD); PL 1999, c. 512, Pt. A, §7 (AFF); PL 1999, c. 790, Pt. A, §§58, 60 (AFF).]

17. Repeal.
[PL 2001, c. 346, §1 (RP).]

18. Participation in a state-designated statewide health information exchange. The following provisions apply to participation in a state-designated statewide health information exchange.

A. A health care practitioner may not deny a patient health care treatment and a health insurer may not deny a patient a health insurance benefit based solely on the provider's or patient's decision not to participate in a state-designated statewide health information exchange. Except when otherwise required by federal law, a payor of health care benefits may not require participation in a state-designated statewide health information exchange as a condition of participating in the payor's provider network. [PL 2011, c. 691, Pt. A, §20 (RPR).]

B. Recovery for professional negligence is not allowed against any health care practitioner or health care facility on the grounds of a health care practitioner's or a health care facility's nonparticipation in a state-designated statewide health information exchange arising out of or in connection with the provision of or failure to provide health care services. In any civil action for professional negligence or in any proceeding related to such a civil action or in any arbitration, proof of a health care practitioner's, a health care facility's or a patient's participation or nonparticipation in a state-designated statewide health information exchange is inadmissible as evidence of liability or nonliability arising out of or in connection with the provision of or failure to provide health care services. This paragraph does not prohibit recovery or the admission of evidence of reliance on information in a state-designated statewide electronic health information exchange when there was participation by both the patient and the patient's health care practitioner. [PL 2011, c. 691, Pt. A, §20 (RPR).]

C. A state-designated statewide health information exchange to which health care information is disclosed under this section shall provide an individual protection mechanism by which an individual may opt out from participation to prohibit the state-designated statewide health information exchange from disclosing the individual's health care information to a health care practitioner or health care facility. [PL 2011, c. 691, Pt. A, §20 (RPR).]

D. At point of initial contact, a health care practitioner, health care facility or other entity participating in a state-designated statewide health information exchange shall provide to each patient, on a separate form, at minimum:

(1) Information about the state-designated statewide health information exchange, including a description of benefits and risks of participation in the state-designated statewide health information exchange;

(2) A description of how and where to obtain more information about or contact the state-designated statewide health information exchange;

(3) An opportunity for the patient to decline participation in the state-designated statewide health information exchange; and

(4) A declaration that a health care practitioner, health care facility or other entity may not deny a patient health care treatment based solely on the provider's or patient's decision not to participate in a state-designated statewide health information exchange.

The state-designated statewide health information exchange shall develop the form for use under this paragraph, with input from consumers and providers. The form must be approved by the office

of the state coordinator for health information technology within the Governor's office of health policy and finance. [PL 2011, c. 691, Pt. A, §20 (RPR).]

E. A health care practitioner, health care facility or other entity participating in a state-designated statewide health information exchange shall communicate to the exchange the decision of each patient who has declined participation and shall do so within a reasonable time frame, but not more than 2 business days following the receipt of a signed form, as described in paragraph D, from the patient, or shall establish a mechanism by which the patient may decline participation in the state-designated statewide health information exchange at no cost to the patient. [PL 2011, c. 691, Pt. A, §20 (RPR).]

F. A state-designated statewide health information exchange shall process the request of a patient who has decided not to participate in the state-designated statewide health information exchange within 2 business days of receiving the patient's decision to decline, unless additional time is needed to verify the identity of the patient. A signed authorization from the patient is required before a patient is newly entered or reentered into the system if the patient chooses to begin participation at a later date.

Except as otherwise required by applicable law, regulation or rule or state or federal contract, or when the state-designated statewide health information exchange is acting as the agent of a health care practitioner, health care facility or other entity, the state-designated statewide health information exchange shall remove health information of individuals who have declined participation in the exchange. In no event may health information retained in the state-designated statewide health information exchange as set forth in this paragraph be made available to health care practitioners, health care facilities or other entities except as otherwise required by applicable law, regulation or rule or state or federal contract, or when the health care practitioner, health care facility or other entity is the originator of the information. [PL 2011, c. 691, Pt. A, §20 (RPR).]

G. A state-designated statewide health information exchange shall establish a secure website accessible to patients. This website must:

(1) Permit a patient to request a report of who has accessed that patient's records and when the access occurred. This report must be delivered to the patient within 2 business days upon verification of the patient's identity by the state-designated statewide health information exchange;

(2) Provide a mechanism for a patient to decline participation in the state-designated statewide health information exchange; and

(3) Provide a mechanism for the patient to consent to participation in the state-designated statewide health information exchange if the patient had previously declined participation. [PL 2011, c. 691, Pt. A, §20 (RPR).]

H. A state-designated statewide health information exchange shall establish for patients an alternate procedure to that provided for in paragraph F that does not require Internet access. A health care practitioner, health care facility or other entity participating in the state-designated statewide health information exchange shall provide information about this alternate procedure to all patients. The information must be included on the form identified in paragraph D. [PL 2011, c. 691, Pt. A, §20 (RPR).]

I. A state-designated statewide health information exchange shall maintain records regarding all disclosures of health care information by and through the state-designated statewide health information exchange, including the requesting party and the dates and times of the requests and disclosures. [PL 2011, c. 691, Pt. A, §20 (RPR).]

J. A state-designated statewide health information exchange may not charge a patient or an authorized representative of a patient any fee for access or communication as provided in this subsection. [PL 2011, c. 691, Pt. A, §20 (RPR).]

K. Notwithstanding any provision of this subsection to the contrary, a health care practitioner, health care facility or other entity shall provide the form and communication required by paragraphs D and F to all existing patients following the effective date of this subsection. [PL 2011, c. 691, Pt. A, §20 (RPR).]

L. A state-designated statewide health information exchange shall meet or exceed all applicable federal laws and regulations pertaining to privacy, security and breach notification regarding personally identifiable protected health information, as defined in 45 Code of Federal Regulations, Part 160. If a breach occurs, the state-designated statewide health information exchange shall arrange with its participants for notification of each individual whose protected health information has been, or is reasonably believed by the exchange to have been, breached. For purposes of this paragraph, "breach" has the same meaning as in 45 Code of Federal Regulations, Part 164, as amended. [PL 2011, c. 691, Pt. A, §20 (RPR).]

M. The state-designated statewide health information exchange shall develop a quality management plan, including auditing mechanisms, in consultation with the office of the state coordinator for health information technology within the department, who shall review the plan and results. [PL 2011, c. 691, Pt. A, §20 (RPR).]

[PL 2011, c. 691, Pt. A, §20 (RPR).]

20. Exemption from freedom of access laws. Except as provided in this section, the names and other identifying information of individuals in a state-designated statewide health information exchange are confidential and are exempt from the provisions of Title 1, chapter 13.

[PL 2011, c. 373, §4 (NEW).]

SECTION HISTORY

RR 1997, c. 2, §44 (COR). PL 1997, c. 793, §A8 (NEW). PL 1997, c. 793, §A10 (AFF). PL 1999, c. 3, §§1,2 (AMD). PL 1999, c. 3, §§3,5 (AFF). PL 1999, c. 512, §A5 (AMD). PL 1999, c. 512, §A6, 7 (AFF). PL 1999, c. 790, §§A58,60 (AFF). RR 2001, c. 1, §26 (COR). PL 2001, c. 346, §1 (AMD). PL 2009, c. 211, Pt. B, §17 (AMD). PL 2009, c. 292, §3 (AMD). PL 2009, c. 292, §6 (AFF). PL 2009, c. 387, §§1, 2 (AMD). PL 2011, c. 347, §§6-8 (AMD). PL 2011, c. 373, §§1-4 (AMD). PL 2011, c. 572, §1 (AMD). PL 2011, c. 691, Pt. A, §20 (AMD). PL 2013, c. 289, §§1, 2 (AMD). PL 2013, c. 326, §1 (AMD). PL 2013, c. 528, §1 (AMD). PL 2013, c. 528, §12 (AFF). RR 2015, c. 1, §17 (COR). PL 2015, c. 218, §1 (AMD). PL 2015, c. 370, §§4, 5 (AMD). PL 2017, c. 203, §§2-4 (AMD). PL 2017, c. 402, Pt. C, §44 (AMD). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2017, c. 407, Pt. A, §72 (AMD). PL 2019, c. 417, Pt. B, §14 (AFF). PL 2021, c. 398, Pt. MMMM, §§3-5 (AMD). RR 2021, c. 2, Pt. B, §106 (COR). PL 2023, c. 648, Pt. F, §§1-5 (AMD).

§1711-D. Designation of visitors in hospital settings

1. Designation of visitors. A patient in a hospital licensed pursuant to chapter 405 may designate persons to be considered as immediate family members for the purpose of granting visitation rights. The following provisions apply to the designation of visitors under this section.

A. The patient must be 18 years of age or older or a minor who is authorized by law to consent to health care. [PL 2001, c. 378, §1 (NEW).]

B. The patient must be a patient in a critical care unit that restricts visitors to immediate family members, or emergency room that restricts visitors to immediate family members. [PL 2001, c. 378, §1 (NEW).]

C. The patient may designate visitors under this section by communicating the designation to a health care provider at the hospital orally or in writing. The patient may designate visitors, change the designation or revoke the designation at any time. [PL 2001, c. 378, §1 (NEW).]

D. A hospital shall provide to patients in the hospital a process by which to designate visitors under this section and shall note in the patient's medical record the names of designated visitors, the date of the designation and any changes in the designation. [PL 2001, c. 378, §1 (NEW).]

E. Except as provided in subsection 2, a hospital may not deny visitation to the patient by a designated visitor during hospital visiting hours. [PL 2001, c. 378, §1 (NEW).]

[PL 2001, c. 378, §1 (NEW).]

2. Exceptions. A hospital may deny visitation with a patient to any visitor designated under this section if:

A. The hospital denies all visitors; [PL 2001, c. 378, §1 (NEW).]

B. The hospital determines that the presence of the visitor might endanger the health or safety of the patient or interfere with the primary operations of the hospital; or [PL 2001, c. 378, §1 (NEW).]

C. The patient has communicated orally or in writing the choice not to visit with the visitor. [PL 2001, c. 378, §1 (NEW).]

[PL 2001, c. 378, §1 (NEW).]

3. Rulemaking. By March 1, 2002, the department shall adopt rules to implement this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

[PL 2001, c. 378, §1 (NEW).]

SECTION HISTORY

PL 2001, c. 378, §1 (NEW).

§1711-E. Confidentiality of prescription drug information

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

A. "Carrier" has the same meaning as in Title 24-A, section 4301-A, subsection 3. [PL 2005, c. 589, §1 (NEW).]

A-1. "Administrator" has the same meaning as in Title 24-A, section 1901, subsection 1. [PL 2007, c. 460, §1 (NEW).]

A-2. "Detailing" means one-to-one contact with a prescriber or employees or agents of a prescriber for the purpose of increasing or reinforcing the prescribing of a certain drug by the prescriber. [PL 2007, c. 460, §1 (NEW).]

B. "Electronic transmission intermediary" means an entity that provides the infrastructure that connects the computer systems or other electronic devices used by and between health care practitioners, prescribers, pharmacies, health care facilities, pharmacy benefit managers, carriers and administrators and agents and contractors of those persons and entities in order to facilitate the secure transmission of an individual's prescription drug order, refill, authorization request, claim, payment or other prescription drug information. [PL 2007, c. 460, §1 (AMD).]

C. "Health care facility" has the same meanings as in section 1711-C, subsection 1, paragraph D. [PL 2005, c. 589, §1 (NEW).]

D. "Health care practitioner" has the same meanings as in section 1711-C, subsection 1, paragraph F. [PL 2005, c. 589, §1 (NEW).]

E. "Health plan" means a health plan providing prescription drug coverage as authorized under the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173. [PL 2005, c. 589, §1 (NEW).]

F. "Individual" means a natural person who is the subject of prescription drug information. [PL 2005, c. 589, §1 (NEW).]

F-1. "Marketing" means any of the following activities undertaken or materials or products made available to prescribers or to their employees or agents related to the transfer of prescription drugs from the producer or seller to the consumer or buyer:

(1) Advertising, publicizing, promoting or selling a prescription drug;

(2) Activities undertaken for the purpose of influencing the market share of a prescription drug or the prescribing patterns of a prescriber, a detailing visit or a personal appearance;

(3) Activities undertaken to evaluate or improve the effectiveness of a professional detailing sales force; or

(4) A brochure, media advertisement or announcement, poster or free sample of a prescription drug.

"Marketing" does not include pharmacy reimbursement, formulary compliance, pharmacy file transfers in response to a patient request or as a result of the sale or purchase of a pharmacy, patient care management, utilization review by a health care provider or agent of a health care provider or the patient's health plan or an agent of the patient's health plan, and health care research. [PL 2007, c. 460, §1 (NEW).]

F-2. "Pharmacy" means a mail order prescription pharmacy as defined in Title 32, section 13702-A, subsection 17 or a pharmacy as defined in Title 32, section 13702-A, subsection 24. [PL 2007, c. 695, Pt. C, §6 (AMD).]

G. "Pharmacy benefits manager" has the same meaning as in Title 24-A, section 4347, subsection 17. [PL 2019, c. 469, §1 (AMD); PL 2019, c. 469, §9 (AFF).]

G-1. "Prescriber" means a person who is licensed, registered or otherwise authorized in the appropriate jurisdiction to prescribe and administer drugs in the course of professional practice. [PL 2007, c. 460, §1 (NEW).]

H. "Prescription drug information" means information concerning prescription drugs as defined in Title 32, section 13702-A, subsection 30 and includes prescription drug orders as defined in Title 32, section 13702-A, subsection 31. [PL 2007, c. 695, Pt. C, §7 (AMD).]

I. "Prescription drug information intermediary" means a person or entity that communicates, facilitates or participates in the exchange of prescription drug information regarding an individual or a prescriber. "Prescription drug information intermediary" includes, but is not limited to, a pharmacy benefits manager, a health plan, an administrator and an electronic transmission intermediary and any person or entity employed by or contracted to provide services to that entity. [PL 2007, c. 460, §1 (AMD).]

[PL 2019, c. 469, §1 (AMD); PL 2019, c. 469, §9 (AFF).]

1-A. Findings.

[PL 2011, c. 494, §1 (RP).]

