Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. III Section 26**, Day Health Services
Filing number:	**2015-054**
Effective date:	3/31/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule is being proposed to provide financial stability to Day Health Service providers. The rule is being proposed to be retroactive to November 1, 2014. These changes are subject to CMS approval.

Basis statement:

The Department has determined that the adoption of this rule is necessary to provide financial stability to Day Health Services providers. The rule is being adopted to have a retroactive application to November 1, 2014, subject to approval by the Centers for Medicare and Medicaid Services.

This rule-making will not impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Fiscal impact of rule:

This rule-making is estimated to cost $38,676.00 for State Fiscal Year 2015 and $51,326.00 for State Fiscal Year 2016 and all future years.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; *Social Security Act* §1915(b), 42 U.S.C. 1396n; *Rosa's Law*, Pub. L. 111-256; PL 2012, ch. 542, §B(5)
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II Section 113**, Non-Emergency Transportation (NET) Services
Filing number:	**2015-055**
Effective date:	4/5/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

In August 2013, MaineCare began delivering NET services using regional, risk-based, pre-paid ambulatory health plan brokerages, in alignment with Maine's eight (8) transit regions, pursuant to a §1915(b) waiver that was approved by the Centers for Medicare and Medicaid (CMS). NET brokers were selected through a competitive procurement process, following the Department's Request for Proposals (RFP). During the first year of implementation, significant problems were experienced in several NET regions. As a result, the Department decided to re-issue the RFP for NET services in six of the eight regions. In two regions, the original NET brokers' contracts were renewed. For the other six regions, the Department selected new NET brokers, based on the bids they submitted in response to the RFP.

On July 7, 2014, CMS approved the Department's request to renew its NET waiver for a two year period, beginning July 1, 2014 and ending on June 30, 2016. The Department negotiated new contracts with its NET brokers, effective August 1, 2014, and these contracts include several important changes. As a result, MaineCare's NET policy must be changed to conform to the NET waiver and the contracts.

Basis statement:

This rule is being adopted in order to bring the policy into conformity with Department-negotiated contracts with transportation Brokers. In August 2013, MaineCare began delivering non-emergency transportation (NET) services using regional, risk-based, pre-paid ambulatory health plan brokerages, in alignment with Maine's eight (8) transit regions, pursuant to a §1915(b) waiver that was approved by the Centers for Medicare and Medicaid Services (CMS). NET Brokers were selected through a competitive procurement process, following the Department's Request for Proposals (RFP). During the first year of implementation, there were significant problems in several NET regions. As a result, the Department re-issued the RFP for NET services in six of the eight regions. In two regions, the original NET Brokers' contracts were renewed. For the other six regions, the Department selected new NET Brokers, based on the bids they submitted in response to the RFP.

On July 7, 2014, CMS approved the Department's request to renew its NET waiver for a two year period, beginning July 1, 2014 and ending on June 30, 2016. The Department negotiated new contracts with its NET Brokers, effective August 1, 2014, and these contracts include several important changes. Therefore, MaineCare's NET policy has been changed to conform to the NET waiver and the contracts.

These changes include: the allowance of pharmacy trips, including those required on an urgent basis; revisions to the map of NET regions that more clearly delineate all eight regions and reflect a slight change in the geographic distribution of one region; addition of the requirement that parents or guardians of minors under the age of 12 years old authorize the specific type of transportation when minors travel unaccompanied; addition of language

requiring prior authorization for out-of-state NET trips; addition of the requirement that the NET Broker contacts a Member's assigned care coordinator to verify services for members receiving "Home and Community Based Services" under Sections 18 and 20 of the *MaineCare Benefits Manual*; as well as several other changes designed to help clarify existing requirements of the NET program.

Additionally, the Department made a number of changes to the rule as a result of comments made during the rule-making and subsequent Departmental findings. These changes include: the addition of and clarification to certain definitions; clarification of provisions regarding related travel expenses; amendment to the NET advisory committee meeting requirement to every six months; addition of "Autism Spectrum Disorder" to the rule permitting the accompaniment of an Escort without the need for a Departmental determination; further explanation of the reimbursement rules; clarification on the limited circumstances for out-of-region Broker cooperation; as well as several other non-substantive technical, grammatical, and formatting changes.

Fiscal impact of rule:

This rule-making is estimated to have no fiscal impact.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II Section 15**, Chiropractic Services
Filing number:	**2015-062**
Effective date:	4/10/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The Department changes the limit calculation methodology from "rolling year" to a calendar year for purposes of clarity. This rule also removes the current hard cap of 12 visits per year and allow for additional visits when medically necessary. The Department imposes a prior authorization requirement for additional visits for members over the age of twenty-one (21).

In addition, the changes clarify the types of medical providers that are required to be involved in determining a member's eligibility for Chiropractic Services.

If approved by the Centers for Medicare and Medicaid (CMS), x-ray services that are medically necessary for diagnosis and treatment of a subluxation shall be a covered service in Section 15. This rule-making includes language that explains the reimbursement for chiropractic x-rays. X-ray services provided through this section do not require prior authorization.

Finally, the Department makes a number of technical changes in an effort to provide clarity and eliminate duplicative language. These changes include the elimination of Sec. 15.04 "Specific Eligibility for Care"; elimination of the reference to the Division of Program Integrity (Sec. 15.08); and elimination of other unnecessary language regarding reimbursement, co-pays, and dispute resolution.

Basis statement:

The adoption of this rule will change the limit calculation methodology for chiropractic services from "rolling year" to a calendar year, for purposes of clarity. This rule removes the current hard cap of 12 visits per year and allows for additional visits when medically necessary. The Department will impose a prior authorization requirement for additional visits for members over the age of twenty-one (21). This rule will ensure MaineCare members will receive the medically necessary Chiropractic Services they require.

In addition, these adopted changes will clarify the types of medical providers that are required to be involved in determining a member's eligibility for Chiropractic Services. This requirement will help in determining if services are medically necessary.

X-ray services that are medically necessary for diagnosis and treatment of a subluxation shall be a covered service in Section 15. This rule-making language explains the reimbursement for chiropractic x-rays. X-ray services provided through this section do not require prior authorization. This will be consistent with other provider medical services that do not require a prior authorization for x-rays.

Additionally, the Department has made a number of technical changes in an effort to provide clarity and eliminate duplicative language. These changes include the elimination of Sec. 15.04 "Specific Eligibility for Care"; elimination of the reference to the Division of Program Integrity (Sec. 15.08); and elimination of other unnecessary language regarding reimbursement, co-pays, and dispute resolution.

Following the public comment period, the Department made several non-substantive changes to the rule as a result of further review. These changes include the elimination of redundant language in Section 15.02-3; clarification to language in Section 15.03; and the relocation of certain provisions to best reflect the responsibilities of different providers under the Section and to emphasize that medical necessity is a requirement for all members to be eligible for services.

Additionally, the Department inserted language in the final rule to reflect provisions that are subject to approval by the Centers for Medicare and Medicaid Services (CMS). Chiropractic services are currently covered under the Department's State Plan. However, the Department is awaiting State Plan Amendment approval from CMS for changes it seeks to make to these services as reflected in the rule.

Finally, the Department expects that this rule-making will cost in State funds approximately $13,906.87 in SFY15 and $27,680.86 in SFY16. When the Department filed the "Notice of Agency Rule-making Proposal" for Section 15, the Department inaccurately reported the SFY15 fiscal impact to be $27,814.00 in State funds on the Fact Sheet. The numbers contained in this Basis Statement reflect the Department's updated and accurate estimates.

Fiscal impact of rule:

The Department expects that this rule-making in SFY15 will cost approximately $27,814.00 in State funds.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; 22 MRS §3174-WW and 22 MRS §42(8)
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II & III Section 65**, Behavioral Health Services
Filing number:	**2015-065**
Effective date:	4/13/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
(See Basis statement.)

Basis statement:
Adoption of this rule brings Maine into compliance with LD 386, *An Act to Reduce Tobacco-related Illness and Lower Health Care Costs in MaineCare* (22 MRS §3174-WW). The rule adds comprehensive tobacco cessation treatment including counseling and products as a covered service for all members, regardless of age, who wish to cease the use of tobacco. There are no annual or lifetime dollar limits on tobacco cessation treatment, nor are there any limits on attempts to quit. Members may not be charged a co-pay for tobacco cessation treatment and they may not be required to participate in counseling to receive products.

Tobacco cessation products are "Covered Drugs," reimbursable pursuant to Ch. II, Section 80.05 of the MBM. As Covered Drugs, tobacco cessation products are included on the Department's Preferred Drug List (PDL), as set forth in Ch. II, Section 80.07-5. The PDL may be accessed via the Department's website. There are no annual or lifetime dollar limits on tobacco cessation treatment, nor are there any limits on attempts to quit. Members may not be charged a co-pay for tobacco cessation products and they may not be required to participate in counseling to receive medications.

The following four Current Procedural Terminology (CPT) codes are added to Ch. III Section 65: 99406 (smoking and tobacco use cessation counseling; individual, greater than 3 minutes up to 10 minutes), 99407 (smoking and tobacco use cessation counseling; individual, greater than 10 minutes), 99411 (preventive medicine, group counseling; 30 minutes) and 99412 (preventive medicine, group counseling; 60 minutes).

If the Centers for Medicare and Medicaid Services (CMS) approve the Department's State Plan Amendment, and pursuant to 22 MRS §42(8), these changes to Section 65 will be effective retroactively to August 1, 2014.

Three additional technical changes are also included in this proposed rulemaking:

1. Update of language referencing the former Children's Behavioral Health Services (CBHS) and Office of Adult Mental Health Services (OAMHS) to the current Office of Child and Family Services (OCFS) and Office of Substance Abuse and Mental Health Services (SAMHS), to reflect current Departmental structure;
2. Replacement of the term "Authorized Agent" to "Authorized Entity" and,
3. In Ch. III, a change to the rate listed for CPT code H2012 with HN UQ TL and HN UQ TM modifiers from $16.65 to $14.65.