1-B. Purposes.

[PL 2011, c. 494, §2 (RP).]

2. Confidentiality of prescription drug information that identifies the individual. A carrier or prescription drug information intermediary may not license, use, sell, transfer or exchange for value,

for any marketing purpose, prescription drug information that identifies directly or indirectly the individual who is prescribed the prescription drug.
[PL 2011, c. 494, §3 (AMD).]

2-A. Confidentiality of prescription drug information that identifies the prescriber.
[PL 2011, c. 494, §4 (RP).]

3. Enforcement. A violation of subsection 2 is a violation of the Maine Unfair Trade Practices Act.
[PL 2011, c. 494, §5 (AMD).]

4. Confidentiality protection procedures.

[PL 2011, c. 494, §6 (RP).]

5. Rules. The department shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A.
[PL 2011, c. 90, Pt. J, §10 (AMD).]

SECTION HISTORY

PL 2005, c. 589, §1 (NEW). PL 2007, c. 460, §1 (AMD). PL 2007, c. 695, Pt. C, §§6, 7 (AMD). PL 2011, c. 90, Pt. J, §10 (AMD). PL 2011, c. 443, §1 (AMD). PL 2011, c. 461, §1 (AMD). PL 2011, c. 494, §§1-6 (AMD). PL 2019, c. 469, §1 (AMD). PL 2019, c. 469, §9 (AFF).

§1711-F. Transfer of member health care information by MaineCare program for purpose of diagnosis, treatment or care

The MaineCare program established under chapter 855 may transfer member health care information to a health care practitioner or health care facility for the purpose of diagnosis, treatment or care of the member through an electronic health information exchange in accordance with this section. [PL 2009, c. 387, §3 (NEW).]

1. Definitions. For the purposes of this section, "health care facility" has the same meaning as in section 1711-C, subsection 1, paragraph D and "health care practitioner" has the same meaning as in section 1711-C, subsection 1, paragraph F.
[PL 2009, c. 387, §3 (NEW).]

2. Individual protection mechanism. The department shall provide an individual protection mechanism for MaineCare members by which an individual may prohibit a health information exchange from disclosing the individual's health care information to a health care practitioner or health care facility.
[PL 2009, c. 387, §3 (NEW).]

3. Health care information subject to other laws, rules and regulations. Health care information that is subject to the provisions of 42 United States Code, Section 290dd-2 (Supplement 1998); chapters 710-B and 711; Title 5, section 200-E; Title 5, chapter 501; Title 24 or 24-A; Title 34-B, section 1207; Title 39-A; or other confidentiality provisions of state or federal law, rule or regulation is governed solely by those provisions.
[PL 2009, c. 387, §3 (NEW).]

SECTION HISTORY

PL 2009, c. 387, §3 (NEW).

§1711-G. Designated lay caregivers

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

A. "Aftercare" means any assistance to a patient, after the patient's discharge, that is directly related to the content of the patient's hospital discharge plan and that is provided by a lay caregiver designated pursuant to subsection 2, including assistance with basic or instrumental activities of daily living, performance of medical and nursing tasks, assistance in administering medication and operation of medical equipment. [PL 2015, c. 370, §6 (NEW).]

B. "Discharge" means a patient's exit or release from a hospital to the patient's residence or another health care setting following any medical care or treatment at the hospital or observation at the hospital for a period that includes midnight of at least one calendar day. [PL 2015, c. 370, §6 (NEW).]

C. "Residence" means a dwelling that a person considers to be the person's home. "Residence" does not include a rehabilitation facility, hospital, nursing home, assisted living facility, group home or any other health care facility licensed by the State. [PL 2015, c. 370, §6 (NEW).]

[PL 2015, c. 370, §6 (NEW).]

2. Designation of lay caregiver. In accordance with this subsection, a hospital licensed under chapter 405, but not a private mental hospital as described in chapter 404, shall allow for the designation of a lay caregiver to provide aftercare to a patient.

A. For a patient with capacity to make health care decisions, as described in Title 18-C, Article 5, Part 8, the hospital shall provide the patient with at least one opportunity to designate a lay caregiver following the patient's admission to the hospital, or observation at the hospital for a period that includes midnight of at least one calendar day, and prior to the patient's discharge. [PL 2017, c. 402, Pt. C, §45 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

B. For a patient without capacity to make health care decisions, as described in Title 18-C, Article 5, Part 8, the hospital shall provide the patient's legal guardian, agent or surrogate who is reasonably available and acting pursuant to Title 18-C, Article 5, Part 8 with at least one opportunity to designate a lay caregiver following the patient's admission to the hospital, or observation at the hospital for a period that includes midnight of at least one calendar day, and prior to the patient's discharge. [PL 2017, c. 402, Pt. C, §45 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

C. The hospital shall document the designation of a lay caregiver under this subsection in the patient's medical record, including the lay caregiver's name, relationship to the patient, telephone number, address and any other contact information as provided. If the patient or the patient's legal guardian, agent or surrogate who is reasonably available and acting pursuant to Title 18-C, Article 5, Part 8 declines to designate a lay caregiver, the hospital shall document that decision in the patient's medical record and that documentation constitutes compliance by the hospital with the requirements of this section. A designated lay caregiver may be removed or changed by the patient or the patient's legal guardian, agent or surrogate at any time, so long as the change or removal is documented by the hospital in the patient's medical record. [PL 2017, c. 402, Pt. C, §45 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

D. Designation of a lay caregiver under this subsection by the patient or the patient's legal guardian, agent or surrogate who is reasonably available and acting pursuant to Title 18-C, Article 5, Part 8 is optional. A designated lay caregiver is not obligated under this section to perform any aftercare tasks for the patient. [PL 2017, c. 402, Pt. C, §45 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

[PL 2017, c. 402, Pt. C, §45 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

3. Written consent. If a lay caregiver is designated under subsection 2, the hospital shall request that the patient or the patient's legal guardian, agent or surrogate who is reasonably available and acting pursuant to Title 18-C, Article 5, Part 8 provide written consent to release medical information regarding the scope of care to the patient's designated lay caregiver to carry out the purposes of this section. Written consent under this subsection must be provided pursuant to the hospital's established procedures for releasing personal health information and in compliance with state and federal law.

[PL 2017, c. 402, Pt. C, §45 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

4. Notice to designated lay caregiver. For a patient unable to effectively communicate with a lay caregiver designated under subsection 2, and for whom written consent is received under subsection 3, a hospital shall make reasonable efforts to notify the designated lay caregiver prior to the patient's discharge or transfer to another hospital licensed under chapter 405. The hospital may not withhold, delay or otherwise fail to deliver medical care to the patient or an appropriate discharge or transfer of the patient because the hospital is unable to notify the designated lay caregiver in accordance with this subsection prior to the patient's discharge or transfer. A hospital shall document in the patient's medical record its attempt to notify the designated lay caregiver under this subsection.
[PL 2015, c. 370, §6 (NEW).]

5. Discharge plan. If written consent is received under subsection 3, a hospital shall make reasonable efforts to communicate with a lay caregiver designated under subsection 2 regarding the development of a patient's discharge plan to help prepare the designated lay caregiver for the patient's aftercare needs at the patient's residence in accordance with the hospital's discharge policy.
[PL 2015, c. 370, §6 (NEW).]

6. Instruction to designated lay caregiver. If written consent is received under subsection 3, prior to a patient's discharge, the hospital shall make reasonable efforts to instruct the patient's lay caregiver designated under subsection 2, in a culturally competent manner, on how to meet the patient's aftercare needs and shall provide a meaningful opportunity for the designated lay caregiver to ask questions about the patient's discharge plan.
[PL 2015, c. 370, §6 (NEW).]

7. Noninterference with health care directives. The provisions of this section may not be construed to interfere with the rights of an agent of a patient operating under a valid health care directive under Title 18-C, Article 5, Part 8.
[PL 2017, c. 402, Pt. C, §45 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

8. Rules. The department may adopt rules to carry out the purposes of this section, including defining the content and scope of any instruction given under subsection 5 or 6. In the development of any rules pursuant to this subsection, the department shall consult with representatives of hospitals, consumers and organizations that represent seniors. Rules adopted pursuant to this subsection are routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A.
[PL 2015, c. 370, §6 (NEW).]

SECTION HISTORY

PL 2015, c. 370, §6 (NEW). PL 2017, c. 402, Pt. C, §45 (AMD). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2019, c. 417, Pt. B, §14 (AFF).

§1712. Itemized bills

Each hospital licensed by the State under chapter 405 shall inform all patients, or their legal guardians, in writing, at the time of the patient's discharge, that it will provide an itemized bill upon their request. [PL 1983, c. 166 (NEW).]

The request may be made by the patient or the patient's legal guardian at discharge or at any time within 7 years after discharge. [RR 2021, c. 2, Pt. B, §107 (COR).]

The hospital shall provide an itemized bill to the person making the request within 30 days of the request. [PL 1983, c. 166 (NEW).]

Notwithstanding this section, effective July 1, 1985, each hospital shall itemize on the hospital bill of each patient the cost of nursing services provided to that patient. [PL 1983, c. 166 (NEW).]

SECTION HISTORY

PL 1983, c. 166 (NEW). RR 2021, c. 2, Pt. B, §107 (COR).

§1713. Transitional hospital reimbursement

(REPEALED)

SECTION HISTORY

PL 1983, c. 824, §X2 (NEW). PL 2007, c. 466, Pt. A, §41 (RP).

§1714. Debts owed the department by providers

(REPEALED)

SECTION HISTORY

PL 1989, c. 34 (NEW). PL 1991, c. 9, §G3 (RP).

§1714-A. Debts owed the department by providers

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

A. "Boarding home" means any facility that meets the definition of former section 7901-A, subsection 4 or the definition of residential care facility in section 7852, subsection 14. [PL 2001, c. 596, Pt. B, §3 (AMD); PL 2001, c. 596, Pt. B, §25 (AFF).]

B. "Debt" means any amount of money that is owed to the department as a result of:

(1) Overpayments that have been determined by a department audit pursuant to the applicable principles of reimbursement, overpayments as reported by a provider in an unaudited cost report or overpayments that have been discovered in any other manner;

(2) The department's authority to recapture depreciation;

(3) The assessment of fines and sanctions;

(4) Projected overpayments reported in an interim cost report. If an interim report is not filed at least 30 days prior to the transfer, "debt" also includes 5% of Medicaid reimbursement or cost reimbursement for the last fiscal year or $50,000, whichever is less; or

(5) A final reconciliation decision and order by the former Maine Health Care Finance Commission. [PL 2007, c. 466, Pt. A, §42 (AMD).]

C. "Former provider" means the person reimbursed by the department for the provision of health care services at a nursing home, boarding home, hospital or other provider of health care services prior to its transfer. [PL 2011, c. 687, §5 (AMD).]

D. "Hospital" means any facility licensed pursuant to sections 1811 and 1817. [PL 1991, c. 9, Pt. G, §4 (NEW).]

E. "Interim cost report" means a cost report that covers the current fiscal year and any prior periods not covered by a previously filed cost report. Cost incurred in the 90 days prior to the transfer need not be covered in the interim cost report. [PL 1991, c. 9, Pt. G, §4 (NEW).]

F. "Nursing home" means any facility that meets the definition of section 1812-A, including an intermediate care facility for persons with intellectual disabilities. [PL 2011, c. 542, Pt. A, §27 (AMD).]

G. "Person" means any natural person, partnership, association, corporation or other entity including any county, local or other governmental unit. [PL 1991, c. 9, Pt. G, §4 (NEW).]

H. "Provider" means a person reimbursed by the department for the provision of health care services. [PL 1991, c. 9, Pt. G, §4 (NEW).]

I. "Transfer" means any change in the ownership or control of a nursing home, boarding home, hospital or other provider of health care services, including, but not limited to, a sale, lease or gift of the land, building or operating entity, that results in:

(1) The department reimbursing a person other than the former provider for the provision of care or services; or

(2) The discontinuation of the provision of care or services. [PL 2011, c. 687, §6 (AMD).]

J. "Transferee" means any person to whom a nursing home, boarding home, hospital or other provider of health care services is transferred. [PL 2011, c. 687, §6 (AMD).]

[PL 2011, c. 542, Pt. A, §27 (AMD); PL 2011, c. 687, §§5, 6 (AMD).]

2. Establishment of debt. A debt is established by the department when it notifies a provider of debt that the provider owes the department pursuant to a decision and order that constitutes final agency action. A debt is collectible by the department 31 days after exhaustion of all administrative appeals and any judicial review available under Title 5, chapter 375.

[PL 2003, c. 419, §4 (AMD).]

3. Notice of debt. Any notice of debt issued to a provider by the department must include the following:

A. A statement of the debt accrued; [PL 1991, c. 9, Pt. G, §4 (NEW).]

B. A statement of the time period during which the debt accrued; [PL 1991, c. 9, Pt. G, §4 (NEW).]

C. The basis for the debt; [PL 1991, c. 9, Pt. G, §4 (NEW).]

D. The debtor's right to request a fair hearing within 30 days of receipt of the notice; and [PL 1991, c. 9, Pt. G, §4 (NEW).]

E. A statement that after a debt is established, the department may proceed to collect that debt through administrative offset, lien and foreclosure, or other collection action. [PL 1991, c. 9, Pt. G, §4 (NEW).]

[PL 1991, c. 568, §1 (AMD).]

4. Successor liability. Liability of transferees is governed by this subsection.

A. When a nursing home, boarding home, hospital or other provider of health care services is transferred, the transferee is liable for debts owed to the department by the former provider unless by the time of sale:

(1) All debts owed by the former provider to the department have been paid, except as stated in subparagraph (2);

(2) If the indebtedness is the subject of an administrative appeal, an escrow account has been created and funded in an amount sufficient to cover the debt as claimed by the department; or

(3) An interim cost report has:

(a) Been filed and an escrow account has been created and funded in an amount sufficient to cover any overpayment identified in the report; or

(b) Not been filed and an escrow account has been created and funded in an amount sufficient to cover 5% of Medicaid reimbursement or cost reimbursement for the last fiscal year or $50,000, whichever is less. [PL 2011, c. 687, §7 (AMD).]