The additional proposed technical changes are intended to keep policy language updated and reflect correct rate allowances.

Fiscal impact of rule:
This rule-making is estimated to have a minimal fiscal impact to the Department.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; PL 2013 §SS-2; Resolves 2015 ch. 1
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. III Section 21**, Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder
Filing number:	**2015-094**
Effective date:	6/14/2015
Type of rule:	Major Substantive
Emergency rule:	No

Principal reason or purpose for rule:

The Department is adding procedure codes and modifiers for the new services to the corresponding Ch. II of Section 21. These include:

- New procedure codes for Assistive Technology services, which has three components: the Assessment and Training, the Assistive Technology Devices and the monthly cost of the internet or cable transmission.
- New procedure codes for Career Planning services, Home Support-Remote Support services, Shared Living services, Work Support-Group services and Maintenance Occupational Therapy services delivered by an Certified Occupational Therapy Assistant (COTA).
- Modifiers for Home Support-Remote Support services to indicate whether interactive support is being delivered or the member is only being monitored.
- A new modifier for Home Support-Family Centered Support to indicate that the service is Home Support-Family Centered Support.

Additionally, the Department proposes the addition of billing instructions to Work Support-Group to describe how to submit for reimbursement when services are delivered in a group setting.

Basis statement:

This is a final adoption of a major substantive rule. The following outlines the procedural history of this rule adoption as well as the specific changes to the rule.

By way of background, Section 21 services are governed by the Centers for Medicare and Medicaid Services (CMS). On April 18, 2014, CMS approved changes to the Section 21 waiver, effective July 1, 2014, adding new services and clarifying other services, as requested by the Department. In order to add these new services, the Department promulgated a routine technical rule-making for Ch. II Section 21. The Commissioner adopted the Ch. II Section 21 rule-making on or about August 22, 2014, with an effective date of the changes to services of September 1, 2014.

However, Ch. III Section 21, which governs the reimbursement of services under Ch. II, is a major substantive rule. As such, Ch. III Section 21 needs approval by the Legislature before becoming effective. Pursuant to 5 MRS §8072, the Department engaged in the rule-making process set forth under 5 MRS §8052 up until the point of adoption. This included conducting a public hearing on April 14, 2014, and accepting public comments until April 24, 2014. Thereafter, the Commissioner provisionally adopted the Ch. III Section 21 rule on August 22, 2014. The Department submitted the provisionally adopted rule to the Legislature for its review on or about August 29, 2014.

Meanwhile, because federal law requires that provider claims for Medicaid services be submitted within one year of providing the Medicaid service (42 CFR 447.45), and because

Medicaid reimbursement must be made timely, the Department determined to concurrently adopt an emergency major substantive rule for Ch. III Section 21. **The emergency major substantive rule became effective on September 1, 2014**. Thus, the Department has been able to reimburse for new services under Ch. II Section 21 pending the Legislature's review of the provisionally adopted major substantive rule.

On March 17, 2015, the Legislature authorized the final adoption of the major substantive rule in *Resolve, Regarding Legislative Review of Portions of Chapter 101, MaineCare Benefits Manual, Chapter III, Section 21: Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder, a Major Substantive Rule of the Department of Health and Human Services* (Resolves 2015 ch. 1).

Given the Legislature's authorization for final adoption, as well as the limit on the application of an emergency rule, the Department now finally adopts the Ch. III Section 21 major substantive rule the Commissioner had provisionally adopted on August 22, 2014. This final adopted rule mirrors those changes currently in place since September 1, 2014, under the emergency major substantive rule. These changes correspond to the CMS-approved Section 21 waiver and include:

MaineCare reimbursement for the following services:

Home Support – Remote Support services which includes: (a) Home support- Remote Support – Monitor Only; and (b) Home support – Remote Support – Interactive Support, Assistive Technology services, which includes: (a) Assistive Technology – Assessment services; (b) Assistive Technology – Transmission (Utility Services); and (c) Assistive Technology – Devices services. Adding these services complies with P.L. 2013, Ch. 368, PART SS, which authorized MaineCare "reimbursement for the use of appropriate electronic technology as a means of reducing the costs of supporting people currently being served…"

To comply with the waiver amendment, the Department added a new modifier ("U5") to the code for Home Support – Family Centered Support – which indicates that the services are Family Centered Support services.

The Department also added: Career Planning services.

This adopted major substantive rule also separates Home Support Services into four different services: 1) Home Support-Agency Home Support (Per Diem), 2) Home Support-Quarter Hour (1/4 hour), 3) Home Support-Family Centered Support and 4) Home Support-Shared Living.

The Department deleted some of the language in the second paragraph of Principle 1900 (Billing Procedure), that relates to rates for Work Support Services – Group, and replaced the language with the actual rates per unit, depending on the number of members in a group.

This adopted major substantive rule also added: Occupational Therapy (Maintenance) – which can be provided by a Certified Occupational Therapy Assistant (COTA) under the supervision of an Occupational Therapist Registered (OTR).

This final adoption of a major substantive rule shall take effect upon the Commissioner's final adoption and filing with the Secretary of State, at which time the emergency major substantive rule in effect since September 1, 2014 will expire.

Fiscal impact of rule:

This rule-making is estimated to be cost neutral.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; PL 2013 ch. 441
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II & III Section 5**, Ambulance Services
Filing number:	**2015-105**
Effective date:	6/3/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The Department is seeking to make several changes in this rule-making. The changes are as follows:

1. In Ch. II, remove two references to a telephone number provided for out-of-state providers to request prior authorization. This number is no longer in service. Instead of calling the number, providers are instructed to obtain prior authorization (PA) through the MaineCare portal.
2. In Ch. III, change reimbursement rates for Medicare reimbursable ambulance codes to 65% of Medicare rates. This change is being proposed pursuant to the directive in LD 1274, Public Law ch. 441, 22 MRS §3174-JJ, Sec. 1.;
3. In Ch. III, remove a clarifying sentence from HCPCS code A0998 "Ambulance Response and Treatment, No Transport." The sentence states, "Patient is treated but refuses transport or is deceased and therefore requires no transport." This clarifier does not appear in the HCPCS manual and should be removed.

Basis statement:

This rule is being adopted in order to comply with P.L. 2013 ch. 441 §1, *An Act to Sustain Emergency Medical Services throughout the State*, codified at 22 MRS §3174-JJ, which requires that MaineCare change reimbursement rates for Medicare reimbursable ambulance codes to 65% of Medicare rates beginning March 1, 2015. Additionally, the rule is being adopted to remove references to outdated telephone numbers and to provide updated instructions for out-of-state providers to request prior authorization through the MaineCare portal. Finally, Ch. III of the rule adoption deletes a clarifying sentence contained in the fee schedule that does not appear in the HCPCS manual.

Following public hearing and further review by the Department, the Department made additional non-substantive changes to the rule proposal, including: (1) replacement of the outdated terms "Intermediate Care Facility for People with Mental Retardation" and "ICF-MR" with the terms "Intermediate Care Facility for Individuals with Intellectual Disabilities" and "ICF-IID"; (2) clarification of the prior authorization requirements in Ch. II Sections 5.05-1 and 5.08-2 to be consistent with changes in the rule proposal about the MaineCare portal; (3) removal of the provisions in Ch. III Section 5.05 which address MaineCare's billing system to align with the reimbursement changes set forth in P.L. 2013 ch. 441 §1 and 22 MRS §3174-JJ; and (4) correction of a clerical error in the fee schedule in Ch. III Section 5.06 to properly reflect that the fixed fee of $285.00 for HCPCS code A0428 is associated with ambulance services associated with an involuntary admission to a psychiatric facility.

If the Centers for Medicare and Medicaid Services (CMS) approves the Department's State Plan Amendment, and pursuant to 22 MRS §42(8), changes to the reimbursement rates under Section 5 will be effective retroactive to March 1, 2015.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Fiscal impact of rule:

The Department expects that this rulemaking will be cost a total of $138,858.92 in State Fiscal Year 2015, $53,391.26 of which will be from the General Fund. In State Fiscal Year 2016, the cost is expected to be $416,576.77, $160,173.77 of which will be from the General Fund.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II & III Section 35**, Hearing Aids and Services
Filing number:	**2015-106**
Effective date:	6/13/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The Department repeals *MaineCare Benefits Manual*, Ch. II & III Section 35, "Hearings Aids & Services".

Basis statement:

The Department is repealing *MaineCare Benefits Manual*, Ch. II & III Section 35, "Hearing Aids and Services". The services covered under this section will instead be covered under Ch. II Section 60, "Medical Supplies and Durable Medical Equipment". Changes to Section 60 are being adopted concurrently with the repeal of Section 35.

These changes to the *MaineCare Benefits Manual* are dependent upon approval by the Centers for Medicare and Medicaid Services (CMS).

In addition, all reimbursement rates will be set forth per the fee schedule located at the following website: http://www.maine.gov/dhhs/audit/rate-setting/documents/S60MedSuppandDME_002.pdf .