B. Any person affected by this subsection may request that the department identify the amount of any debt owed by a nursing home, boarding home, hospital or other provider of health care services. When the department receives such a request, it shall identify the debt within 30 days. Failure to identify the amount of a debt when a request is made in writing at least 30 days prior to the transfer

precludes the department from recovering that debt from the transferee. [PL 2011, c. 687, §7 (AMD).]

C. The department shall provide written notice of the requirements of this section to the transferee in a letter acknowledging receipt of a request for a certificate of need or waiver of the certificate of need for a nursing home or hospital transfer or in response to a request for an application for a license to operate a boarding home or to provide other health care services. [PL 2011, c. 687, §8 (AMD).]

D. If a transferee becomes liable for a debt pursuant to this subsection, the transferee shall succeed to any defenses to the debt that could have been exercised by the former provider. [PL 1991, c. 9, Pt. G, §4 (NEW).]

E. Nothing in this subsection may limit the liability of the former provider to the department for any debts whether or not they are identified at the time of sale. In addition, a transferee has a cause of action against a former provider to the extent that debts of the former provider are paid by the transferee, unless the transferee has waived the right to sue the former provider for those debts. [PL 1991, c. 568, §2 (AMD).]

F. The commissioner may waive all or part of a transferee's liability under this subsection if the commissioner finds that a waiver of liability is in the public interest. [PL 1991, c. 568, §3 (NEW).]

[PL 2011, c. 687, §§7, 8 (AMD).]

5. Department may offset. The department may offset against current reimbursement owed to a provider or any entity related by ownership or control to that provider any debt it is owed by that provider after the debt becomes collectible. The department shall adopt rules that implement this subsection and define the ownership or control relationships that are subject to an offset under this subsection, except that the department may not define any ownership or control relationship as subject to an offset unless the relationship allows the person whose relationship is the subject of the offset to control at least the number of votes of the provider's governing body or management that is needed to govern the operations of the provider. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2017, c. 442, §1 (AMD).]

6. Liens. Collection by lien is as follows.

A. After a debt is collectible, the amount stated in the notice of debt or overpayment is a lien in favor of the department against all real or personal property of the provider or any entity related by ownership or control to the provider. [PL 1991, c. 568, §4 (NEW).]

B. The lien attaches to all real and personal property of the responsible party when the department files in the registry of deeds of any county, or with any office appropriate for a notice with respect to personal property, a certificate that states the name of the responsible party, that party's address, the amount of debt accrued, the date of the underlying audit or decision and the name and address of the authorized agent of the department who issues the lien. [PL 1991, c. 568, §4 (NEW).]

C. When a lien has been filed and the person having notice of the lien possesses any property that may be subject to the lien, that property may not be paid over, released, sold, transferred, encumbered or conveyed unless:

(1) A release or waiver signed by the commissioner has been delivered to the person in possession of the property; or

(2) A court has ordered the release of the lien. A court may order a release only when alternative security has been provided for the debt owed the department. [PL 1991, c. 568, §4 (NEW).]

D. The commissioner may hold title to real or personal property for the purpose of foreclosure on filed liens. Foreclosure must proceed as follows.

(1) Actions to foreclose liens on real property filed under this subsection may be brought in the county where the lien is filed pursuant to the procedures of Title 14, chapter 713, subchapter VI. For purposes of foreclosure by civil action as described in Title 14, chapter 713, subchapter VI, a lien filed in accordance with this subsection constitutes a mortgage claim of the department on any real property owned by the debtor. Failure to pay the debt owed the department constitutes a breach of condition in the mortgage.

(2) Actions to foreclose liens on personal property filed under this subsection may be brought, pursuant to Title 14, chapter 509, subchapter III, in the county where the lien is filed. [PL 1991, c. 568, §4 (NEW).]

[PL 1991, c. 568, §4 (NEW).]

7. Other collection actions. In addition to the other remedies provided in this section, the department may seek collection of any debt established under subsection 2 pursuant to Title 14, chapter 502, Title 36, chapter 7 and Title 36, section 185-A.

A business entity, including a sole proprietorship, is considered out of business for the purposes of the department's recovering indebtedness if, after reasonable investigation, the department or its legal counsel has certified in writing that the business entity is no longer conducting operations and that there is no realistic expectation of collecting any significant money from the entity based upon one or more of the following conditions:

A. The business entity has ceased offering retail or wholesale goods and services to the public; [PL 2003, c. 673, Pt. YYY, §1 (NEW).]

B. Upon reasonable investigation, nonexempt assets of the business entity of substantial value can not be identified or are otherwise unavailable for attachment and recovery; [PL 2003, c. 673, Pt. YYY, §1 (NEW).]

C. The business entity's physical location or locations of business are closed to the public; [PL 2003, c. 673, Pt. YYY, §1 (NEW).]

D. The business entity's corporate status is no longer in good standing; [PL 2003, c. 673, Pt. YYY, §1 (NEW).]

E. The business entity has admitted that it has insufficient assets to satisfy the debt; [RR 2007, c. 2, §8 (COR).]

F. After reasonable investigation, the department or its counsel can not locate the business entity or identify the debtor's nonexempt assets; and [PL 2003, c. 673, Pt. YYY, §1 (NEW).]

G. The business entity has transferred substantially all of its business assets to a 3rd party and there are no recoverable assets as a result of the transfer. [PL 2003, c. 673, Pt. YYY, §1 (NEW).]

Certification by the department that a business entity is out of business under this subsection does not preclude further collection and recovery procedures by the department, whether to formally adjudicate the indebtedness or to proceed with collection and recovery if the department becomes aware of facts that merit further recovery efforts.

[PL 2019, c. 659, Pt. D, §5 (AMD).]

8. Rulemaking. The department may adopt or amend any rule as necessary to implement this section.

[PL 1991, c. 568, §4 (NEW).]

9. Cost-of-care overpayments. On or before June 30, 2015, the department shall collect the total amount of debt arising from cost-of-care overpayments that exceeds by $4,000,000 the amount of that

debt that had been budgeted for fiscal year 2014-15 as of April 15, 2014. To the extent necessary to meet this requirement, the department may establish payment terms, modify as otherwise permitted by law existing payment agreements to accelerate payment terms and offset current payments in accordance with subsection 5. If 7 days' notice and opportunity to comment are provided, the department may adopt rules on an emergency basis to modify its implementation of subsection 5 on an emergency basis for purposes of collecting cost-of-care overpayments without making the emergency findings otherwise required by Title 5, section 8054, subsection 2.
[PL 2013, c. 594, §2 (NEW).]

10. No imposition of liability on other persons. The department may not by any means, including without limitation any rule or any contract or agreement with a provider, impose liability for a debt under this section on any person other than the provider notified of the debt pursuant to subsection 2 or a person subject to collection by offset pursuant to rules adopted under subsection 5. This subsection does not prohibit the department from seeking recovery of civil penalties from any person as provided in section 15.
[PL 2017, c. 442, §2 (NEW).]

SECTION HISTORY

PL 1991, c. 9, §G4 (NEW). PL 1991, c. 568, §§1-4 (AMD). PL 2001, c. 596, §§B3,4 (AMD). PL 2001, c. 596, §B25 (AFF). PL 2003, c. 419, §§4,5 (AMD). PL 2003, c. 673, §YYY1 (AMD). RR 2007, c. 2, §8 (COR). PL 2007, c. 466, Pt. A, §42 (AMD). PL 2007, c. 539, Pt. OO, §1 (AMD). PL 2011, c. 542, Pt. A, §27 (AMD). PL 2011, c. 687, §§5-8 (AMD). PL 2013, c. 594, §2 (AMD). PL 2017, c. 442, §§1, 2 (AMD). PL 2019, c. 659, Pt. D, §5 (AMD).

§1714-B. Critical access hospital reimbursement

(REPEALED)

SECTION HISTORY

PL 2005, c. 12, §ZZZ1 (NEW). PL 2005, c. 342, §1 (AMD). PL 2005, c. 342, §2 (AFF). PL 2005, c. 519, §PP1 (AMD). PL 2009, c. 213, Pt. CC, §1 (AMD). MRSA T. 22 §1714-B (RP).

§1714-C. Critical access hospital staff enhancement reimbursement

From April 1, 2011 to December 31, 2024, the department shall reimburse critical access hospitals from the total allocated from hospital tax revenues under Title 36, chapter 377 at least $1,000,000 in state and federal funds to be distributed annually among critical access hospitals for staff enhancement payments. [PL 2023, c. 643, Pt. LL, §1 (AMD).]

SECTION HISTORY

PL 2009, c. 213, Pt. CC, §2 (NEW). PL 2011, c. 548, §8 (AMD). PL 2023, c. 643, Pt. LL, §1 (AMD).

§1714-D. Critical access hospital reimbursement

From April 1, 2012 to December 31, 2024, the department shall reimburse licensed critical access hospitals at 109% of MaineCare allowable costs for both inpatient and outpatient services provided to patients covered by the MaineCare program. Beginning January 1, 2025, the department shall reimburse licensed critical access hospitals at 104.5% of MaineCare allowable costs for both inpatient and outpatient services provided to patients covered by the MaineCare program. [PL 2023, c. 643, Pt. LL, §2 (AMD); PL 2023, c. 643, Pt. LL, §3 (AFF).]

REVISOR'S NOTE: §1714-D. Credible allegations of fraud; provider payment suspensions (As enacted by PL 2011, c. 687, §9 is REALLOCATED TO TITLE 22, SECTION 1714-E)

SECTION HISTORY

RR 2011, c. 2, §25 (RAL). PL 2011, c. 657, Pt. H, §1 (NEW). PL 2011, c. 657, Pt. H, §5 (AFF). PL 2011, c. 687, §9 (NEW). PL 2023, c. 643, Pt. LL, §2 (AMD). PL 2023, c. 643, Pt. LL, §3 (AFF).

§1714-E. Credible allegations of fraud; provider payment suspensions

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

(WHOLE SECTION TEXT EFFECTIVE UNTIL CONTINGENCY: See T. 22, §1714-E, sub-§7)

(REALLOCATED FROM TITLE 22, SECTION 1714-D)

(WHOLE SECTION TEXT REPEALED ON CONTINGENCY: See T. 22, §1714-E, sub-§7)

If the department determines that there is a credible allegation of fraud by a provider under the MaineCare program, the following procedures apply. [RR 2011, c. 2, §25 (RAL).]

1. Suspension of payments. The department shall suspend payment in whole or in part to a MaineCare provider when a suspension is necessary to comply with Section 6402(h)(2) of the federal Patient Protection and Affordable Care Act, Public Law 111-148 and 42 Code of Federal Regulations, Part 455.
[PL 2015, c. 329, Pt. A, §5 (AMD).]

2. Administrative appeal; scope. A MaineCare provider may administratively appeal the department's decision to suspend payment under subsection 1.
[RR 2011, c. 2, §25 (RAL).]

3. No stay during administrative appeal. A suspension of payments under subsection 1 may not be stayed during an administrative appeal of the department's decision to suspend payment. The department may provide a fair opportunity for appropriate expedited relief from a suspension of payments consistent with federal law.
[RR 2011, c. 2, §25 (RAL).]

4. Final determination; offset. Upon a final determination that fraud has occurred and that money is owed by the MaineCare provider to the department, and 31 days after exhaustion of all administrative appeals and any judicial review available under Title 5, chapter 375, the department may retain and apply as an offset to amounts determined to be owed to the department any payments to the provider that were suspended by the department pursuant to this section. The amount retained pursuant to this subsection may not exceed the amount determined finally to be owed.
[RR 2011, c. 2, §25 (RAL).]

5. Confidentiality. Except as necessary for purposes of the investigation of fraud or the administration of the MaineCare program, the department's records regarding a determination of a credible allegation of fraud are confidential until the relevant MaineCare provider has been given notice of a suspension of payments under subsection 1.
[RR 2011, c. 2, §25 (RAL).]

6. Rules. The department shall adopt rules to implement this section, including rules to define "credible allegation of fraud" and to provide exception and appeal procedures as required by and in accordance with the requirements of federal law and regulations. If the department provides a procedure for expedited relief from suspension of payments, as authorized in subsection 3, the rules must include that procedure. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[RR 2011, c. 2, §25 (RAL).]

7. Repeal. This section is repealed if Section 6402(h)(2) of the federal Patient Protection and Affordable Care Act, Public Law 111-148 and 42 Code of Federal Regulations, Part 455 are invalidated by the United States Supreme Court. The department shall notify the Secretary of State, the Secretary

of the Senate, the Clerk of the House of Representatives and the Revisor of Statutes if the section of law and the regulation are invalidated.
[PL 2015, c. 494, Pt. C, §1 (AMD).]

SECTION HISTORY

RR 2011, c. 2, §25 (RAL). PL 2015, c. 329, Pt. A, §5 (AMD). PL 2015, c. 494, Pt. C, §1 (AMD).

§1715. Access requirements applicable to certain health care providers

1. Access requirements. Any person, including, but not limited to an affiliated interest as defined in former section 396-L, that is subject to the requirements of this subsection, shall provide the services listed in paragraph C to individuals who are eligible for charity care in accordance with a charity care policy adopted by the affiliate or provider that is consistent with rules applicable to hospitals under section 1716. A person is subject to this subsection if that person:

A. Is either a direct provider of major ambulatory service, as defined in former section 382, subsection 8-A, or is or has been required to obtain a certificate of need under section 329 or former section 304 or 304-A; [PL 2017, c. 475, Pt. A, §29 (AMD).]

B. Provides outpatient services as defined in former section 382, subsection 9-A; and [PL 2017, c. 475, Pt. A, §29 (AMD).]