Fiscal impact of rule:

This rule-making is cost neutral.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; §440.70 (b)(3) ,P.L.2012 ch. 542 §B (5), 42 CFR, Part 440 Public Law 111-256, (also referred to as "Rosa's Law"), Public Law 111-148, Subtitle F, Section 6505
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II Section 60**, Medical Supplies and Durable Medical Equipment
Filing number:	**2015-107**
Effective date:	6/13/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
This rule is being adopted to amend several sections of Ch. 101, MaineCare Benefits Manual, Ch. II Section 60, "Medical Supplies and Durable Medical Equipment". The Department is adopting the following changes to the rule:
1. This rule replaces all references to the term "Mentally Retarded" or "MR" to "Individual with Intellectual Disability" or "IID" as required by P.L. 2012 ch. 542 §B (5), *An Act to Implement the Recommendations of the Department of Health and Human Services and the Maine Developmental Disabilities Council Regarding Respectful Language*.
2. The Department adds medically necessary hearing aids as a covered service for members age twenty-one (21) and older and includes hearing aid services for members under age twenty-one (21) in Section 60. Both monaural and binaural hearing aids are available to members meeting the Department's criteria for medical necessity.
3. The Department also adds Continuous Glucose Monitors (CGM) as a covered MaineCare service, to include prior authorization criteria used to determine medical necessity. The Department has made this change in order to assure that members have access to the most appropriate and cost effective treatment available.
4. The Department also increases the limits for Orthopedic modifications and inserts classified with HCPCS Level II codes as Medical and Surgical Supplies (i.e. Diabetic Shoes, Fittings and Modifications), as identified in Section 60.07-1(A), to allow eligible members to receive up to a combined total of six (6) units of modifications and/or inserts per year (meaning three (3) pairs of inserts or six (6) modifications). This change is adopted in order to maintain consistency with established Medicare limits.
5. The Department made a number of technical changes in an effort to provide clarity and eliminate duplicative language. These changes include updating the limitations of incontinence supplies (Sec.60.07-1(c), re-organization of the list of equipment normally used in a NF or ICF-IID care facility (Sec. 60.05-13), to provide clarity (no equipment has been added or eliminated), adding definitions for the terms Aesthetic or Deluxe Durable Medical Equipment, Hearings Aids and Prior Authorization have been added , revision of the term "store" in Section 60.01-12(C) and update website addresses to assure accuracy.
6. Following public comments on this rule, the Department: (1) clarified the replacement criteria for hearing aids in Section 60.05-8; (2) created a new section to ensure medically necessary binaural hearing aid coverage for members under 21 years old; (3) clarified the language distinguishing adults from children under this policy; (4) amended the language in Section 60.05 regarding which types of providers can perform the face-to-face encounter and

write orders for DME; (5) corrected a clerical error related to the criteria for Continuous Glucose Monitors; (6) and made some minor technical and formatting changes.
7. This rule is being adopted in conjunction with the repeal of *MaineCare Benefits Manual*, Ch. II and III Section 35, "Hearing Aids and Services", and is dependent upon the approval of the Centers for Medicare and Medicaid Services.

Fiscal impact of rule:

The Department expects that this rule-making will cost in state funds approximately $544,860.00 in SFY15 and $597,259.00 in SFY16. The Department does not anticipate that this rule-making will impose any cost on municipal or county governments, or on small businesses employing fewer than twenty employees.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. III Section 45**, Hospital Services
Filing number:	**2015-122**
Effective date:	7/7/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule is a recommendation of the MaineCare Redesign Task Force, established pursuant to PL 2011, Ch. 657, Part T, "An Act To Make Supplemental Appropriations and Allocations for the Expenditures of State Government and to Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 2013." In addition, this rule will implement a hospital classification change that resulted in a methodology change to the supplemental pool.

Basis statement:

This adopted rule reduces the supplemental pool for non-critical access hospitals and hospitals reclassified to a wage area outside Maine and rehabilitation hospitals from $65,321,301 to $64,769,417. The rule also changes the definition of "discharge" to change the time span for which readmissions are not reimbursed to fourteen (14) days. This change has been approved by CMS. However, due to comments received, the Department in the adopted rule is adding an exception to the fourteen (14) day readmission policy, for members with mental illness and chemical dependency and substance abuse conditions. This exception needs the approval of CMS. Additionally, if CMS approves, due to comments received, the Department will not adopt the proposed change of "the same primary diagnosis" in the definition of "discharge", so that the rule will continue to use "a diagnosis within the same DRG". Finally, the Department removed "if CMS approves" from those provisions which have been approved by CMS.

The reason the Department is adopting the fourteen (14) day policy is because this change was recommended by the MaineCare Redesign Task Force December, 2012, *Report*. The fourteen (14) day policy is a budget initiative that is also designed to increase the quality of the hospital readmission policies. CMS has approved the fourteen (14) day policy.

Fiscal impact of rule:

The Department anticipates that this rule-making will save the Department approximately $145,069 in SFY 15 and $1,737,122 in SFY 16.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; PL 2013 ch. 368 §SS-2; Resolve ch. 24 (LD 8)
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. III Section 29**, Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder
Filing number:	**2015-124**
Effective date:	8/8/2015
Type of rule:	Major Substantive
Emergency rule:	No

Principal reason or purpose for rule:

The Department is adding procedure codes and modifiers for the new services added to the corresponding Ch. II of Section 29. These include:

- New procedure codes for Assistive Technology services, which has three components: the Assessment and Training, the Assistive Technology Devices and the monthly cost of the internet or cable transmission.
- New procedure codes for Career Planning services, Home Support-Quarter Hour services, Home Support-Remote Support services, Work Support-Group services and Work Support-Individual services.
- Modifiers for Home Support-Remote Support services to indicate whether interactive support is being delivered or the member is only being monitored.

Additionally, the Department is adding billing instructions to Work Support-Group to describe how to submit for reimbursement when services are delivered in a group setting. The reason for the rule changes are to comply with the budget bill PL 2013 ch. 368 directing the Department to add Assistive Technology. The Department is complying with Resolve ch. 24, LD 8, *Resolve, Directing the Department of Health and Human Services to Provide Coverage under the MaineCare Program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder*. This Resolve directs the Department to add Home Support as a covered Service to this waiver. The Department is also complying with a CMS directive to separate Home Support into separate services. The Work Support and Career Planning changes are to comply with LD 8, *Resolve, Directing the Department of Health and Human Services to provide coverage under the MaineCare program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder*.

Basis statement:

This is a final adoption of a major substantive rule. The following outlines the procedural history of this rule adoption as well as the specific changes to the rule.

Section 29 services are governed by a Centers for Medicare and Medicaid Services (CMS) Medicaid waiver. On April 18, 2014, CMS approved changes to the Section 29 waiver, effective July 1, 2014, adding new services as requested by the Department. In order to add these additional services to the *MaineCare Benefits Manual*, the Department engaged in routine technical rulemaking for Ch. II Section 29. The Commissioner adopted the Ch. II Section 29 rule with changes to these services effective September 1, 2014.

However, Ch. III Section 29, which governs the reimbursement of services under Ch. II, is a major substantive rule. As such, Ch. III Section 29 requires legislative approval before becoming effective. Pursuant to 5 MRS §8072, the Department engaged in the rule-making process set forth under 5 MRS §8052 up until the point of adoption. This included conducting a public hearing on April 15, 2014, and accepting public comments until

April 25, 2014. The Commissioner provisionally adopted the Ch. III Section 29 rule on August 22, 2014. Thereafter, the Department submitted the provisionally adopted rule to the Legislature for its review.

Meanwhile, because federal law requires that provider claims for Medicaid services be submitted within one year of providing the Medicaid service (42 CFR 447.45), and because Medicaid reimbursement must be made timely, the Department determined to concurrently adopt an emergency major substantive rule for Ch. III Section 29. The emergency major substantive rule became effective on September 1, 2014. Thus, the Department has been able to reimburse for new services under Ch. II Section 29 pending the Legislature's review of the provisionally adopted major substantive rule.

On April 28, 2015 the Legislature enacted *Resolve, Regarding Legislative Review of Portions of Ch. 101: MaineCare Benefits Manual, Ch. III, Section 29: Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder, a Major Substantive Rule of the Department of Health and Human Services* (Resolves 2015, Ch. 13). The law took effect May 10, 2015.

Given the Legislature's authorization for final adoption, as well as the limit on the application of an emergency rule, the Department now finally adopts the Ch. III Section 29 major substantive rule the Commissioner had provisionally adopted on August 22, 2014.

This final adopted rule mirrors those changes currently in place since September 1, 2014, under the emergency major substantive rule. These changes correspond to the CMS-approved Section 29 waiver and include:

1. Allowances for Assistive Technology services, including (a) Assistive Technology-Assessment; (b) Assistive Technology – Transmission (Utility Services); and (c) Assistive Technology – Devices. Adding these services complied with PL 2013 ch. 368 §SS, which authorized MaineCare "reimbursement for the use of appropriate electronic technology as a means of reducing the costs of supporting people currently being served [on the Section 29 waiver]." Assistive Technology – Devices are limited to a cap of $6,000 per year, and Assistive Technology – Transmission (Utility Services) are limited to a cap of $50.00 per month.
2. Allowances for Home Support services, including: (a) Home Support – Quarter Hour; (b) Home Support – Remote Support – Monitor Only; and (c) Home Support – Remote Support – Interactive Support. Adding these services complied with Resolves 2013, Ch. 24 (*Resolve, Directing the Department of Health and Human Services to Provide Coverage under the MaineCare Program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder*).

Additionally, the Department clarified the reimbursement and billing for Work Support – Group services so that the exact reimbursement rate, depending on the number of members in the group, is indicated.

Finally, the Department deleted Home Accessibility Adaptation services from the calculation for the Standard Unit Rate, since this service is paid per invoice, as indicated in Appendix I.

Fiscal impact of rule:

This rule-making is estimated to be cost neutral.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; PL 2014 ch. 582
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II & III Section 67**, Nursing Facility Services
Filing number:	**2015-167**
Effective date:	9/15/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making will: (1) provide a new methodology for calculating recapture of depreciation upon the sale of a nursing facility, and (2) add reimbursement for Ventilator Care Services as a separately reimbursable service (i.e., above and beyond the daily NF rate). The purpose of providing a new methodology for calculating recapture of depreciation upon the sale of a nursing facility is to comply with Public Law 2014 ch. 582. The purpose of adding reimbursement for Ventilator Care Services as a separately reimbursable service is to ensure that nursing facilities may be reimbursed for members that need Ventilator Care Services.