C. Provides one or more of the following services:

(1) Imaging services, including, but not limited to, magnetic resonance imaging, computerized tomography, mammography and radiology. For purposes of this section, imaging services do not include:

(a) Screening procedures that are not related to the diagnosis or treatment of a specific condition; or

(b) Services when:

(i) The services are owned by a community health center, a physician or group of physicians;

(ii) The services are offered solely to the patients of that center, physician or group of physicians; and

(iii) Referrals for the purpose of performing those services are not accepted from other physicians;

(2) Laboratory services performed by a hospital or by a medical laboratory licensed in accordance with the Maine Medical Laboratory Commission, or licensed by an equivalent out-of-state licensing authority, excluding those licensed laboratories owned by community health centers, a physician or group of physicians where the laboratory services are offered solely to the patients of that center, physician or group of physicians;

(3) Cardiac diagnostic services, including, but not limited to, cardiac catheterization and angiography but excluding electrocardiograms and electrocardiograph stress testing;

(4) Lithotripsy services;

(5) Services provided by free-standing ambulatory surgery facilities certified to participate in the Medicare program; or

(6) Any other service performed in an out-patient setting requiring the purchase of medical equipment costing in the aggregate $500,000 or more and for which the charge per unit of service is $250 or more. [PL 1989, c. 919, §15 (NEW); PL 1989, c. 919, §18 (AFF).]
[PL 2017, c. 475, Pt. A, §29 (AMD).]

2. Enforcement. The requirements of subsection 1 are enforced through the following mechanisms.

A. Any person who knowingly violates any provision of this section or any valid order or rule made or adopted pursuant to section 1716, or who willfully fails, neglects or refuses to perform any of the duties imposed under this section, commits a civil violation for which a forfeiture of not less than $200 and not more than $500 per patient may be adjudged with respect to each patient denied access unless specific penalties are elsewhere provided. Any forfeiture imposed under this section may not exceed $5,000 in the case of the first judgment under this section against the provider, $7,500 in the case of a 2nd judgment against the provider or $10,000 in the case of the 3rd or subsequent judgment against the provider. The Attorney General is authorized to prosecute the civil violations. [PL 1995, c. 653, Pt. B, §6 (AMD); PL 1995, c. 653, Pt. B, §8 (AFF); PL 1995, c. 696, Pt. A, §35 (AMD).]

B. Upon application of the Attorney General or any affected patient, the Superior Court or District Court has full jurisdiction to enforce the performance by providers of health care of all duties imposed upon them by this section and any valid rules adopted pursuant to section 1716. [PL 1995, c. 653, Pt. B, §6 (AMD); PL 1995, c. 653, Pt. B, §8 (AFF); PL 1995, c. 696, Pt. A, §35 (AMD).]

C. In any civil action under this section, the court, in its discretion, may allow the prevailing party, other than the Attorney General, reasonable attorney's fees and costs and the Attorney General is liable for attorney's fees and costs in the same manner as a private person. [PL 1989, c. 919, §15 (NEW); PL 1989, c. 919, §18 (AFF).]

D. It is an affirmative defense to any legal action brought under this section that the person subject to this section denied access to services on the grounds that the economic viability of the facility or practice would be jeopardized by compliance with this section. [PL 1989, c. 919, §15 (NEW); PL 1989, c. 919, §18 (AFF).]

[PL 1995, c. 653, Pt. B, §6 (AMD); PL 1995, c. 653, Pt. B, §8 (AFF); PL 1995, c. 696, Pt. A, §35 (AMD).]

SECTION HISTORY

PL 1989, c. 919, §§15,18 (NEW). PL 1995, c. 653, §§B5,6 (AMD). PL 1995, c. 653, §B8 (AFF). PL 1995, c. 696, §§A34,35 (AMD). RR 2001, c. 2, §A34 (COR). PL 2017, c. 475, Pt. A, §29 (AMD).

§1716. Charity care guidelines

The department shall adopt reasonable guidelines for policies to be adopted and implemented by hospitals with respect to the provision of health care services to patients who are determined unable to pay for the services received. The department shall adopt income guidelines that are consistent with the guidelines applicable to the Hill-Burton Program established under 42 United States Code, Section 291, et seq. (1995). The guidelines and policies must include the requirement that upon admission or, in cases of emergency admission, before discharge of a patient, hospitals must investigate the coverage of the patient by any insurance or state or federal programs of medical assistance. The guidelines must include provisions for notice to the public and the opportunity for a fair hearing regarding eligibility for charity care. [PL 1995, c. 653, Pt. B, §7 (NEW); PL 1995, c. 653, Pt. B, §8 (AFF); PL 1995, c. 696, Pt. A, §36 (NEW).]

SECTION HISTORY

PL 1995, c. 653, §B7 (NEW). PL 1995, c. 653, §B8 (AFF). PL 1995, c. 696, §A36 (NEW).

§1717. Licensing of personal care agencies

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

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

A. "Activities of daily living" means tasks that are routinely performed by an individual to maintain bodily function, including, but not limited to, mobility; transfers in position among sitting, standing and prone positions; dressing; eating; toileting; bathing; and personal hygiene assistance. [PL 1997, c. 716, §1 (NEW).]

A-1. "Direct access" means access to the property, personally identifiable information, financial information or resources of an individual or physical access to an individual who is a Medicare or Medicaid beneficiary or other individual served by a provider subject to this chapter. [PL 2015, c. 196, §1 (NEW); PL 2015, c. 299, §1 (NEW).]

A-2. "Direct access personnel" means individuals employed in positions that have direct access. [PL 2015, c. 196, §1 (NEW); PL 2015, c. 299, §1 (NEW).]

A-3. "Direct care worker" means an individual who by virtue of employment generally provides to individuals direct contact assistance with personal care or activities of daily living or has direct access to provide care and services to clients, patients or residents regardless of setting. "Direct care worker" does not include a certified nursing assistant employed in that person's capacity as a certified nursing assistant. [PL 2015, c. 196, §1 (NEW); PL 2015, c. 299, §1 (NEW).]

B. "Hires and employs" means recruits, selects, trains, declares competent, schedules, directs, defines the scope of the positions of, supervises or terminates individuals who provide personal care. [PL 1997, c. 716, §1 (NEW).]

B-1. "Home care services" means assistance with activities of daily living and related tasks. [PL 2007, c. 324, §2 (NEW).]

C. "Personal care agency" means a business entity or subsidiary of a business entity that is licensed by the department's division of licensing and certification and that hires and employs direct access personnel or individuals who work in direct contact with clients, patients or residents to provide home care services to individuals in the places in which they reside, either permanently or temporarily. An individual who hires and employs direct access personnel or individuals who work in direct contact with clients, patients or residents to provide care for that individual is not a personal care agency, except when permitted by rule of the department. "Personal care agency" does not include a home health care provider licensed under chapter 419. [PL 2023, c. 309, §2 (AMD).]

C-1. [PL 2023, c. 309, §3 (RP).]

D. [PL 2015, c. 196, §3 (RP); PL 2015, c. 299, §3 (RP).]

[PL 2023, c. 309, §§2, 3 (AMD).]

2. (TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25) Registration of personal care agencies. Until June 30, 2024, a personal care agency not otherwise licensed by the department shall register with the department. The department shall adopt rules establishing the annual registration fee, which must be between $25 and $250. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

This subsection is repealed July 1, 2025.

[PL 2023, c. 309, §4 (AMD).]

2-A. Licensing of personal care agencies. Beginning July 1, 2024, an entity may not provide home care services without a personal care agency license issued by the department in accordance with this section. All application fees for a license under this section are nonrefundable and are due upon submission of the application.

A. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** A personal care agency that holds an unexpired registration issued in accordance with subsection 2 may continue to provide home care services until the registration expires.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §5 (NEW).]

B. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** A personal care agency holding an unexpired registration issued in accordance with subsection 2 is not required to obtain a license until the registration expires.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §5 (NEW).]
[PL 2023, c. 309, §5 (NEW).]

2-B. Licensing standards for personal care agencies. The department shall adopt rules to establish standards and fees for the licensing of personal care agencies. The licensing standards must include, but are not limited to:

A. General licensing requirements; [PL 2023, c. 309, §6 (NEW).]

B. Quality measures; [PL 2023, c. 309, §6 (NEW).]

C. Personnel qualifications; [PL 2023, c. 309, §6 (NEW).]

D. Mandatory and minimum training requirements; [PL 2023, c. 309, §6 (NEW).]

E. Home care services; [PL 2023, c. 309, §6 (NEW).]

F. Services provided and coordination of services; [PL 2023, c. 309, §6 (NEW).]

G. Supervision and organizational structure, including lines of authority; [PL 2023, c. 309, §6 (NEW).]

H. Record-keeping and confidentiality practices; [PL 2023, c. 309, §6 (NEW).]

I. Business records requirements; [PL 2023, c. 309, §6 (NEW).]

J. Licensing fees that are no less than $200 and no more than $2,000; and [PL 2023, c. 309, §6 (NEW).]

K. Other aspects of services provided by a personal care agency that may be necessary to protect the public. [PL 2023, c. 309, §6 (NEW).]

Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2023, c. 309, §6 (NEW).]

2-C. Types of licenses; terms. Pursuant to subsection 2-A, the department may issue licenses to personal care agencies in accordance with this subsection. The department may issue:

A. A provisional license for an applicant that:

(1) Has not previously operated as a personal care agency;

(2) Complies with all applicable laws and rules, except those that can only be complied with once clients, patients or residents are served by the applicant; and

(3) Demonstrates the ability to comply with all applicable laws and rules by the end of the provisional license term.

A provisional license may be issued for a period of time of at least 3 months and not more than 12 months; [PL 2023, c. 309, §7 (NEW).]

B. A full license for an applicant that has operated a personal care agency or for an applicant renewing a license that complies with all applicable laws and rules. A full license may be issued for a period of time not more than 24 months; and [PL 2023, c. 309, §7 (NEW).]

C. A conditional license for a personal care agency with a provisional or a full license that fails to comply with applicable laws and rules when, in the judgment of the commissioner, issuing a conditional license is in the best interest of the public. The conditional license must specify what corrections the personal care agency is required to make during the term of the conditional license and a timeline for those corrections. The conditional license may be issued for a period of time not more than 12 months or the remaining period of the personal care agency's full license, whichever the commissioner determines is appropriate considering the laws and rules violated. [PL 2023, c. 309, §7 (NEW).]

[PL 2023, c. 309, §7 (NEW).]

2-D. Licenses not assignable or transferable. A personal care agency may not assign or transfer a license issued under subsection 2-C. A license is immediately void if ownership or control of the personal care agency changes.

[PL 2023, c. 309, §8 (NEW).]

2-E. Quality assurance and technical assistance for personal care agencies. This subsection governs quality assurance and technical assistance for personal care agencies.

A. The department may conduct the following activities to ensure that quality home care services are provided by personal care agencies:

(1) Issue notices of deficiency for a personal care agency's failure to comply with applicable federal or state laws, rules or regulations;

(2) Require personal care agencies to submit acceptable plans of corrective action to remedy deficiencies identified under subparagraph (1);

(3) Direct personal care agencies to comply with plans of corrective action issued under subparagraph (2);

(4) Apply sanctions in accordance with subsection 13-A, paragraph A, subparagraph (5); or

(5) Condition, suspend, revoke or refuse to renew a personal care agency's license issued under subsection 2-C on the basis of the agency's noncompliance with plans of corrective action. [PL 2023, c. 309, §9 (NEW).]

B. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** The provisions of paragraph A apply to a personal care agency that holds a registration during the time the registration is in effect.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §9 (NEW).]

The department shall adopt rules to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2023, c. 309, §9 (NEW).]

3. Prohibited employment based on disqualifying offenses. A personal care agency shall conduct a comprehensive background check for direct access personnel and immediate supervisors of direct access personnel in accordance with state law and rules adopted by the department and is subject to the employment restrictions set out in section 1812-G and other applicable federal and state laws when hiring, employing or placing direct access personnel, including, but not limited to, a certified nursing assistant or a direct care worker, and immediate supervisors of direct access personnel.

A. [PL 2015, c. 196, §5 (RP); PL 2015, c. 299, §5 (RP).]

B. [PL 2015, c. 196, §5 (RP); PL 2015, c. 299, §5 (RP).]

C. [PL 2015, c. 196, §5 (RP); PL 2015, c. 299, §5 (RP).]

[PL 2023, c. 309, §10 (AMD).]

3-A. Verification of listing on the registry. Prior to hiring a certified nursing assistant, a direct care worker or an immediate supervisor of a certified nursing assistant or direct care worker, a personal care agency shall check the Maine Registry of Certified Nursing Assistants and Direct Care Workers established pursuant to section 1812-G and verify that the certified nursing assistant, direct care worker or immediate supervisor of a certified nursing assistant or direct care worker listed on the registry has no disqualifying notations.

The department may adopt rules necessary to implement this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2023, c. 309, §11 (AMD).]

4. Penalties. The following penalties apply to violations of this section.

A. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** An entity that operates a personal care agency without registering with the department as required by subsection 2 commits a civil violation for which a fine of not less than $500 per day of operation but not more than $10,000 may be adjudged. Each day of violation constitutes a separate offense.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §12 (AMD).]

A-1. An entity that operates a personal care agency without obtaining a license from the department as required by subsection 2-A commits a civil violation for which a fine of not less than $500 per day of operation but not more than $10,000 may be adjudged. Each day of violation constitutes a separate offense. [PL 2023, c. 309, §12 (NEW).]

B. An entity that operates a personal care agency in violation of the employment prohibitions in subsection 3 or 3-A commits a civil violation for which a fine of not less than $500 per day of operation in violation but not more than $10,000 per day may be adjudged, beginning on the first day that a violation occurs. Each day of violation constitutes a separate offense. [PL 2023, c. 309, §12 (AMD).]
[PL 2023, c. 309, §12 (AMD).]

5. Injunctive relief. Notwithstanding any other remedies provided by law, the Office of the Attorney General may seek an injunction to require compliance with the provisions of this section.
[PL 2007, c. 324, §2 (NEW).]

6. Enforcement actions by the Office of the Attorney General. The Office of the Attorney General may file a complaint with the District Court seeking civil penalties or injunctive relief or both for violations of this section.
[PL 2023, c. 309, §13 (AMD).]

7. Jurisdiction. The District Court has jurisdiction pursuant to Title 4, section 152 for violations of this section.
[PL 2007, c. 324, §2 (NEW).]

8. Burden of proof. The burden is on the department to prove, by a preponderance of the evidence, that the alleged violations of this section occurred.
[PL 2007, c. 324, §2 (NEW).]

9. Right of entry. This subsection governs the department's right of entry.

A. An application for licensure of a personal care agency constitutes permission for entry and inspection to verify compliance with applicable laws and rules. [PL 2023, c. 309, §14 (AMD).]