Basis statement:

The Department of Health and Human Services (the "Department") determined that the adoption of this rule is necessary to (1) provide a new methodology for calculating recapture of depreciation upon the sale of a nursing facility ("NF"), and (2) to add ventilator care services as a separately reimbursable service in NFs for eligible MaineCare members.

On April 29, 2014, as a result of Public Law 2014 ch. 582, the 126th Maine Legislature enacted 22 MRS §3175-D(2), which requires a new methodology for calculating the recapture of depreciation upon the sales of nursing facilities that occur on or after July 1, 2014. On October 30, 2014, the Department published a notice of reimbursement methodology change, pursuant to 42 CFR §447.205. In December of 2014, the Department submitted proposed changes regarding depreciation recapture to its State Plan Amendment for NF services to the Centers for Medicare and Medicaid Services ("CMS"). While CMS has not yet approved those changes, the Department anticipates receiving CMS approval in the near future. The Department requested that the NF SPA changes regarding depreciation recapture be made effective November 1, 2014. As such, if CMS approves, for sales of NFs occurring on or after July 1, 2014, the depreciation recapture rule changes in Ch. III Section 67 will have a retroactive effective date of November 1, 2014.

Certain NFs in the state of Maine provide ventilator care services to MaineCare members, however, the Department seeks to broaden the availability of these services to NFs state-wide. As such, through this rule-making, the Department is making ventilator care services a separately reimbursable service for NFs, over and above their standard rate of reimbursement for NF services, effective July 1, 2015. To receive this separate reimbursement for eligible members, the NF must seek and obtain prior authorization from the Department. During the prior authorization process, the Department will determine an appropriate rate of reimbursement for the NF on a case by case basis, depending on the member's needs. The prior authorization will include each item or service included in the reimbursement rate.

On August 12, 2015, pursuant to 42 CFR §447.205, the Department published a notice of reimbursement methodology change for the Section 67 changes regarding ventilator care services. The Department has not yet submitted the corresponding SPA changes to CMS, but

it intends to submit the Section 67 SPA changes regarding ventilator care services on or before September 30, 2015.

As a result of comments, the Department made changes to both the depreciation recapture language, as well as the ventilator care provisions, and it also made various technical changes.

Based on a recent State Plan Amendment approval from Centers for Medicare and Medicaid Services, a number of "if CMS approves" references have been deleted from the final rule. The following areas in Ch. III were affected:

- 1.4, page 2, Base Year definition.
- 17.4.2, page 25, Allowable Administration and Management Expenses.
- 17.4.3, page 27, Central Office operational costs.
- 17.4.4, page 28, Dividends and Bonuses.
- 17.4.5, page 28, Management Fees.
- 18.12, page 51, Payment for High MaineCare Utilization.
- 22.3.3.1, page 55, Source of Base Year Cost Data.
- 2.3.3.2, page 56 Case Mix Index.
- 22.3.3.2. a, page 57, Direct Care Regional Index.
- 22.3.3.4. a. & b., page 57, Array of the base year case mix and regionally adjusted cost per day.
- 22.3.4.2, page 58, Direct Care Add-on.
- 22.3.4.3, page 58, Hold Harmless Provision.
- 22.4.1 & 22.4.3, page 59, 22.4.4 & 22.4.5, page 60 Routine Cost Component.
- 23.3, page 62, Prospective Rate.
- 23.4, page 62, Funding Adjustment.
- 31.1, page 69, COLA.

The anticipated fiscal impact of these rule changes are as follows:

(1) Per the Public Law 2014 ch.582 (22 MRS §3175-D(2)), providing a new methodology for calculating recapture of depreciation upon the sale of a nursing facility carries a potential current biennium cost increase, but the impact cannot be quantified at this time because it is dependent upon the timing and details of federal approval of the SPA changes, and on the timing and number of facility sales.

(2) The Department estimates that the General Fund impact of adding separate reimbursement for Ventilator Care Services as a separately reimbursed service is $220,792 in SFY 2016 and $219,615 in SFY 2017.

This rule-making will not impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Fiscal impact of rule:

(1) Per the Public Law, providing a new methodology for calculating recapture of depreciation upon the sale of a nursing facility carries a potential current biennium cost increase, but the impact cannot be quantified at this time because it is dependent upon the timing and details of federal approval and on the timing and number of facility sales. (2) The Department estimates that the General Fund impact of adding reimbursement for Ventilator Care Services as a separately reimbursable service is $220,792 in SFY 2016 and $219,615 in SFY 2017.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; 5 MRS §8054; PL 2015 ch. 267 Part A, UU
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. III Section 45**, Hospital Services
Filing number:	**2015-181**
Effective date:	10/1/2015
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

In compliance with the State's biennial budget, this rulemaking reduces reimbursement for non-emergency use of the Emergency Department ("ED"). This reimbursement reduction applies to in-state Acute Care Non-Critical Access Hospitals only. The rule change reduces reimbursement of non-emergency use of the ED to the rate of a comparable visit delivered in a private physician office for a non-facility based provider.

Basis statement:

Pursuant to the State's biennial budget, Public Law 2015, Ch. 267 (702 – L.D. 1019), the Department of Health and Human Services (the "Department") is reducing the reimbursement rate for non-emergency use of the emergency department ("ED") for in-state Acute Care Non-Critical Access Hospitals only.

On June 30, 2015, the Maine State Legislature voted to override the Governor's veto of the budget, which then became effective on July 1, 2015. Pursuant to Part UU Sec. UU-1 of the budget, the Legislature provided that the Department need not demonstrate emergency findings in support of this emergency rule-making.

In an effort to reduce the inappropriate and costly use of ED services, if the Centers for Medicare and Medicaid Services ("CMS") approves, effective October 1, 2015, these rule changes reduce reimbursement of non-emergency use of the ED to the rate of a comparable physician's office visit. Specifically, the Evaluation and Management portion of the Ambulatory Payment Classification for ED services will be reimbursed at the current outpatient physician's office rate listed in the MaineCare Fee Schedule. Non-emergent use of the ED will be identified by the primary diagnosis, as indicated by the ICD-10 codes listed in *MaineCare Benefits Manual*, Ch. III Section 45, "Hospital Services", Appendix B.

On September 14, 2015, the Department published a notice of change in reimbursement methodology, pursuant to 42 CFR §447.205. The Department intends to submit its State Plan Amendment changes to CMS for approval on or before September 30, 2015, with a requested effective date of October 1, 2015.

These emergency rule changes to Section 45 Ch. III shall be effective for ninety (90) days. To prevent lapse, after filing this emergency rulemaking, the Department shall propose these changes pursuant to 5 MRS §8052.

Fiscal impact of rule:

This rule-making is estimated to result in a total cost savings in SFY 2016 of $3,083,707 including $1,157,315 state dollars and a total savings in SFY 2017 of $4,111,609 including $1,534,864 state dollars**.**

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173; PL 2015 ch. 267, 702 – L.D. 1019, Parts A, UU, UUUU
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. III Section 2**, Adult Family Care Services
Filing number:	**2015-188**
Effective date:	Retroactive to July 1, 2015
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

The purpose of this emergency rule is to increase the reimbursement rates by 4% for Adult Family Care Services at residential care facilities provided under the *MaineCare Benefits Manual*, Ch. III Section 2. This rate increase accords with the State's biennial budget, which likewise authorizes the Department to implement the rate increases retroactive to July 1, 2015, though emergency rule-making. See P.L. 2015, ch. 267, 702 - L.D. 1019, Parts A, UU, and UUUU.

Basis statement:

The Department of Health and Human Services adopts this emergency rule to increase reimbursement rates by 4% for adult family care services at residential care facilities.

In conjunction with the development of the State's biennial budget, the Department proposed to increase the reimbursement rate for providers of adult family care services at residential care facilities. The Maine State Legislature approved this rate increase when it enacted the budget, Public Law 2015, Ch. 267 (702 – L.D. 1019). Specifically, Part A, Section A-32, "Medical Care – Payments to Providers 0147" provides funding to increase the reimbursement rates by 3% beginning July 1, 2015. Part UUUU, Section UUUU-1, "Medical Care – Payments to Providers 0147" provides additional funding to increase that rate from 3% to 4%.

To implement this rate increase, the budget also authorized the Department to adopt emergency rules pursuant to 5 MRS §8054 "without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety or general welfare." Part UU, Sec. UU-1.

Given that the budget approved the rate increase as of July 1, 2015, the Department's adoption of this emergency rule makes the rate increases retroactively effective to July 1, 2015. The Department has authority for the retroactive effective date under 22 MRS §42(8) because these changes increase reimbursement for providers, ensure that members have access to medically necessary covered services, and otherwise have no adverse impact on either MaineCare providers or members.

This emergency rule adoption for Ch. III Section 2 shall be effective for ninety (90) days. 5 MRS §8054(3). To prevent a lapse in this increased reimbursement rate following the expiration of the emergency period, the Department is concurrently engaging in the routine rulemaking process for this rule.

Fiscal impact of rule:

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

The Department expects that this emergency rule-making in conjunction with the routine rule-making for Ch. III Section 2 will cost the Department approximately $82,987 in SFY 20 16.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173; 5 MRS §8054; PL 2015 ch. 267, Parts A, UU
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II & III Section 96**, Private Duty Nursing and Personal Care Services
Filing number:	**2015-201**
Effective date:	Retroactive to July 1, 2015
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

The purpose of this emergency rule is to increase the reimbursement rates for Personal Support Services (PSS) provided under the *MaineCare Benefits Manual*, Ch. II and III, Section 96. This rate increase is pursuant to the State's biennial budget, which likewise authorizes the Department to implement the rate increases retroactive to July 1, 2015, through emergency rulemaking. See P.L. 2015, ch. 267, Parts A and UU. To avoid a reduction in services available to members as a result of the increase in reimbursement rates for PSS, this emergency rule-making includes a proportional increase in the monthly cost caps for affected levels of care.

Basis statement:

The Department of Health and Human Services (the "Department") adopts this emergency rule to increase reimbursement rates for personal support services.