B. The department has the right to enter and inspect the premises of a personal care agency licensed by the department at a reasonable time and, upon demand, has the right to inspect and copy any books, accounts, papers, records and other documents in order to determine the state of compliance with applicable laws and rules. [PL 2023, c. 309, §14 (AMD).]

C. To inspect a personal care agency that the department knows or believes is being operated without being licensed, the department may enter only with the permission of the owner or person in charge or with an administrative inspection warrant issued pursuant to the Maine Rules of Civil Procedure, Rule 80E by the District Court authorizing entry and inspection. [PL 2023, c. 309, §14 (AMD).]

D. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** The provisions of paragraphs A, B and C apply to a personal care agency that holds, is applying for or does not hold a registration during the time registration may be required.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §14 (NEW).]
[PL 2023, c. 309, §14 (AMD).]

10. Administrative inspection warrant. This subsection governs administrative inspection warrants.

A. The department and a duly designated officer or employee of the department have the right to enter upon and into the premises of an unlicensed personal care agency with an administrative inspection warrant issued pursuant to the Maine Rules of Civil Procedure, Rule 80E by the District Court at a reasonable time and, upon demand, have the right to inspect and copy any books, accounts, papers, records and other documents in order to determine the state of compliance with this section. The right of entry and inspection may extend to any premises and documents of a person, firm, partnership, association, corporation or other entity that the department has reason to believe is operating without being licensed. [PL 2023, c. 309, §15 (NEW).]

B. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** The provisions of paragraph A apply to a personal care agency that does not hold a registration during the time registration may be required.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §15 (NEW).]
[PL 2023, c. 309, §15 (RPR).]

11. Noninterference. This subsection prohibits interfering with department investigations.

A. An owner or operator of an unlicensed personal care agency may not interfere with, impede or obstruct an investigation by the department, including but not limited to interviewing persons receiving home care services or persons with knowledge of the agency. [PL 2023, c. 309, §16 (NEW).]

B. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** The provisions of paragraph A apply to an owner or operator of a personal care agency that does not hold a registration during the time registration may be required.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §16 (NEW).]
[PL 2023, c. 309, §16 (RPR).]

12. Violation of injunction. A person, firm, partnership, association, corporation or other entity that violates the terms of an injunction issued under this section shall pay to the State a fine of not less than $500 nor more than $10,000 for each violation. Each day of violation constitutes a separate offense. In any action brought by the Office of the Attorney General against a person, firm, partnership, association, corporation or other entity for violating the terms of an injunction under this section, the District Court may make the necessary orders or judgments regarding violation of the terms of the injunction.

In an action under this section, when a permanent injunction has been issued, the District Court may order the person, firm, partnership, association, corporation or other entity against which the permanent injunction is issued to pay to the General Fund the costs of the investigation of that person, firm,

partnership, association, corporation or other entity by the Office of the Attorney General and the costs of suit, including attorney's fees.
[PL 2007, c. 324, §2 (NEW).]

13. Suspension or revocation. This subsection governs suspension or revocation of licenses for personal care agencies.

A. A personal care agency found to be in violation of this section may have its license to operate as a personal care agency suspended or revoked. The department may file a complaint with the District Court requesting suspension or revocation of a license to operate a personal care agency. [PL 2023, c. 309, §17 (NEW).]

B. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** The provisions of paragraph A apply to a personal care agency that holds a registration during the time the registration is in effect.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §17 (NEW).]
[PL 2023, c. 309, §17 (RPR).]

13-A. Enforcement actions by the department. This subsection governs the department's enforcement authority.

A. If a personal care agency fails to comply with applicable laws and rules, the department may:

(1) Refuse to issue or renew a license;

(2) Issue a conditional license in accordance with subsection 2-C;

(3) File a complaint with the District Court in accordance with Title 4, section 184 or the Maine Administrative Procedure Act to suspend or revoke a license pursuant to subsection 13;

(4) Petition the Superior Court to appoint a receiver to operate the personal care agency in accordance with chapter 1666-A; and

(5) Impose one or more of the following sanctions as necessary and appropriate to ensure compliance with applicable laws and rules or to protect an individual served by the personal care agency:

(a) Direct a personal care agency to stop admissions or intake of new clients, patients or residents regardless of payment source, until the department determines that the personal care agency has taken corrective action;

(b) Direct a personal care agency to correct any deficiencies in a manner and within a time frame that the department determines appropriate to ensure compliance with applicable laws and rules or to protect an individual served by a personal care agency; or

(c) In addition to, or in lieu of, the penalties imposed pursuant to subsection 4, impose a penalty upon a personal care agency for a violation of this section or rules adopted pursuant to this section. The department shall by rule establish a schedule of penalties according to the nature of the violation that are no less than $500 per day of operation but not more than $10,000 per day. Each day of a violation constitutes a separate offense. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2023, c. 309, §18 (NEW).]

B. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** The provisions of paragraph A apply to a personal care agency that holds, is applying for or does not hold a registration during the time registration may be required.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §18 (NEW).]

The department shall engage in monitoring activities on at least a biennial basis to ensure that a personal care agency, regardless of its licensure status, is in compliance with applicable laws and rules. [PL 2023, c. 309, §18 (NEW).]

13-B. Appeals. This subsection governs appeals of certain department decisions.

A. An entity aggrieved by the department's decisions on any of the following actions may request an administrative hearing as provided by the Maine Administrative Procedure Act:

(1) Denial of or refusal to renew a full license;

(2) Denial of a provisional license;

(3) Issuance of a conditional license;

(4) Amendment or modification of a license; or

(5) Imposition of sanctions. [PL 2023, c. 309, §19 (NEW).]

B. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** The provisions of paragraph A apply to a registration during the time the registration is in effect.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §19 (NEW).]
[PL 2023, c. 309, §19 (NEW).]

14. Rules. The department may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2007, c. 324, §2 (NEW).]

15. Confidentiality of records. This subsection governs confidentiality.

A. A department record that contains personally identifiable information or health information of clients, patients or residents created or obtained in connection with the department's licensing or quality assurance activities under this section is confidential. [PL 2023, c. 309, §20 (NEW).]

B. **(TEXT EFFECTIVE UNTIL 7/1/25) (TEXT REPEALED 7/1/25)** The provisions of paragraph A apply to a department record that contains personally identifiable information or health information of clients, patients or residents created or obtained in connection with the department's registration activities.

This paragraph is repealed July 1, 2025. [PL 2023, c. 309, §20 (NEW).]
[PL 2023, c. 309, §20 (NEW).]

SECTION HISTORY

PL 1997, c. 716, §1 (NEW). PL 2003, c. 634, §§1,2 (AMD). PL 2003, c. 673, §NN1 (AMD). PL 2007, c. 324, §2 (AMD). PL 2011, c. 257, §1 (AMD). PL 2015, c. 196, §§1-7 (AMD). PL 2015, c. 299, §§1-7 (AMD). PL 2015, c. 494, Pt. A, §15 (AMD). PL 2023, c. 309, §§1-20 (AMD).

§1718. Consumer information

Each hospital or ambulatory surgical center licensed under chapter 405 shall, upon request by an individual, provide the average charge for any inpatient service or outpatient procedure provided by the licensee. If a single medical encounter will involve services or procedures to be rendered by one or more 3rd-party health care entities as defined in section 1718-B, subsection 1, paragraph B, the hospital or ambulatory surgical center shall identify each 3rd-party health care entity to enable the individual to seek an estimate of the total price of services or procedures to be rendered directly by each health care entity to that individual. For emergency services, the hospital must provide the average charges for facility and physician services according to the level of emergency services provided by the hospital and based on the time and intensity of services provided. The hospital or ambulatory surgical center shall prominently display a notice informing individuals of an individual's authority to request

information on the average charges described in this paragraph from the hospital or ambulatory surgical center. [PL 2013, c. 560, §1 (AMD).]

1. Inpatient services.
[PL 2009, c. 71, §3 (RP).]

2. Outpatient nonemergent procedures.
[PL 2009, c. 71, §3 (RP).]

3. Emergency services.
[PL 2009, c. 71, §3 (RP).]

SECTION HISTORY

RR 2003, c. 1, §16 (COR). PL 2003, c. 469, §C15 (NEW). PL 2005, c. 391, §1 (AMD). PL 2009, c. 71, §3 (RPR). PL 2013, c. 560, §1 (AMD).

§1718-A. Consumer information regarding health care practitioner prices

(REPEALED)

SECTION HISTORY

PL 2013, c. 332, §1 (NEW). PL 2013, c. 332, §3 (AFF). PL 2013, c. 515, §1 (RP).

§1718-B. Consumer information regarding health care entity prices

This section applies to the disclosure of health care prices by a health care entity. [PL 2013, c. 515, §2 (NEW).]

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

A. "Frequently provided health care services and procedures" means those health care services and procedures that were provided by the health care entity at least 50 times in the preceding calendar year. [PL 2013, c. 515, §2 (NEW).]

A-1. "Facility fee" means a fee charged or billed by a health care entity for outpatient services provided in a hospital-based facility that is:

(1) Intended to compensate the hospital or health system for the operational expenses of the hospital or health system; and

(2) Separate and distinct from a professional fee. [PL 2023, c. 672, §1 (NEW).]

B. "Health care entity" means a health care practitioner, as defined in section 1711-C, subsection 1, paragraph F; a group of health care practitioners; or a health care facility, as defined in section 1711-C, subsection 1, paragraph D, that charges patients for health care services and procedures. A health care entity does not include a pharmacy or a pharmacist. [PL 2013, c. 515, §2 (NEW).]

C. "Hospital-based facility" means a facility that is owned or operated, in whole or in part, by a hospital or health system where hospital services or professional medical services are provided. [PL 2023, c. 672, §2 (NEW).]

D. "Professional fee" means a fee charged or billed by a health care entity for professional medical services provided in a hospital-based facility. [PL 2023, c. 672, §3 (NEW).]
[PL 2023, c. 672, §§1-3 (AMD).]

2. Requirements. The following requirements apply to health care entities.

A. A health care entity shall have available to patients the prices of the health care entity's most frequently provided health care services and procedures. The prices stated must be the prices that the health care entity charges patients directly when there is no insurance coverage for the services

or procedures or when reimbursement by an insurance company is denied. The prices stated must be accompanied by descriptions of the services and procedures and the applicable standard medical codes or current procedural technology codes used by the American Medical Association. [PL 2013, c. 515, §2 (NEW).]

B. A health care entity shall inform patients about the availability of prices for the most frequently provided health care services and procedures and the right of a patient to request information about the price of medical services pursuant to section 1718-C, subsection 1 or 2 by posting a notice on prominent display to patients. [PL 2023, c. 584, Pt. A, §1 (AMD).]

B-1. A health care entity shall include notice of a patient's right to request information about the price of medical services pursuant to section 1718-C, subsection 1 or 2 in any written document provided to a patient prior to rendering health care treatment for the purpose of obtaining informed consent to that treatment. [PL 2023, c. 584, Pt. A, §2 (NEW).]

C. A health care entity shall prominently display in a location that is readily accessible to patients information on the price transparency tools available from the publicly accessible website of the Maine Health Data Organization established pursuant to chapter 1683 to assist consumers with obtaining estimates of costs associated with health care services and procedures. [PL 2013, c. 515, §2 (NEW).]

D. Beginning January 1, 2018, at the time a referral or recommendation is made for a comparable health care service as defined in Title 24-A, section 4318-A, subsection 1, paragraph A during an in-person visit, the health care entity making that referral or recommendation shall notify a patient who has private health insurance coverage of the patient's right to obtain services from a different provider. A health care entity shall comply with this paragraph by providing a written notice at the time the health care entity recommends or refers a patient for a health care service or procedure that may qualify as a comparable health care service. A written notice provided under this paragraph must include a notification that, prior to obtaining the recommended service, the patient may review the health care price transparency tool provided by the patient's carrier or contact the patient's carrier directly via a toll-free telephone number so that the patient may consider whether the recommended provider of the comparable health care service represents the best value for the patient. A written notice provided under this paragraph must also include a description of the service or the applicable standard medical codes or current procedural terminology codes used by the American Medical Association sufficient to allow the carrier to assist the patient in comparing prices for the comparable health care service. [PL 2017, c. 232, §1 (NEW).]

E. A health care entity shall prominently display in a location that is readily accessible to a patient, including a patient waiting area, and on the health care entity's publicly accessible website the following information:

(1) Whether the health care entity is a hospital-based facility and, if so, the name of the hospital or health system and whether the health care entity charges a facility fee; and

(2) How to access the publicly accessible website of the Maine Health Data Organization established pursuant to chapter 1683 for educational materials about facility fees and whether and under what circumstances depending on payor and type of service a facility fee may be charged. [PL 2023, c. 672, §4 (NEW).]

A health care entity that does not routinely render services directly to patients in an office setting may satisfy this subsection by providing the information on its publicly accessible website.
[PL 2023, c. 584, Pt. A, §§1, 2 (AMD); PL 2023, c. 672, §4 (AMD).]

SECTION HISTORY

PL 2013, c. 515, §2 (NEW). PL 2017, c. 232, §1 (AMD). PL 2023, c. 584, Pt. A, §§1, 2 (AMD). PL 2023, c. 672, §§1-4 (AMD).

§1718-C. Patient request for good faith estimate or other information related to price of medical services

1. Uninsured or self-pay patient; good faith estimate. Upon the request of an uninsured or self-pay patient, a health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall provide to the patient a good faith estimate of the total price of medical services to be rendered directly by that health care entity during a single medical encounter as follows.

A. The health care entity shall provide the good faith estimate within the following time frames:

(1) When the medical encounter is scheduled at least 3 business days before the date the medical encounter is scheduled to be furnished or when the patient is seeking urgent care as defined in Title 24-A, section 4301-A, subsection 21, the estimate must be provided no later than one business day after the date of scheduling or the date of the request if the patient is seeking urgent care;

(2) When the medical encounter is scheduled at least 10 business days before the encounter is scheduled to be furnished, the estimate must be provided no later than 3 business days after the date of scheduling; or

(3) In all other circumstances, the estimate must be provided no later than 3 business days after the date of the request. [PL 2023, c. 584, Pt. A, §3 (NEW).]