Pursuant to the State's biennial budget, the Department is increasing the reimbursement rate for providers of personal support services. On June 30, 2015, the Maine State Legislature enacted the budget, Public Law 2015, Ch. 267. Specifically, Part A, Section A-32, "Medical Care – Payments to Providers 0147," provides funding to increase the rates for personal support services beginning July 1, 2015.

Services reimbursed by *MaineCare Benefits Manual*, Section 96, "Private Duty Nursing and Personal Care Services" must be delivered in accordance with an authorized plan of care that meets medical necessity criteria and is reimbursable within a pre-determined monthly cost cap. The monthly cap is based on the members' eligibility category. To avoid a reduction in services available to members as a result of the increase in reimbursement rates for personal support services, the Department is adopting a proportional increase in the applicable monthly cost caps set forth in Ch. II, Section 96, Appendix #2.

To implement this rate increase, the budget authorized the Department to adopt emergency rules pursuant to 5 MRS §8054 "without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety or general welfare." Part UU, Sec. UU-1.

Given that the budget approved the rate increase as of July 1, 2015, the Department's adoption of this emergency rule makes the rate increases retroactively effective to July 1, 2015. The Department has authority for the retroactive effective date under 22 MRS §42(8) because these changes increase reimbursement for providers, ensure that members have access to medically necessary covered services, and otherwise have no adverse impact on either MaineCare providers or members.

This emergency rule adoption for Ch. II and Ch. III, Section 96 shall be effective for ninety (90) days. 5 MRS §8054(3). To prevent a lapse in this increased reimbursement rate following the expiration of the emergency period, the Department is concurrently engaging in the routine rule-making process for this rule.

Fiscal impact of rule:

The Department expects that this emergency rulemaking, in conjunction with the routine technical rulemaking for Chapters II and III, Section 96, will cost the Department approximately $1,112,552 in SFY 2016 including $417,513 in state dollars and $1,118,512 in SFY 2017 including $417,540 in state dollars.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173, Part UU Sec. UU-1; 5 MRS §8054, P.L. 2015 Ch. 267 (Sec. A-32)
Ch. number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II & III Section 19**, Home and Community Benefits for the Elderly and for Adults with Disabilities
Filing number:	**2015-202**
Effective date:	Retroactive to July 1, 2015
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
Effective July 1, 2015, the state's biennial budget, increased the reimbursement rate for providers of Attendant Care Services and Personal Care Services in the *MaineCare Benefits Manual*, Ch. III Section 19, "Home and Community-Based Benefits for the Elderly and for Adults with Disabilities". In Ch. II Section 19, the Department also proposed to increase, the monthly limits for members' Section 19 services from $4,200/month to $4,603/month. The Maine State Legislature approved of these increases when it enacted the budget, P.L. 2015, Ch. 267 (702 - L.D. 109).

Section 19 services are governed by a Section 1915(c) waiver approved by the Centers for Medicare and Medicaid Services (CMS). Pursuant to 5 MRS §8054, the Department makes these reimbursement changes in Section 19 through emergency rule making. Pursuant to Part UU Sec. UU-l of the budget, the Legislature provided that the Department need not demonstrate emergency findings in support of this emergency rulemaking.

In Ch. III Section 19, these emergency rule changes allow MaineCare to increase: (1) Attendant Care Services (Personal Care Services, Participant Directed Option), billing code S5125, from $2.93 per quarter hour to $3.21 per quarter hour; and (2) Personal Care Services (Agency PSS), billing code TI019 from $3.75 per quarter hour to $4.10 per quarter hour.

Because the Department is increasing reimbursement for services in Ch. III of Section 19, it also seeks to increase the monthly program cap for MaineCare members, so that they are not adversely affected by the reimbursement changes. As such, these emergency rule changes in Ch. II Section 19 increase the limitation in Sec. 19.06(A) from $4,200 per member per month to $4,603 per member per month.

Given that the budget was effective July 1, 2015, the Department seeks to make these changes retroactive to July 1, 2015. The Department has authority for the retroactive effective date under 22 MRS §42(8), because these changes increase reimbursement for providers, ensure that members have access to medically necessary covered services, and otherwise have no adverse impact on either MaineCare providers or members.

These emergency rule changes to Section 19 Ch. II and III shall be effective for ninety (90) days. To prevent lapse, after filing this emergency rulemaking, the Department shall propose these changes pursuant to 5 MRS §8052.

Fiscal impact of rule:
The Department expects that this rulemaking will cost an additional $883,727.00 in state funding, annually.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173; P. L. 2015 Parts A & UU; Resolves 2015 ch. 34, An Act *To Implement the Recommendations of the Commission to Continue the Study of Long-term Care Facilities.*
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. III Section 67**, Nursing Facility Services
Filing number:	**2015-225**
Effective date:	Retroactive to July 1, 2015
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

This emergency rule change seeks to implement the following:

1. Increase the final prospective rate from 95.12 percent to 97.44 percent.
2. Include the cost of continuing education for direct care staff as a direct care cost component rather than a routine cost component.

These changes are being done in order to comply with P.L. 2015 ch. 267, Part A and Resolves 2015 ch. 34, An Act *To Implement the Recommendations of the Commission to Continue the Study of Long-term Care Facilities.* The Department has submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS). If CMS approves, the final prospective rate increase and the cost of continuing education for direct care staff as a direct care cost component will be effective retroactive to July 1, 2015.

Basis statement:

The adoption of this emergency rule brings Maine into compliance with Public Law 2015 ch. 267, Part A, and Resolves 2015 ch. 34, An Act *to Implement the Recommendations of the Commission to Continue the Study of Long-term Care Facilities.* The rule increases the final prospective rate from 95.12 percent to 97.44 percent and includes the cost of continuing education for direct care staff as a direct care cost component rather than a routine cost component.

The Department has submitted a State Plan Amendment to the Center for Medicare and Medicaid Services (CMS). If CMS approves, the final prospective rate increase and the cost of continuing education for direct care staff as a direct care cost component will be effective retroactive to July 1, 2015.

The Department's adoption of this emergency rule makes the increase in the final prospective rate and the cost of continuing education for direct care staff as a direct care cost component effective retroactive to July 1, 2015, pursuant to 22 MRS §42(8). The Department has determined that immediate adoption of this rule is necessary. The Legislature authorized the Department to do emergency rule-making as part of P.L. 2015, Part UU.

This emergency rule adoption for Ch. III Section 67, "Nursing Facility Services", shall be effective for ninety (90) days pursuant to 5 MRS §8054(3). To prevent a lapse in the increased final prospective rate and the inclusion of cost of continuing education for direct care staff as a direct care cost component, following the expiration of the emergency period, the Department is concurrently engaging in the routine rulemaking process for this rule.

Fiscal impact of rule:

For Fiscal Year 2016, there will be a General Fund cost of $9,522,360 and federal expenditures of $15,850,303. For Fiscal Year 2017, there will be a General Fund cost of $9,532,078 and federal expenditures of $16,002,554.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; 22 MRS § 3174-WW; PL 2012 ch.542, §B-5
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II Section 80**, Pharmacy Services
Filing number:	**2015-230**
Effective date:	November 29, 2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making seeks to delete the Wholesale Acquisition Cost (WAC) from the reimbursement rate options. Furthermore, in order to be consistent with state statute 22 MRS §3174-WW, the no co-payment requirement for smoking cessation products has been added to the pharmacy benefits retroactive to August 1, 2014, for members eighteen (18) years of age or older or who are pregnant. In addition, some terms have been replaced with nationally recognized language that is considered more respectful of the individual. The term ICF-MR (Intermediate Care Facility for Persons with Mental Retardation) has been changed to ICF-IID (Intermediate Care Facility for Individuals with Intellectual Disabilities).

Basis statement:

This adopted rule deletes the Wholesale Acquisition Cost (WAC) from the reimbursement rate options. While WAC was added to the rule, it was never implemented nor used. Furthermore, in order to be consistent with 22 MRS §3174- WW, the no co-payment requirement for tobacco cessation products has been added to the pharmacy benefits retroactive to August 1, 2014 per 22 MRS §42(8) for members eighteen (18) years of age or older or who are pregnant. CMS approved these changes December 9, 2014.

In addition, some terms have been replaced with nationally recognized language that is considered more respectful of the individual. The term ICF-MR (Intermediate Care Facility for Persons with Mental Retardation) has been changed to ICF-IID (Intermediate Care Facility for Individuals with Intellectual Disabilities).

The Department of Health and Human Services' primary source of information for this rule includes 22 MRS §3174- WW, *An Act to Reduce Tobacco-related Illness and Lower Health Care Costs in MaineCare* and P.L. 2012 ch.542, §B-5, *An Act To Implement the Recommendations of the Department of Health and Human Services and the Maine Developmental Disabilities Council Regarding Respectful Language*.

Fiscal impact of rule:

The addition of the provision for no copayment for tobacco cessation products to member benefits will increase the cost to MaineCare by $6,021.37 in SFY 2016 and $9,032.05 in SFY 2017.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II Section 32**, Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders
Filing number:	**2015-239**
Effective date:	December 9, 2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The Department repeals Ch. II Section 32 as no members have ever received services under this Section. The Department originally promulgated the rule after receiving approval from the Centers for Medicare and Medicaid Services (CMS) to operate a Section 1915(c), "Home and Community-Based Services waiver for Children with Intellectual Disabilities and/or Pervasive Developmental Disorders". The waiver has since expired and, through CMS guidance, the Department determined not to renew the waiver. Children who would have been eligible to receive Section 32 services already receive and will continue to receive these services through other sections of the Medicaid State Plan, through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, and through state-funded programs at the Office of Child and Family Services.