B. If the health care entity is unable to provide an accurate estimate of the total price of a specific medical service because the amount of the medical service to be rendered during the medical encounter is unknown in advance, the health care entity shall provide a brief description of the basis for determining the total price of that particular medical service. [PL 2023, c. 584, Pt. A, §3 (NEW).]

C. If the single medical encounter will involve medical services to be rendered by one or more 3rd-party health care entities, the health care entity shall identify each 3rd-party health care entity to enable the uninsured patient to seek an estimate of the total price of medical services to be rendered directly by each health care entity to that patient. [PL 2023, c. 584, Pt. A, §3 (NEW).]

D. A good faith estimate must separately disclose the prices for each component of medical services, including any facility fees or fees for professional services, and the current procedural terminology codes used by the American Medical Association for those services. [PL 2023, c. 584, Pt. A, §3 (NEW).]

E. When providing an estimate as required by this subsection, the health care entity shall also notify the uninsured patient of any financial assistance policy adopted by the health care entity and the availability of public or private health care coverage. [PL 2023, c. 584, Pt. A, §3 (NEW).]

F. Notwithstanding other provisions of this subsection, a health care entity does not violate this subsection if it provides a good faith estimate to the patient in compliance with federal regulations. [PL 2023, c. 584, Pt. A, §3 (NEW).]

[PL 2023, c. 584, Pt. A, §3 (NEW).]

2. Insured patient; description of medical services and current procedural terminology codes. Upon the request of an insured patient, a health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall provide to the patient a description of the medical services to be rendered directly by that health care entity during a single medical encounter and the applicable standard medical codes or current procedural terminology codes used by the American Medical Association for those services as follows.

A. The health care entity shall comply with the request within the following time frames:

(1) When the medical encounter is scheduled at least 3 business days before the date the medical encounter is scheduled to be furnished or when the patient is seeking urgent care as

defined in Title 24-A, section 4301-A, subsection 21, the health care entity must respond no later than one business day after the date of scheduling or the date of the request if the patient is seeking urgent care;

(2) When the medical encounter is scheduled at least 10 business days before the encounter is scheduled to be furnished, the health care entity must respond no later than 3 business days after the date of scheduling; or

(3) In all other circumstances, the health care entity must respond no later than 3 business days after the date of the request. [PL 2023, c. 584, Pt. A, §3 (NEW).]

B. If the single medical encounter will involve medical services to be rendered by one or more 3rd-party health care entities, the health care entity shall identify each 3rd-party health care entity to enable the patient to seek a description of the medical services to be rendered directly by that 3rd-party health care entity to that patient and the applicable standard medical codes or current procedural terminology codes used by the American Medical Association for those services. [PL 2023, c. 584, Pt. A, §3 (NEW).]

C. The health care entity shall also notify the patient that the patient may use the information provided to request an estimate of the out-of-pocket costs expected to be paid by the patient from the patient's health insurance carrier. [PL 2023, c. 584, Pt. A, §3 (NEW).]

D. When providing the information required by this subsection, the health care entity shall also notify the insured patient of any financial assistance policy adopted by the health care entity and the availability of other public or private health insurance coverage. [PL 2023, c. 584, Pt. A, §3 (NEW).]

E. Notwithstanding this subsection, if federal regulations are implemented that set forth requirements for health care entities to provide estimates to an insured patient, a health care entity shall comply with federal regulations and does not commit a violation of this subsection. [PL 2023, c. 584, Pt. A, §3 (NEW).]

[PL 2023, c. 584, Pt. A, §3 (NEW).]

SECTION HISTORY

PL 2013, c. 560, §2 (NEW). PL 2023, c. 584, Pt. A, §3 (RPR).

§1718-D. Prohibition on balance billing for surprise bills and bills for out-of-network emergency services; disputes of bills for uninsured patients and persons covered under self-insured health benefit plans; disclosure related to referrals

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

A. "Enrollee" has the same meaning as in Title 24-A, section 4301-A, subsection 5. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

B. "Health plan" has the same meaning as in Title 24-A, section 4301-A, subsection 7. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

B-1. "Knowingly elected to obtain the services from an out-of-network provider" means that an enrollee chose the services of a specific provider, with full knowledge that the provider is an out-of-network provider with respect to the enrollee's health plan, under circumstances that indicate that the enrollee had and was informed of the opportunity to receive services from a network provider but instead selected the out-of-network provider. The disclosure by a provider of network status does not render an enrollee's decision to proceed with treatment from that provider a choice made knowingly pursuant to this paragraph. [PL 2019, c. 668, §1 (NEW).]

C. "Provider" has the same meaning as in Title 24-A, section 4301-A, subsection 16. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

D. "Surprise bill" has the same meaning as in Title 24-A, section 4303-C, subsection 1. [PL 2017, c. 218, §1 (NEW); PL 2017, c. 218, §3 (AFF).]

E. "Visit" means any interaction between an enrollee and one or more providers for the purpose of assessing the health status of an enrollee or providing one or more health care services between the time an enrollee enters a facility and the time an enrollee is discharged. [PL 2019, c. 668, §1 (NEW).]

[PL 2019, c. 668, §1 (AMD).]

2. Prohibition on balance billing. An out-of-network provider reimbursed for a surprise bill or a bill for covered emergency services under Title 24-A, section 4303-C or, if there is a dispute, under Title 24-A, section 4303-E or a bill for COVID-19 screening and testing under Title 24-A, section 4320-P may not bill an enrollee for health care services beyond the applicable coinsurance, copayment, deductible or other out-of-pocket cost expense that would be imposed for the health care services if the services were rendered by a network provider under the enrollee's health plan. For an enrollee subject to coinsurance, the out-of-network provider shall calculate the coinsurance amount based on the median network rate for that health care service under the enrollee's health plan. An out-of-network provider is also subject to the following with respect to any overpayment made by an enrollee.

A. If an out-of-network provider provides health care services covered under an enrollee's health plan and the out-of-network provider receives payment from the enrollee for health care services for which the enrollee is not responsible pursuant to this subsection, the out-of-network provider shall reimburse the enrollee within 30 calendar days after the earlier of the date that the provider received notice of the overpayment and the date the provider became aware of the overpayment. [PL 2019, c. 668, §1 (NEW).]

B. An out-of-network provider that fails to reimburse an enrollee for an overpayment as required by paragraph A shall pay interest on the overpayment at the rate of 10% per annum beginning on the earlier of the date the provider received notice of the overpayment and the date the provider became aware of the overpayment. An enrollee is not required to request the accrued interest from the out-of-network provider in order to receive interest with the reimbursement amount. [PL 2019, c. 668, §1 (NEW).]

[PL 2021, c. 28, Pt. A, §1 (AMD).]

3. Uninsured patients; disputes of bills. An uninsured patient who has received a bill for emergency services from a provider for one or more emergency health care services rendered during a single visit totaling $750 or more may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-E. The independent dispute resolution entity contracted to resolve the dispute over the surprise bill shall select either the out-of-network provider's fee or the uninsured patient's proposed payment amount in accordance with Title 24-A, section 4303-E. An uninsured patient may not be charged by a provider more than the amounts generally billed to a patient who has insurance covering emergency services as determined using the method described in 26 Code of Federal Regulations, Section 1.501(r)-5, paragraph (b)(3) or (b)(4). A provider shall hold the uninsured patient harmless for the duration of the independent dispute resolution process and may not seek payment until the independent dispute resolution process is completed. Notwithstanding Title 24-A, section 4303-E, subsection 1, paragraph F, payment for the independent dispute resolution process is the responsibility of the provider. In the event a claim includes more than one emergency health care service rendered during a single visit, the independent dispute resolution entity may allocate the prorated independent dispute resolution costs at its discretion among providers.

[PL 2019, c. 668, §1 (NEW).]

REVISOR'S NOTE: (Subsection 3 as enacted by PL 2019, c. 670, §1 is REALLOCATED TO TITLE 22, SECTION 1718-D, SUBSECTION 5)

4. Person covered under self-insured health benefit plan; disputes of surprise bills or bills for covered emergency services rendered by an out-of-network provider. A person covered under a self-insured health benefit plan that is not subject to the provisions of Title 24-A, section 4303-E pursuant to Title 24-A, section 4303-E, subsection 2 and who has received a surprise bill for emergency services or a bill for covered emergency services rendered by an out-of-network provider may dispute the bill and request resolution of the dispute using the process under Title 24-A, section 4303-E, subsection 1. The independent dispute resolution entity contracted to resolve the dispute over the bill shall select either the out-of-network provider's fee or the covered person's proposed payment amount in accordance with Title 24-A, section 4303-E, subsection 1. This subsection does not apply to a person covered under a self-insured health benefit plan who knowingly elected to obtain the services from an out-of-network provider.
[PL 2019, c. 668, §1 (NEW).]

5. (REALLOCATED FROM T. 22, §1718-D, sub-§3) Referral to an out-of-network provider. A provider receiving a nonemergency referral or self-referral for any in-person health care service or procedure shall disclose to the enrollee whether that provider to whom the enrollee is being referred is a member of the provider network under the enrollee's health plan before the enrollee schedules the appointment for that service or procedure.
[RR 2019, c. 2, Pt. A, §25 (RAL).]

SECTION HISTORY

PL 2017, c. 218, §1 (NEW). PL 2017, c. 218, §3 (AFF). PL 2019, c. 668, §1 (AMD). RR 2019, c. 2, Pt. A, §§24, 25 (COR). PL 2019, c. 670, §1 (AMD). PL 2021, c. 28, Pt. A, §1 (AMD).

§1718-E. Prohibition on fees for transferring a patient or a patient's medical records

A health care entity, as defined in section 1718-B, subsection 1, paragraph B, may not require any fee or other payment from any patient for the transfer of a patient between health care entities or for the transfer of any medical records related to a patient between health care entities unless the fee or other payment is disclosed to the patient and is directly related to the costs associated with establishing the patient as a patient of the health care entity or transferring that patient's medical records. This section does not prohibit the use of current procedural technology codes used by the American Medical Association for new office visits that include the cost of care. [PL 2019, c. 670, §2 (NEW).]

SECTION HISTORY

PL 2019, c. 670, §2 (NEW).

§1718-F. Disclosure related to observation status for Medicare patients

A health care entity, as defined in section 1718-B, subsection 1, paragraph B, shall disclose to a patient who is covered by the federal Medicare program and who is on observation status and not an admitted patient at the health care entity the following information in a single notice: [PL 2019, c. 670, §3 (NEW).]

1. Medicare outpatient observation notice. The Medicare outpatient observation notice required under 42 Code of Federal Regulations, Section 489.20(y);
[PL 2019, c. 670, §3 (NEW).]

2. Impact on patient's financial liability. Notification that observation status may have an impact on the patient's financial liability; and
[PL 2019, c. 670, §3 (NEW).]

3. Opportunity to discuss potential financial liability. Notification that the patient may meet with a representative from the health care entity's financial office to discuss the patient's potential financial liability.
[PL 2019, c. 670, §3 (NEW).]

SECTION HISTORY

PL 2019, c. 670, §3 (NEW).

§1718-G. Requirements for notice to patients of costs for COVID-19 screening and testing and prohibited charges for COVID-19 vaccination for uninsured patients

1. COVID-19 defined. For the purposes of this section, "COVID-19" has the same meaning as in Title 24-A, section 4320-P, subsection 1, paragraph A.
[PL 2021, c. 28, Pt. A, §2 (NEW).]

2. Notice of costs for COVID-19 screening and testing. A provider, as defined in Title 24-A, section 4301-A, subsection 16, shall, at the time a patient schedules or registers for screening or testing services and before providing screening or testing services for COVID-19:

A. Provide notice of any payment or upfront charge and the amount of that payment or charge that will be due from the patient for the services, including payments or charges for which the provider will submit a claim on the patient's behalf or for which the patient will need to submit a claim for reimbursement to the patient's health insurance carrier or to the department; [PL 2021, c. 28, Pt. A, §2 (NEW).]

B. To the extent applicable, provide the form for requesting coverage from the department through emergency MaineCare coverage; and [PL 2021, c. 28, Pt. A, §2 (NEW).]

C. To the extent applicable, inform any patient who will be required to make a payment or upfront charge that there are locations where COVID-19 screening and testing services are provided without such payments and that those locations are identified on the State's publicly accessible website. [PL 2021, c. 28, Pt. A, §2 (NEW).]
[PL 2021, c. 28, Pt. A, §2 (NEW).]

3. Charges to uninsured patients for COVID-19 vaccination prohibited. A provider, as defined in Title 24-A, section 4301-A, subsection 16, may not charge an uninsured patient any amount for administering a COVID-19 vaccine or any associated costs of administration.
[PL 2021, c. 28, Pt. A, §2 (NEW).]

4. Rules. The department may adopt rules to implement and administer this section to align with any applicable federal regulations. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2021, c. 28, Pt. A, §2 (NEW).]

SECTION HISTORY

PL 2021, c. 28, Pt. A, §2 (NEW).

§1718-H. Disclosure related to annual wellness visit

A health care entity, as defined in section 1718-B, subsection 1, paragraph B, at the time of an annual wellness visit by an insured patient, shall disclose to the patient that not all services provided during the course of an annual wellness visit may be covered as preventive services without any out-of-pocket costs to the patient by the patient's health plan, as defined in Title 24-A, section 4301-A, subsection 7, and that, if the patient has questions about the scope of covered services under the patient's health plan, the patient should contact the patient's health insurance carrier. [PL 2023, c. 80, §1 (NEW).]

SECTION HISTORY

PL 2023, c. 80, §1 (NEW).

§1718-I. Hospital price transparency

1. Compliance with federal regulations. A hospital must comply with the price transparency requirements established in 45 Code of Federal Regulations, Part 180, Subparts A and B, as in effect on January 1, 2024.
[PL 2023, c. 584, Pt. B, §1 (NEW).]

2. Standard format; rules. A hospital must provide price transparency data in a standardized format established in rule by the Maine Health Data Organization. The Maine Health Data Organization shall adopt by rule a standardized format for a hospital to disclose price transparency data that is the same or substantially similar to any format required by federal regulations. Rules adopted pursuant to this subsection are routine technical rules as described in Title 5, chapter 375, subchapter 2-A.
[PL 2023, c. 584, Pt. B, §1 (NEW).]