Basis statement:

This rule adoption shall repeal Ch. II Section 32, "Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders", which, since its July 1, 2011, implementation has existed without any member enrollment. No members have ever received services under Section 32. The Department originally promulgated the rule after receiving approval from the Centers for Medicare and Medicaid Services (CMS) to operate a Section 1915(c), "Home and Community-Based Services waiver for Children with Intellectual Disabilities and/or Pervasive Developmental Disorders". The waiver has since expired and, through CMS guidance, the Department determined not to renew the waiver as all waiver services are currently being offered to this population elsewhere. With the expired waiver, the Department is no longer authorized to operate this program.

No members will be affected by the repeal of Ch. II Section 32. Children who would have been eligible for these waiver services already receive and will continue to receive these services through other sections of the Medicaid State Plan, through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, and through state-funded programs at the Office of Child and Family Services.

The Department is concurrently proposing to repeal Ch. III Section 32, on the same basis. This rule, Ch. II Section 32, is a routine technical rule. Ch. III Section 32 is a major substantive rule and requires authorization from the Legislature.

Fiscal impact of rule:

There will be no fiscal impact as a result of this rule.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; P.L. 2015 ch. 267, Part A
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. III Section 45**, Hospital Services
Filing number:	**2015-255**
Effective date:	December 31, 2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

Pursuant to the State's biennial budget, this rule-making reduces reimbursement for non-emergent use of the Emergency Department ("ED"). This reimbursement reduction applies to in-state Acute Care Non-Critical Access Hospitals only. The rule change reduces reimbursement of non-emergency use of the ED to the rate of a comparable visit delivered in a private physician office for a non-facility based provider.

Basis statement:

Pursuant to the State's biennial budget, P. L. 2015 ch. 267, Part A, Section A-32, the Department of Health and Human Services (the "Department") is reducing the reimbursement rate for non-emergent use of the emergency department ("ED") for in-state Acute Care Non-Critical Access Hospitals only.

In an effort to reduce the inappropriate and costly use of ED services this rule adoption reduces reimbursement of non-emergency use of the ED to the rate of a comparable physician's office visit. Specifically, the hospital will be paid the outpatient physician's professional evaluation and management service fee schedule rate. This will be determined by using the current physician's payment rate listed in the MaineCare Fee Schedule associated with the ED CPT code reported on the UB04 claim. Non-emergent use of the ED will be identified by the primary diagnosis, as indicated by the ICD-l0 codes in *MaineCare Benefits Manual*, Ch. III Section 45, “Hospital Services”, Appendix B.

To implement these changes, the Department published a notice of change in reimbursement methodology on September 14, 2015, pursuant to 42 CFR §447.205. The Department also submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services ("CMS") for approval, with a requested effective date of October 1, 2015. The Department is currently awaiting a response from CMS.

In addition, the Department engaged in emergency rule-making to implement these changes effective October 1, 2015, for ninety days. 5 MRS §8054(3). That rule expires December 30, 2015. To prevent lapse, after filing the emergency rule-making, the Department proposed these routine technical rule-making changes pursuant to 5 MRS §8052. The Department now finally adopts these changes with an effective date of December 31, 2015.

Finally, this rule adoption is consistent with the rule proposal with the exception of the Department clarifying reimbursement language in 45.03-1(D) as a result of public comments, and removing language in 45.01-6, 45.07, and 45.12 where components of this rule were listed as contingent upon approval from the CMS because CMS approval has been granted.

Fiscal impact of rule:

This rule-making is estimated to result in a total cost savings in SFY 2016 of $3,083,707, including $1,157,315 State dollars and a total savings in SFY 2017 of $4,111,609, including $1,534,864 State dollars.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101,** MaineCare Benefits Manual: **Ch. II Section 55**, Laboratory Services
Filing number:	**2015-261**
Effective date:	**January 2, 2016**
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
This rule was adopted to reflect current industry standards, and to ensure compliance with federal requirements for Laboratory Services, pursuant to 42 CFR §§ 440.30 and 447.201. The Department has adopted changes to this rule in order to align the language in Section 55 with the language of the Department's State Plan Amendment (SPA). In particular, the adopted changes increase the reimbursement rate from fifty-three percent (53%) of the lowest level in the current Medicare fee schedule for Maine in effect at that time, to seventy percent (70%) of the 2009 CMS rate or seventy percent (70%) of the rate in the year CMS assigns a rate for that code. The Department will seek approval from CMS for an amendment to its SPA to reflect that the provider's usual and customary charge is one of the several benchmarks utilized by the Department to determine reimbursement for laboratory services.

In addition, the Department has updated several provisions, including Sections 55.04-1, 55.04-2, 55.07, and 55.09, to add an updated reference to the current rates in the Maine HealthPAS Portal Provider Fee Schedule and to remove outdated references such as Section 90, Ch. III, “Physician Services”. The Department also updated 55.02 to reflect current eligibility provisions to be consistent with other policies and current practice. It additionally updated the language in various other provisions, including Sections 55.05-3, 55.05-6, and 55.08-2, to make them consistent with current terminology. It further eliminates language referencing the diagnosis code "EMR" in Section 5 5 .09 to align with current Medicaid billing practices. Finally, the Department removed Section 55.08-3 (Copayment Disputes), given that those requirements are set forth in Ch. I Section 1 of the *MaineCare Benefits Manual*.

Fiscal impact of rule:
The Department anticipates that this rule-making will save approximately: $802,166.26 in SFY 16 and $1,063,855.29 in SFY 17 in State match.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Maine Center for Disease Control and Prevention, Division of Environmental Heath, Drinking Water Program – Wastewater Unit**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS ch. 1683 §8704 sub-§4, and §8708
Chapter number/title:	**Ch. 241**, Subsurface Wastewater Disposal Rules
Filing number:	**2015-138**
Effective date:	8/3/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule amendment adds clarifying language to the general submission requirements; updates references, data element names and types; and corrects data element mappings, in conformance to current national and industry standards.

Basis statement:

These rules provide minimum State design criteria for subsurface wastewater disposal, to assure environmental sanitation and safety. These rules are intended to complement municipal planning, zoning, and land use control.

Changes include the correction of errors and omissions from previous rule changes, adding both a definition and design standards for in-law apartments (to provide clarity for subsurface wastewater disposal system designers, property owners and local officials), and adding a new section which combines, organizes and clarifies requirements when working in the Shoreland Zone or adjacent to protected natural resources.

Previous versions of the rules did not include standards for in-law apartments, resulting in confusion for designers and uncertainty for property owners. Inclusion of standards for in-law apartments simplifies the design process and allows property owners to easily understand the requirements for subsurface wastewater disposal when an in-law apartment is considered. In many instances, in-law apartments, as defined, will be allowed without expansion of the existing subsurface wastewater disposal system.

The regulated community has asked for clear guidance regarding work adjacent to, or in, protected natural resources. Previous versions of the rules included references and standards for disposal systems located in the Shoreland Zone or adjacent to protected natural resources in several different sections. The new section that compiles and organizes these references and standards will greatly simplify the design of disposal systems in these locations and allow property owners a greater understanding of the regulatory requirements for protecting them. These standards and requirements are not new. Instead, they are the result of existing laws and regulations protecting natural resources, including Mandatory Shoreland Zoning and the *Natural Resources Protection Act*. The section has been reviewed by staff at the Maine Department of Environmental Protection for accuracy and completeness. This new section will allow designers and property owners to remain in compliance with relevant Maine environmental protection laws and regulations simply by adhering to the standards found in these rules.

Fiscal impact:

There is no fiscal impact on state municipalities, counties or businesses.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Maine Center for Disease Control and Prevention**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1); 22 MRS ch. 250; 5 MRS ch. 501
Chapter number/title:	**Ch. 258**, Rules for the Control of Notifiable Diseases and Conditions
Filing number:	**2015-166**
Effective date:	9/8/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The Department proposes updates to the Rules for the Control of Notifiable Diseases and Conditions to better align with new and emerging diseases and more efficient methods of reporting being adopted nationally. The Department is proposing updates to the notifiable diseases and conditions list to better reflect diseases that are most important to prevent and control to protect public health in Maine.

Basis statement:

The Rules for the Control of Notifiable Diseases and Conditions were first drafted in 1976 by the Department of Health and Human Services. Since that time, they have been amended several times to reflect changes in notifiable diseases and the reporting of diseases. The Notifiable Diseases Workgroup, consisting of staff from the Infectious Disease Epidemiology Program and Medical Epidemiology, has worked since early 2012 to determine what revisions should be made. Experts from multiple divisions within Maine CDC have been consulted during this process regarding these rule revisions. The decisions to make changes to the list of notifiable diseases were made based on many factors, including, but not limited to, which diseases are nationally reportable, incidence of the disease in Maine, severity and morbidity of the disease, and required public health disease interventions.

The adopted rules add diseases, subtract diseases, and clarify the diseases on the Notifiable Diseases and Conditions List. In order to adequately protect the public from these emerging threats, updates are necessary for sufficient prevention, detection, and control of infectious diseases that pose health risks to the public. In order to facilitate better responses to emerging public health threats, the updated rules authorize the director of the Maine CDC to advise through Health Alerts the public health need for the temporary reporting of any disease or condition as if listed on the Notifiable Diseases list. Maine CDC's ability to obtain temporary reporting of diseases is intended to facilitate the study and control of any apparent outbreak or unusual occurrence of communicable disease not specifically listed in the Notifiable Diseases list. This will aid Maine CDC infectious disease epidemiologists in their efforts to decrease morbidity and mortality due to infectious diseases in Maine people.

The adopted rules add requirements for electronic laboratory reporting of notifiable diseases and the reporting of syndromic surveillance data from emergency departments throughout Maine. In regard to syndromic surveillance, most hospital emergency departments already follow these requirements. The adopted rules clarify the state's position on these advanced and efficient methods of surveillance and detection of infectious disease in the state.

The adopted rules update the definition and reporting requirements of non-compliant persons and public health threats. The adopted rules clarify several other definitions used in the rule and clarify the reporting requirements for disease reporting.