3. Failure to comply. A hospital that fails to comply with subsection 2 or any rule adopted by the Maine Health Data Organization may be subject to a fine for failure to comply under section 8705-A. Notwithstanding any provision of law to the contrary, the Maine Health Data Organization shall retain any fine collected from a hospital for a failure to comply with this section pursuant to a compliance action taken under section 8705-A.
[PL 2023, c. 584, Pt. B, §1 (NEW).]

4. Determination of material compliance; notice. Upon a determination that a hospital is not in material compliance with subsections 1 and 2, the Maine Health Data Organization shall notify the hospital that the hospital is not in material compliance and require the hospital to take corrective action within 60 days to become materially compliant. The Maine Health Data Organization shall adopt by rule standards for material compliance that align with federal regulations. Rules adopted pursuant to this subsection are routine technical rules as described in Title 5, chapter 375, subchapter 2-A.
[PL 2023, c. 584, Pt. B, §1 (NEW).]

SECTION HISTORY

PL 2023, c. 584, Pt. B, §1 (NEW).

§1718-J. Prohibition of collection actions for noncompliance with good faith estimate requirements for uninsured or self-pay patients

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

A. "Collection action" means any of the following actions:

(1) Attempting to collect a debt from a patient or patient guarantor by referring the debt directly or indirectly to a debt collector, collection agency or other 3rd party retained by or on behalf of a health care entity;

(2) Suing the patient or patient guarantor or enforcing an arbitration or mediation clause in any health care entity documents, including contracts, agreements, statements and bills; or

(3) Directly or indirectly causing a report to be made to a consumer reporting agency. [PL 2023, c. 584, Pt. A, §4 (NEW).]

B. "Collection agency" has the same meaning as "debt collector" has in Title 32, section 11002, subsection 6. [PL 2023, c. 584, Pt. A, §4 (NEW).]

C. "Consumer reporting agency" means any person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to 3rd parties. "Consumer reporting agency" includes any person

defined in 15 United States Code, Section 1681a(f). "Consumer reporting agency" does not include any business entity that exclusively provides check verification or check guarantee services. [PL 2023, c. 584, Pt. A, §4 (NEW).]

D. "Health care entity" has the same meaning as in section 1718-B, subsection 1, paragraph B. [PL 2023, c. 584, Pt. A, §4 (NEW).]

E. "Items or services" means all items and services, including individual items and services and service packages, that are provided by a health care entity to a patient in connection with an inpatient admission or an outpatient visit for which the patient is charged. [PL 2023, c. 584, Pt. A, §4 (NEW).]

F. "Patient guarantor" means the individual held responsible for a patient's bill. [PL 2023, c. 584, Pt. A, §4 (NEW).]

[PL 2023, c. 584, Pt. A, §4 (NEW).]

2. Failure to comply with good faith estimate requirements; relief from collection action. A health care entity that has not provided a good faith estimate in material compliance with section 1718-C, subsection 1 on the date that items or services are purchased by a patient or provided to a patient may not initiate or pursue a collection action against the patient or patient guarantor for a debt owed for the items or services. Unless a health care entity can demonstrate that the health care entity provided a good faith estimate to the patient as requested, the health care entity or hospital may not further pursue a collection action against the patient or patient guarantor.

[PL 2023, c. 584, Pt. A, §4 (NEW).]

SECTION HISTORY

PL 2023, c. 584, Pt. A, §4 (NEW).

§1719. Patients' rights

This section applies to hospitals licensed pursuant to chapter 405 that are nonstate mental health institutions as defined in Title 34-B, section 3801, subsection 6 and that are not subject to the grievance procedures of the Department of Behavioral and Developmental Services. [PL 2003, c. 649, §1 (NEW).]

1. Adoption of rules. The commissioner shall adopt rules for the enhancement and protection of the rights of adult patients receiving inpatient mental health services from a hospital subject to the requirements of this section. The commissioner shall hold a public hearing before adopting rules under this section and shall give notice of the public hearing pursuant to Title 5, section 8053. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2003, c. 649, §1 (NEW).]

2. Rights protected. The rules adopted pursuant to subsection 1 must meet the requirements of Title 34-B, section 3003, subsection 2, paragraphs A to K and must provide for the same opportunity for hearing and type of hearing as described in rules of the Department of Behavioral and Developmental Services relating to grievances filed by adult mental health consumers.

[PL 2003, c. 649, §1 (NEW).]

3. Delegation. The department shall delegate to the Department of Behavioral and Developmental Services responsibility for hearing and resolving all grievances that are submitted in a timely manner by patients receiving inpatient mental health services in hospitals subject to the requirements of this section.

[PL 2003, c. 649, §1 (NEW).]

4. Final agency action. Final resolution of a grievance by the Department of Behavioral and Developmental Services under the rules adopted pursuant to subsection 1 is the final agency action of the department for the purposes of judicial review under Title 5, section 11001.

[PL 2003, c. 649, §1 (NEW).]

SECTION HISTORY

PL 2003, c. 649, §1 (NEW).

§1720. Nursing facility medical director reimbursement

The department shall include in its calculation of reimbursement for services provided by a nursing facility an allowance for the cost of a medical director in a base year amount not to exceed $10,000, with that amount being subject to an annual cost-of-living adjustment. [PL 2005, c. 242, §1 (NEW).]

SECTION HISTORY

PL 2005, c. 242, §1 (NEW).

§1721. Prohibition on payment for health care facility mistakes or preventable adverse events

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

A. "Health care facility" means a hospital or ambulatory surgical center licensed under chapter 405. [PL 2007, c. 605, §1 (NEW).]

B. "Mistake or preventable adverse event" means any of the following events that is within the health care facility's control to avoid:

(1) Surgery performed on the wrong body part;

(2) Surgery performed on the wrong patient;

(3) The wrong surgical procedure performed on a patient;

(4) Unintended retention of a foreign object in a patient after surgery or another procedure;

(5) Intraoperative or immediately postoperative preventable death of a patient classified as a normal healthy patient under guidelines published by a national association of anesthesiologists;

(6) Patient death or serious disability caused by the use of contaminated drugs, devices or biologics provided by a hospital or ambulatory surgical center;

(7) Patient death or serious disability caused by the use or function of a device in patient care in which the device is used for functions other than as intended;

(8) Patient death or serious disability caused by an intravascular air embolism that occurs while being cared for in a health care facility;

(9) An infant's being discharged to the wrong person;

(10) Patient death or serious disability caused by a patient's elopement for more than 4 hours;

(11) Patient suicide or attempted suicide resulting in serious disability while being cared for in a health care facility;

(12) Patient death or serious disability caused by a medication error such as an error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration;

(13) Patient death or serious disability caused by a hemolytic reaction due to the administration of incompatible blood or blood products;

(14) Maternal death or serious disability caused by labor or delivery in a low-risk pregnancy, labor and delivery while being cared for in a health care facility;

(15) Patient death or serious disability caused by hypoglycemia, the onset of which occurs while the patient is being cared for in a health care facility;

(16) Death or serious disability caused by failure to identify and treat hyperbilirubinemia in neonates prior to discharge;

(17) Stage 3 or 4 pressure ulcers acquired after admission to a health care facility;

(18) Patient death or serious disability due to spinal manipulative therapy;

(19) Patient death or serious disability caused by an electric shock while being cared for in a health care facility;

(20) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

(21) Patient death or serious disability caused by a burn incurred from any source while being cared for in a health care facility;

(22) Patient death caused by a fall by a patient who was or should have been identified as requiring precautions due to risk of falling while being cared for in a health care facility;

(23) Patient death or serious disability caused by the use of restraints or bedrails while being cared for in a health care facility;

(24) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider;

(25) Abduction of a patient of any age;

(26) Sexual assault of a patient within a health care facility;

(27) Death or significant injury of a patient resulting from a physical assault that occurs within a health care facility; and

(28) Artificial insemination with the wrong donor sperm or donor egg. [PL 2007, c. 605, §1 (NEW).]

[PL 2007, c. 605, §1 (NEW).]

2. Prohibition. A health care facility is prohibited from knowingly charging a patient or the patient's insurer or the patient's employer as defined in Title 39-A, section 102, subsection 12 for health care services it provided as a result of or to correct a mistake or preventable adverse event caused by that health care facility.

[PL 2009, c. 31, §1 (AMD).]

3. Patient education. A health care facility is required to inform patients of the prohibition on payment for health care facility mistakes or preventable adverse events.

[PL 2007, c. 605, §1 (NEW).]

REVISOR'S NOTE: §1721. Voluntary restraint (As enacted by PL 2007, c. 629, Pt. C, §1 is REALLOCATED TO TITLE 22, SECTION 1722)

SECTION HISTORY

RR 2007, c. 2, §9 (RAL). PL 2007, c. 605, §1 (NEW). PL 2007, c. 629, Pt. C, §1 (NEW). PL 2009, c. 31, §1 (AMD).

§1722. Voluntary restraint

(REALLOCATED FROM TITLE 22, SECTION 1721)

1. Voluntary restraint. To control the rate of growth of the costs of hospital services, each hospital licensed under chapter 405 may voluntarily restrain cost increases and consolidated operating

margins in accordance with this section. Each hospital shall annually report to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding its efforts made pursuant to this section. The targets and methodology apply to each hospital's fiscal year beginning on or after the effective date of this section.

A. Each hospital may voluntarily hold its consolidated operating margin to no more than 3%. For purposes of this paragraph, a hospital's consolidated operating margin is calculated by dividing its consolidated operating income by its total consolidated operating revenue. [RR 2007, c. 2, §9 (RAL).]

B. Each hospital may voluntarily restrain its increase in its expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge to no more than 110% of the forecasted increase in the hospital market basket index for the coming federal fiscal year, as published in the Federal Register, when the federal Centers for Medicare and Medicaid Services publishes the Medicare program's hospital inpatient prospective payment system rates for the coming federal fiscal year. For purposes of this paragraph, the measure of a hospital's expense per casemix-adjusted inpatient and volume-adjusted outpatient discharge is calculated by:

(1) Calculating the hospital's total hospital-only expenses;

(2) Subtracting from the hospital's total hospital-only expenses the amount of the hospital's bad debt;

(3) Subtracting from the amount reached in subparagraph (2) the hospital taxes paid to the State during the hospital's fiscal year; and

(4) Dividing the amount reached in subparagraph (3) by the product of:

(a) The number of inpatient discharges, adjusted by the all payer case mix index for the hospital; and

(b) The ratio of total gross patient service revenue to gross inpatient service revenue.

For the purposes of this paragraph, a hospital's total hospital-only expenses include any item that is listed on the hospital's Medicare cost report as a subprovider, such as a psychiatric unit or rehabilitation unit, and does not include nonhospital cost centers shown on the hospital's Medicare cost report, such as home health agencies, nursing facilities, swing beds, skilled nursing facilities and hospital-owned physician practices. For purposes of this paragraph, a hospital's bad debt is as defined and reported in the hospital's Medicare cost report and as submitted to the Maine Health Data Organization pursuant to chapter 1683. [PL 2023, c. 405, Pt. A, §51 (AMD).]

[PL 2023, c. 405, Pt. A, §51 (AMD).]

SECTION HISTORY

RR 2007, c. 2, §9 (RAL). PL 2023, c. 405, Pt. A, §51 (AMD).

§1723. Processing fee

Beginning October 1, 2010, a facility or health care provider subject to the licensing, certification or registration processes of this chapter or chapter 405, 411, 412, 417 or 419 shall pay a processing fee not to exceed $10 to the department for the reissuance of a license, certificate or registration when the licensee, certificate holder or registration holder made changes that require the reissuance of a license, certificate or registration. [PL 2009, c. 590, §1 (NEW).]

The department may adopt rules necessary to implement this section. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2009, c. 590, §1 (NEW).]

REVISOR'S NOTE: §1723. Criminal background checks (As enacted by PL 2009, c. 621, §1 is REALLOCATED TO TITLE 22, SECTION 1724)

SECTION HISTORY

RR 2009, c. 2, §49 (RAL). PL 2009, c. 590, §1 (NEW). PL 2009, c. 621, §1 (NEW).

§1724. Criminal background checks

(REALLOCATED FROM TITLE 22, SECTION 1723)

Beginning October 1, 2010, a facility or health care provider subject to the licensing or certification processes of chapter 405, 412 or 419 shall obtain, prior to hiring an individual who will work in direct contact with a consumer, criminal history record information on that individual, including, at a minimum, criminal history record information from the Department of Public Safety, State Bureau of Identification. A facility or provider subject to licensing under chapter 419 shall conduct a comprehensive background check for individuals employed in positions that have direct access to a consumer's property, personally identifiable information, financial information or resources in accordance with applicable federal and state laws. The comprehensive background check must be conducted in accordance with state law and rules adopted by the department. The facility or health care provider shall pay for the comprehensive or criminal background check required by this section as applicable. [PL 2015, c. 196, §8 (AMD); PL 2015, c. 299, §8 (AMD).]

The department may adopt rules necessary to implement this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [RR 2009, c. 2, §49 (RAL).]

SECTION HISTORY

RR 2009, c. 2, §49 (RAL). PL 2015, c. 196, §8 (AMD). PL 2015, c. 299, §8 (AMD).

§1725. Neuropsychological and psychological evaluations

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

A. "Neuropsychological evaluation" means a testing method through which a neuropsychologist or a psychologist can acquire data about a person's cognitive, behavioral and emotional functioning for purposes of diagnosing or confirming a diagnosis of cognitive deficit or abnormalities in the central nervous system. [PL 2013, c. 353, §1 (NEW).]

B. "Neuropsychological or psychological test data" means raw and scaled scores, a person's responses to test questions or stimuli, a neuropsychologist's or psychologist's notes and recordings concerning the person's statements and behavior during a neuropsychological evaluation or psychological evaluation and those portions of neuropsychological or psychological test materials that include the person's responses. [PL 2013, c. 353, §1 (NEW).]

C. "Neuropsychological or psychological test materials" means manuals, instruments, protocols, assessment devices, scoring keys, test questions and stimuli used in conducting a neuropsychological evaluation or psychological evaluation. [PL 2013, c. 353, §1 (NEW).]

D. "Psychological evaluation" means a testing method through which a psychologist acquires data about a person's cognitive and emotional functioning for purposes of determining cognitive ability, diagnosing a mental health condition or confirming a mental health diagnosis. [PL 2013, c. 353, §1 (NEW).]

[PL 2013, c. 353, §1 (NEW).]

2. Disclosure of neuropsychological or psychological test materials and neuropsychological or psychological test data. The disclosure of neuropsychological or psychological test materials and neuropsychological or psychological test data is governed by this subsection.

A. Except as provided in paragraph B, neuropsychological or psychological test materials and neuropsychological or psychological test data, the disclosure of which would compromise the

objectivity or fairness of the evaluation methods or process, may not be disclosed to anyone, including the person who is the subject of the test, and are not subject to disclosure in any administrative, judicial or legislative proceeding. [PL 2013, c. 353, §1 (NEW).]

B. A person who is the subject of a neuropsychological evaluation or psychological evaluation is entitled to have all records relating to that evaluation, including neuropsychological or psychological test materials and neuropsychological or psychological test data, disclosed to any neuropsychologist or psychologist who is qualified to evaluate the test results and who is designated by the person. A neuropsychologist or psychologist designated to receive records under this paragraph may not disclose the neuropsychological or psychological test materials and neuropsychological or psychological test data to another person. [PL 2013, c. 353, §1 (NEW).]

[PL 2013, c. 353, §1 (NEW).]

SECTION HISTORY

PL 2013, c. 353, §1 (NEW).

§1726. Palliative Care and Quality of Life Interdisciplinary Advisory Council

The Palliative Care and Quality of Life Interdisciplinary Advisory Council, as established in Title 5, section 12004-I, subsection 47-I and referred to in this section as "the advisory council," is established to improve the quality and delivery of patient-centered and family-focused care in accordance with this section. [PL 2015, c. 203, §2 (NEW).]

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

A. "Palliative care" means patient-centered and family-focused medical care that optimizes quality of life by anticipating, preventing and treating suffering caused by a medical illness or a physical injury or condition that substantially affects a patient's quality of life, including, but not limited to, addressing physical, emotional, social and spiritual needs; facilitating patient autonomy and choice of care; providing access to information; discussing the patient's goals for treatment and treatment options, including, when appropriate, hospice care; and managing pain and symptoms comprehensively. Palliative care does not always include a requirement for hospice care or attention to spiritual needs. [PL 2017, c. 213, §1 (AMD).]

B. "Serious illness" means a medical illness or physical injury or condition that substantially affects quality of life for more than a short period of time. "Serious illness" includes, but is not limited to, Alzheimer's disease and related dementias, lung disease, cancer, heart, renal or liver failure and chronic, unremitting or intractable pain such as neuropathic pain. [PL 2017, c. 213, §1 (AMD).]

[PL 2017, c. 213, §1 (AMD).]

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

A. Five persons with experience and expertise in palliative care in acute hospital care, long-term care, in-home care and hospice care with respect to pediatric, youth, adult and elderly populations as follows:

(1) Two persons appointed by the Governor. One person must be a physician who is certified by a national board of hospice and palliative medicine. One person must be a registered nurse or advanced practice registered nurse who is certified by a national board for certification of hospice and palliative nurses; and

(2) Three persons appointed by the executive director of the Maine Hospice Council, established in section 8611, who are health professionals with palliative care work experience or expertise in the delivery of palliative care; [PL 2015, c. 203, §2 (NEW).]

B. Two persons appointed by the President of the Senate. One person must be a licensed pharmacist with experience working with persons with serious illnesses. One person must represent hospitals in the State; [PL 2015, c. 203, §2 (NEW).]

C. Two persons appointed by the Speaker of the House of Representatives. One person must be a licensed social worker with experience working with persons with serious illnesses and their family members. One person must represent health insurers; [PL 2015, c. 203, §2 (NEW).]

D. Two persons appointed by the member of the Senate who is the leader of the minority party in the Senate. Both persons must represent statewide organizations that advocate on behalf of persons with serious illnesses; [PL 2015, c. 203, §2 (NEW).]

E. Two persons appointed by the member of the House of Representatives who is the leader of the minority party in the House. One person must be a spiritual counselor with experience working with persons with serious illnesses and their family members. One person must represent persons 55 years of age and older; [PL 2023, c. 78, §1 (AMD).]

F. The executive director of the Maine Hospice Council, established in section 8611, who serves as a nonvoting member; and [PL 2023, c. 78, §2 (AMD).]

G. One person who is an individual receiving palliative care, or a primary caregiver of an individual receiving palliative care, appointed by the Governor. [PL 2023, c. 78, §3 (NEW).]

[PL 2023, c. 78, §§1-3 (AMD).]

3. Terms; vacancies; expense reimbursement. A person appointed to the advisory council serves a 3-year term, subject to termination by decision of the appointing authority. When a vacancy occurs, the appointing authority shall appoint a new member to serve for 3 years. As provided in Title 5, section 12004-I, subsection 47-I, members serve on a voluntary basis, are not eligible for payment for their service and may be reimbursed for necessary expenses.

[PL 2015, c. 203, §2 (NEW).]

4. Conduct of business. At the first meeting of the advisory council and annually thereafter, the members shall elect from the membership a chair and a vice-chair and shall determine their duties. The chair and vice-chair shall call at least 2 meetings per year and other meetings as requested by a majority of the membership or as determined by the chair and vice-chair. A majority of the membership constitutes a quorum. All meetings of the advisory council are public proceedings, are open to the public and must be held in locations that are convenient for public access and that are provided by the Maine Hospice Council, established in section 8611. As appropriate to the agenda for the meeting and in conformance with the Maine Administrative Procedure Act, all meetings must provide an opportunity for public comment.

[PL 2015, c. 203, §2 (NEW).]

5. Duties. The advisory council shall:

A. Consult with and advise the Maine Center for Disease Control and Prevention on matters related to the establishment, maintenance, operation and evaluation of palliative care initiatives in the State; [PL 2015, c. 203, §2 (NEW).]

B. Analyze palliative care being provided in the State; [PL 2015, c. 203, §2 (NEW).]

C. Make recommendations to improve palliative care and the quality of life of persons with serious illnesses; and [PL 2015, c. 203, §2 (NEW).]

D. Submit a report to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs, health and human services matters and insurance and financial services matters by January 1st each year providing the findings and recommendations of the advisory council. [PL 2015, c. 203, §2 (NEW).]

[PL 2015, c. 203, §2 (NEW).]

6. Funding. The advisory council may accept funding that is not public funding.
[PL 2015, c. 203, §2 (NEW).]

REVISOR'S NOTE: §1726. Cooperation with law enforcement (As enacted by PL 2015, c. 218, §2 is REALLOCATED TO TITLE 22, SECTION 1727)

SECTION HISTORY

RR 2015, c. 1, §18 (RAL). PL 2015, c. 203, §2 (NEW). PL 2015, c. 218, §2 (NEW). PL 2017, c. 213, §1 (AMD). PL 2023, c. 78, §§1-3 (AMD).

§1727. Cooperation with law enforcement

(REALLOCATED FROM TITLE 22, SECTION 1726)

A hospital licensed under chapter 404 or 405 shall make a good faith effort to cooperate with law enforcement agencies as provided in this section. [RR 2015, c. 1, §18 (RAL).]

1. Service of protection from abuse order. A law enforcement agency may request that a hospital provide access to a defendant who is receiving care in the hospital for the purpose of serving a protection from abuse order pursuant to Title 19-A, section 4107.

A. The hospital shall provide the law enforcement agency with an opportunity to serve the defendant personally with the order at a time the hospital determines is clinically appropriate with due consideration to the medical condition of the defendant. [RR 2015, c. 1, §18 (RAL).]

B. A hospital may disclose that the defendant is a patient to facilitate service under this section regardless of patient consent. [RR 2015, c. 1, §18 (RAL).]
[PL 2021, c. 647, Pt. B, §48 (AMD); PL 2021, c. 647, Pt. B, §65 (AFF).]

2. Notice of upcoming release. A law enforcement agency may request that a hospital provide notice to the law enforcement agency that a person is to be released from the hospital so that the law enforcement agency may arrest the person.

A. The hospital shall provide notice that the person is to be released from the hospital if the person was transported or was caused to be transported to the hospital by the law enforcement agency. [RR 2015, c. 1, §18 (RAL).]

B. The information contained in the notice provided by the hospital must be no more than the minimum amount necessary to satisfy the requirements of this subsection. [RR 2015, c. 1, §18 (RAL).]
[RR 2015, c. 1, §18 (RAL).]

3. Required consistency with federal requirements. A hospital may provide access under subsection 1 and information under subsection 2 only if the request is consistent with the provisions of 45 Code of Federal Regulations, Section 164.512 (2015) and 42 Code of Federal Regulations, Part 2 (2015).
[RR 2015, c. 1, §18 (RAL).]

4. Immunity; no cause of action. A hospital, hospital agent, employee or other person who in good faith and without gross negligence provides access or information to a law enforcement agency as required by this section or cooperates in an investigation or a criminal or judicial proceeding related to the requirements of this section is immune from civil and criminal liability and professional licensure action arising out of or related to compliance with this section. This section does not create a cause of action against the hospital, hospital agent, employee or other person for failure to comply with this section.
[RR 2015, c. 1, §18 (RAL).]

SECTION HISTORY

RR 2015, c. 1, §18 (RAL). PL 2021, c. 647, Pt. B, §48 (AMD). PL 2021, c. 647, Pt. B, §65 (AFF).

§1728. Prescription drug transparency report

1. Hospital defined. For purposes of this section, "hospital" means:

A. An acute care institution licensed and operating in this State as a hospital under section 1811 or the parent of such an institution; or [PL 2023, c. 276, §1 (NEW).]

B. A hospital subsidiary or hospital affiliate in the State that provides medical services or medically related diagnostic and laboratory services or engages in ancillary activities supporting those services. [PL 2023, c. 276, §1 (NEW).]

[PL 2023, c. 276, §1 (NEW).]

2. Report on participation in federal 340B drug program. Beginning January 1, 2024, each hospital participating in the federal drug pricing program under Section 340B of the federal Public Health Service Act, 42 United States Code, Section 256b, referred to in this section as "the 340B program," shall provide an annual report to the Maine Health Data Organization. The Maine Health Data Organization shall post the report on its publicly accessible website. Each hospital shall report in a standardized format as agreed upon by the Maine Health Data Organization and the hospital, and include, at a minimum, the following information in the report consistent with the annual reporting of hospitals voluntarily participating in the good stewardship program of the American Hospital Association or its successor organization:

A. A description of how the hospital uses savings from participation in the 340B program to benefit its community through programs and services funded in whole or in part by savings from the 340B program, including services that support community access to care that the hospital could not continue without savings from the 340B program; [PL 2023, c. 276, §1 (NEW).]

B. The annual estimated savings from the 340B program to the hospital, comparing the acquisition price of drugs under the 340B program to group purchasing organization pricing. If group purchasing organization pricing is not available for a drug under the 340B program, the acquisition price for that drug must be compared to a price from another acceptable pricing source; [PL 2023, c. 276, §1 (NEW).]

C. A comparison of the hospital's estimated savings under the 340B program to the hospital's total drug expenditures, including examples of the hospital's top drugs purchased through the 340B program; and [PL 2023, c. 276, §1 (NEW).]

D. A description of the hospital's internal review and oversight of the 340B program, which must meet the federal Department of Health and Human Services, Health Resources and Services Administration's program rules and guidance for compliance. [PL 2023, c. 276, §1 (NEW).]

[PL 2023, c. 276, §1 (NEW).]

3. Reporting. The Maine Health Data Organization shall produce and post on its publicly accessible website a report that includes a summary of the aggregate information received from hospitals required to report under subsection 2. The Maine Health Data Organization shall submit the report required by this subsection to the Office of Affordable Health Care, as established in Title 5, section 3122, the Maine Prescription Drug Affordability Board, as established in Title 5, section 12004-G, subsection 14-I, and the joint standing committee of the Legislature having jurisdiction over health data reporting and prescription drug matters.

[PL 2023, c. 276, §1 (NEW).]

SECTION HISTORY

PL 2023, c. 276, §1 (NEW).

§1729. Substance use disorder treatment information

Beginning July 1, 2024, a hospital licensed under chapter 405 shall post in a publicly accessible area of its emergency department information provided by the department that describes how individuals with substance use disorder can access evidence-based treatment services. [PL 2023, c. 463, §1 (NEW).]

SECTION HISTORY

PL 2023, c. 463, §1 (NEW).

§1730. Upper payment limits for aggregate MaineCare payments to hospitals

1. Definitions. As used in this section, the following terms have the following meanings.

A. "Group of hospitals" means a group of hospitals in which each hospital meets the requirements for the same category of facility as described in 42 Code of Federal Regulations, Section 447.272 or 447.321. [PL 2023, c. 643, Pt. MM, §1 (NEW).]

B. "Hospital" means any facility in the State licensed as a hospital under chapter 405. [PL 2023, c. 643, Pt. MM, §1 (NEW).]

[PL 2023, c. 643, Pt. MM, §1 (NEW).]

2. Department to ensure compliance with upper payment limits. Beginning July 1, 2024, if aggregate MaineCare payments made to a group of hospitals exceed the upper payment limit applicable to that group of hospitals under 42 Code of Federal Regulations, Section 447.272 or 447.321, the department shall limit payments to that group of hospitals to the level that ensures compliance with the applicable upper payment limit. At least 60 days prior to taking an action pursuant to this subsection, the department shall share its upper payment calculations, including all data inputs, with the hospitals affected by the action.

[PL 2023, c. 643, Pt. MM, §1 (NEW).]

3. Adjustments when aggregate payments fall below upper payment limits. If the department limits MaineCare payments to a group of hospitals pursuant to subsection 2 and the Federal Government subsequently determines that the payments made to the group of hospitals are below the upper payment limit applicable to that group of hospitals under 42 Code of Federal Regulations, Section 447.272 or 447.321, the department shall increase the payments to an amount determined by the department, as permitted under federal regulations, and not higher than the applicable upper payment limit. The department shall notify the affected hospitals of any payments made under this subsection.

[PL 2023, c. 643, Pt. MM, §1 (NEW).]

SECTION HISTORY

PL 2023, c. 643, Pt. MM, §1 (NEW).