Fiscal impact:

There is no fiscal impact to DHHS. Maine CDC already has the ability to intake and process electronic laboratory reports and emergency department visit data from additional hospitals and laboratories.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3104; 7 CFR §§ 274.6(b) *et seq.*; 7 CFR §271.2(6); 7 CFR §274.2(f)
Chapter number/title:	**Ch. 301,** Food Supplement Program, **Rule #184A**: Trafficking Controls and EBT Card Replacements
Filing number:	**2015-072**
Effective date:	4/20/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
(See Basis Statement.)

Basis statement:
This rule-making codifies provisions in the *Food and Nutrition Act of 2008* that improve Program Integrity. It is expected to enhance the program's ability to serve those who are truly in need, and help to ensure that SNAP benefits are used as intended. Specifically, this rule implements the following:

1. Federal regulation 7 CFR 271.2(6), which expands the definition of Trafficking to include the attempt to buy or sell Food Supplement benefits in cases where an individual makes an offer to sell Food Supplement benefits and/or EBT card.
2. Federal regulation 7 CFR 274.6(b), which requires the State agency to place replacement EBT cards "in the mail within two business days following notice by the household to the State agency that the card has been lost, stolen or damaged."
3. Federal regulation 7 CFR 274.6(b)(5), which allows the State agency to deny a request for a replacement card until contact is made by the household with the State agency, if the requests for replacement cards are determined to be excessive. Excessive is defined as not less than four cards requested within 12 months prior to the request.
4. The fee structure for EBT card replacement is being changed, for clarification, to reflect Federal regulation 7 CFR 274.6(b)(3), which states, "the fee may not exceed the cost to replace the card."
5. There are also adjustments to Federal regulation citations and minor text adjustments for clarification.

Fiscal impact:
All costs associated with monitoring the replacement of EBT cards has been absorbed using existing resources.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3104, 7 CFR 273.18
Chapter number/title:	**Ch. 301,** Food Supplement Program, **Rule #190A**: Overpayment Compromise (FS-777-3 pages 1 – 5)
Filing number:	**2015-144**
Effective date:	8/10/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

Federal regulation 7 CFR 273.18, "Claims against household" requires state agencies to include language in the initial demand letter or notice of adverse action that state "that the State agency may reduce any part of the claim if the agency believes that the household is not able to repay the claim."

By providing a process for which a Food Supplement recipient with an agency-error overpayment may request a compromise for the overpayment, this rule brings the Food Supplement Program into compliance with this federal regulation.

Basis statement:

Federal regulation 7 CFR 273.18, "Claims against households," with regard to notification of an overpayment, states that "the initial demand letter or notice of adverse action must include language stating ... that the State agency may reduce any part of the claim if the agency believes that the household is not able to repay the claim."

The purpose of this rule change is to establish a process by which a Food Supplement recipient with an agency-error overpayment may request a compromise for the overpayment.

Fiscal impact:

None.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3104, 5 MRS §8054
Chapter number/title:	**Ch. 301,** Food Supplement Program, **Rule #193E**: Maine Food Supplement Certification Manual, **Rule #193E**: SUA Changes for FFY 2016 (FS-555-5 pages 1-11)
Filing number:	**2015-176**
Effective date:	10/1/2015
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

An emergency rule change is necessary to remain in compliance with Federal regulation 7 CFR 273.9(d), which requires annual review and adjustment to the SUA(s).

Basis statement:

This rule implements updated standard utility allowances (SUA), as approved by USDA Food and Nutrition Services (FNS), for FFY 2016, effective October 1, 2015. Federal regulation 7 CFR 273.9(d) requires that SUA(s) be reviewed and updated annually. The SUA values are based on changes in the Consumer Price Index (CPI) for fuel and utilities, from June 2014 to June 2015, subject to approval by FNS. CPI data was released on July 17, 2015. New SUA allowances were determined and submitted to FNS for approval on July 28, 2015. FNS provided approval of the SUA allowances on August 3, 2015.

The final approved values, which will cause benefits to decrease, were not provided in a timeframe that would allow the department to comply with the non-emergency rule-making process and implement by the required date of October 1, 2015. An emergency rule change is necessary to preclude federal penalties or loss of federal funds and thereby avoid threats to the public health, safety and general welfare.

Fiscal impact:

There are no implementation costs associated with this rule as the budget for IT already factors in changes associated with rules. Additionally, these values are applied to ACES, our case management system as is, with no additional coding required.

Food Supplement (SNAP) benefits are 100% federally funded; there also is a small state-funded program. Although there may be a small amount of savings realized from the decrease in benefits, for both federal and state programs, this savings will be mitigated by the annual COLA increases in deduction allowances for FFY 2016, which will be implemented in a separate rule, effective for October 1, 2015.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3104; 7 CFR 273.2(j); 7 CFR 273.8(e)(17)
Chapter number/title:	**Ch. 301,** Food Supplement Program, **Rule #191A**: Broad Based Categorical Eligibility – Shelters for Battered Persons
Filing number:	**2015-251**
Effective date:	1/1/2016
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule will enable Food Supplement rules concerning categorical eligibility to more closely align with Federal standards and to implement Federal guidance concerning men as residents of shelters for battered persons.

Basis statement:

This rule applies a $5,000 asset limit to households that are eligible for Food Supplement benefits based on Broad-Based Categorical Eligibility (BBCE). The rule does not affect families with children. Assets such as primary vehicles and homes will not be counted as assets under the rule.

It also changes the reference from residents of shelters for battered women and children to shelters for battered persons, thereby enabling men who are victims of domestic violence to access Food Supplement benefits in these shelters.

The asset limit is allowable under federal law, and has been specifically approved by FNS. The Department expects it to bolster program integrity, as well as save federal and state tax dollars, by providing federal and state-funded benefits only to Mainers that actually need it.

This rule will not have an impact on municipalities or small businesses.

Fiscal impact:

Food Supplement benefits are 100% federally funded. For the small state-funded component, there is an estimated savings of $198 per household.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 42(8), 3104
Chapter number/title:	**Ch. 301,** Food Supplement Program, **Rule #193A**: SUA-COLA Changes for FFY 2016
Filing number:	**2015-256**
Effective date:	Varied effective dates
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule ensures compliance with federal regulations.

Federal regulation 7 CFR 273.9(d) requires that SUA(s) are reviewed and updated annually. The SUA values are based on changes in the Consumer Price Index (CPI) for fuel and utilities, from June 2014 to June 2015, subject to approval by FNS. Federal regulations 7 CFR 273.9(a) and (d) require that the COLA allowances be updated annually, effective October 1st.

Basis statement:

This rule makes permanent emergency rule #193E, *SUA Changes for FFY 2016*, implemented on October 1, 2015, which includes updated standard utility allowances (SUA), as approved by USDA Food and Nutrition Services (FNS), for FFY 2016. Federal regulation 7 CFR 273.9(d) requires that SUA(s) be reviewed and updated annually. The SUA values are based on changes in the Consumer Price Index (CPI) for fuel and utilities, from June 2014 to June 2015, subject to approval by FNS. The SUA values for heating/cooling, non-heat utility and phone costs decreased by 2%, which caused Food Supplement benefits to decrease by a small amount.

This rule also implements the annual cost of living allowance (COLA) increases, retroactively back to October 1, 2015. COLA allowances include adjustments for income eligibility standards, standard deductions and the maximum shelter allowance, as determined by FNS.

Fiscal impact:

Food Supplement (SNAP) benefits are 100% federally funded; there also is a small state-funded program.

There are no implementation costs associated with this rule as the budget for IT already factors in changes associated with rules. Additionally, these values are applied to ACES, our case management system, as is, with no additional coding required.

Although there may be a small amount of savings realized from decreased benefits due to SUA Decreases for both federal and state programs, this savings will be mitigated by the annual increased COLA values.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	PL 2011 ch. 380 §A-33 page 344; 22 MRS §3769-A, §3762 sub-§20
Chapter number/title:	**Ch. 331,** Maine Public Assistance Manual (TANF), **Rule 104A**: **Ch. I**, Eligibility Process, Non-Payment Situations (pages 14, 15, 16) (Felony Drug Convictions
Filing number:	**2015-004**
Effective date:	1/13/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The adopted rule will implement a provision of the State FY2012 and FY2013 Biennial Budget that allows the Department to deny TANF cash assistance based on a positive drug test to an individual who has been convicted of a drug-related felony, after August 1, 1996, as described in Section 115 of PRWORA, unless the individual enrolls in a substance abuse treatment program appropriate to the type of illegal drug being used by the individual.

Basis statement:

It is the objective of the Department of Health and Human Services, in administering its Temporary Assistance to Needy Families ("TANF") program, to make maximum use of its limited resources by attempting to insure, so far as reasonably possible, that all funds disbursed through the program are used for the benefit of dependent children, and are not diverted to inappropriate uses. Additionally, the avoidance of drug dependency is an important step in fostering solid, functional families in which children can be appropriately nurtured and adults can take positive steps toward retraining, education, and/or employment which will enable them to prosper without the need for governmental assistance. This is particularly important with respect to a program such as TANF that has time limits for receipt of benefits. Accordingly, the Department is adopting this rule in an effort to identify TANF recipients who may have drug dependency issues in order to provide them with access to treatment and rehabilitation options that will enable them to move away from such dependency.

This rule will implement a provision of the State FY2012 and FY2013 Biennial Budget, codified at 22 MRS §3762(20), that requires the Department to deny TANF cash assistance based on a positive drug test to an individual who has been convicted of certain serious drug-related offenses (as described within the text of the Rule), unless the individual completes a substance abuse treatment program appropriate to the type of controlled substance for which that individual has tested positive.

As contemplated by the statute, persons who have been convicted of the specified offenses within twenty years of the inquiry are potentially eligible to be tested. The Department has made some changes to the final rule, partly in response to public comments, to more fairly and appropriately identify individuals whom it would be appropriate to test.

In selecting persons to screen for potential abuse, the Department recognizes that more recent convictions provide a greater basis for concern of ongoing substance abuse than those which occurred in the more distant past, and will accordingly focus on recipients with convictions within the preceding ten years. All persons within the twenty-year statutory scope of 22 MRS §3762 (20)(A), however, may at certain times to be determined by Department policy, be required to complete a Substance Abuse Subtle Screening Inventory ("SASSI") to determine whether there exists a reasonable basis for individualized suspicion of current drug abuse. This Inventory is a simple, brief, easily completed questionnaire with objective scoring easily

completed by the examiner. It has been peer-reviewed and empirically determined to be approximately 94% accurate in identifying the existence of (or confirming the absence of) a substance dependence disorder. This accuracy has been confirmed not to be significantly affected by gender, age, socioeconomic status, ethnicity, occupational or marital status, educational level, drug of choice, or general level of functioning. The use of SASSI (or equivalent screening) has been approved by legislation in various other jurisdictions, including Arizona, Mississippi, Missouri, North Carolina, Oklahoma, Tennessee, and Utah. Use of the SASSI obviates the objection (made in other jurisdictions and in public comment) to testing undertaken without individualized suspicion of drug use. The use of the inventory itself is non-testimonial, non-invasive and does not constitute a search, and thus raises no issues of constitutional concern. Use of the SASSI ensures that no search will be undertaken without scientifically verifiable individualized suspicion.

An individual whose SASSI score indicates a probable substance abuse disorder will be required to submit to a urinalysis or other appropriate drug test in order to continue to receive TANF cash benefits. If the individual tests positive for a controlled substance, and cannot demonstrate a legitimate medical basis (such as a legal prescription) for doing so the Department may terminate the individual's TANF assistance unless the individual agrees to enroll, participate in, and complete a substance abuse treatment program appropriate to the type of controlled substance for which the individual tested positive. The individual is entitled to an Administrative Hearing and, where requested, a second test before the termination of benefits.

If a caretaker relative is disqualified from the TANF eligibility, and other eligibility unit members remain eligible, a protective payee must be assigned.

The Department does not expect implementation of the rule to result in a fiscal impact on communities inasmuch as general assistance is not permitted if an applicant is disqualified from TANF for violation of the program's policies.

Fiscal impact of rule:

The fiscal impact adopted was a General Fund savings of $50,000.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3173
Chapter number/title:	**Ch. 332,** MaineCare Eligibility Manual, **Rule #276A** - Cost of Care: **Part 12**, Residential Care: Section 1, Living Arrangements; Section 4.3.1, Determining the Cost of Care for an Individual; Section 4.3.2, Determining Cost of Care for a Couple; Section 4.3.3, Determining Cost of Care for an Individual or Couple Open on SSI
Filing number:	**2015-016**
Effective date:	2/18/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule clarifies and corrects the procedure for calculating cost of care for individuals residing in living arrangements defined in *MaineCare Eligibility Manual*, Part 12 Residential Care.

Basis statement:

For each individual receiving services in certain living arrangements, as set forth in the rule, an assessment or "cost of care" is determined. The cost of care is the monthly amount the individual is expected to contribute toward the cost of his /her care at the facility.

The existing rule combined the explanation for determining cost of care for individuals and couples who only receive an SSI benefit with the explanation for determining a cost of care for individuals and couples who receive an SSI benefit along with other sources of income. This resulted in confusion and cost of care determinations that were sometimes inaccurate (e.g., a federal disregard of $20 could have been incorrectly given to persons who only received an SSI benefit).

Additionally, the existing rule also sometimes inaccurately allowed an earned income disregard to be used in cost of care determinations. It was never the Department's intention to use the earned income disregard to determine cost of care; the earned income disregard should only be used to determine eligibility for coverage. The adopted rule, which is being made as a result of findings from a recent audit of MaineCare eligibility determinations, provides needed clarity by deleting the inaccurate instruction to subtract the earned income disregard from gross monthly income in order to determine the cost of care. This clarification should help prevent future errors in the determination of cost of care.

The adopted rule:

- clarifies the instructions for determining cost of care for individuals and couples who only receive an SSI benefit;
- provides separate instructions for determining cost of care for individuals and couples who receive an SSI benefit along with another source of income; and
- corrects the explanation for determining cost of care for individuals and couples who do not receive an SSI benefit.

Fiscal impact:

Individuals who are receiving the Federal Disregard when they are not eligible will lose the $20 allowance. Implementing this rule will result in estimated annual savings to the State's General Fund of $83,988 per fiscal year.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 42(8), 3173, 3174
Chapter number/title:	**Ch. 332,** MaineCare Eligibility Manual, **Rule #277A** - Brain Injury Waiver: **Part 6**, Supplemental Security Income; **Part 13**, Home and Community-Based Waiver
Filing number:	**2015-041**
Effective date:	Retroactive to 7/1/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

To create a new Home and Community-Based Services Waiver eligibility group for Adults with Brain Injury that corresponds with a new Section 1915(c), "Home and Community Based Waiver Benefit for Adults with Brain Injury", that the Centers for Medicare and Medicaid Services (CMS) approved with an effective date of July 1, 2014. This rule also being removes the Home and Community Benefits for the Physically Disabled Waiver eligibility group and to ensure that the eligibility budgeting process for all Home and Community-Based Waiver programs correspond with the OMS rule changes to comply with Resolve 2011 ch. 71, which blends services from Section 19, "Home and Community Benefits for the Elderly and for Adults with Disabilities" and Section 22, "Home and Community Benefits for the Physically Disabled". These changes are subject to CMS approval; a waiver amendment was submitted March 14, 2014.

Basis statement:

The Centers for Medicare and Medicaid Services (CMS) approved a new Section 1915(c), "Home and Community Based Waiver for Adults with Brain Injury". The Waiver was approved for a 5-year period with an effective date of July 1, 2014.

The Department is adding this new waiver group, "Home and Community Based Waiver for Adults with Brain Injury (ABI)", to provide supports necessary to assist individuals with ABI to live in the community rather than institutional settings. The Department is also merging the waivers for Section 19 ("Home and Community Benefits for the Elderly and for Adults with Disabilities") with Section 22 ("Home and Community Benefits for the Physically Disabled Waiver").

The Office for Family Independence has prepared MaineCare Rule 277A to:

- set forth the financial eligibility rules for the ABI new waiver once it is implemented;
- remove the Home and Community Benefits for the Physically Disabled Waiver eligibility group; and
- change the financial eligibility budgeting process to ensure that all Home and Community-Based Services Waiver programs allow a Personal Needs Allowance equal to 200% of the Federal Poverty Level.

Fiscal impact:

Eligibility criteria for these waiver programs are governed by this rule together with the Office of MaineCare Services (OMS) rules in applicable sections of the *MaineCare Benefits Manual*. There is no anticipated cost to the Department associated with this particular rule-making.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3173; 42 CFR 435.1110
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manual, **Rule #280A**: Part 18, Presumptive Eligibility Determined by Hospitals
Filing number:	**2015-204**
Effective date:	11/2/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
Implementation of a requirement in the Affordable Care Act (42 C.F.R. 435.1110)

Basis statement:
This rule is issued in accordance with requirements listed in 42 CFR 435.1110. The rule allows a qualified hospital defined as a hospital that: is authorized as a MaineCare provider, has received approved training on presumptive eligibility determinations from MaineCare, and has not been disqualified from making presumptive eligibility determinations by MaineCare for failing to make such determinations consistent with State policies and procedures to determine Maine Medicaid eligibility presumptively for the following eligibility groups:

- Pregnant women;
- Infants and children under age 19;
- Parents and other caretaker relatives;
- Former foster care children (i.e., individuals up to the age of 26 who were enrolled in MaineCare at the time they "aged out" of foster care); and
- Certain individuals needing treatment for breast or cervical cancer.

The presumptive eligibility period will begin on the date the determination is made and will end on the earlier of the following dates:

- The date the eligibility determination for regular Medicaid coverage is made if an application for Medicaid is filed by the last day of the month following the month in which the presumptive determination was made; or
- The last day of the month following the month in which the presumptive determination was made if no application for Medicaid is filed by that date.

Periods of eligibility will be limited to no more than one period within twenty-four consecutive months, starting with the effective date of the initial presumptive eligibility period.

All applicants for a presumptive eligibility determination will be required to sign a separate application form for presumptive eligibility created by MaineCare and approved by the Centers for Medicare and Medicaid.

Qualified hospitals will base presumptive eligibility determinations on the following factors:

- The individual's categorical or non-financial eligibility for which the individual's presumptive eligibility is being determined (e.g., parent, child, pregnant woman);
- Income for the MaineCare household in which the individual applying for presumptive eligibility resides must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined (e.g., parent, child, pregnant woman);
- State residency (i.e., the individual must be a resident of the State of Maine); and
- Citizenship.

If a qualified hospital fails on three occasions to submit a regular MaineCare application after making a presumptive eligibility determination and/or makes a presumptive eligibility

determination for someone who is ultimately found ineligible for coverage based on a full eligibility determination in response to receipt of a regular MaineCare application, the hospital will lose the authorization to perform subsequent presumptive eligibility determinations.

On January 13, 2015, the Centers for Medicare and Medicaid (CMS) approved a State Plan Amendment (SPA) that describes the State of Maine's policies related to hospital presumptive eligibility.

Fiscal impact:

SFY 16: State funds $562,397, Federal funds $943,361, All funds $1,505,758

SFY 17: State funds $2,119,249, Federal funds $3,557,828, All funds $5,677,077

The quality standards in the proposed rule are intended to minimize additional financial consequences that could result from incorrect eligibility determinations.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 42(8), 3173, 3174 *et seq*. 42 VSC §1396a; 20 CFR §§ 416.2095, 416.2096
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manual, **Rule #279A**: MaineCare Eligibility Manual, **Rule #279A**: **Charts 3, 4** - Updated Federal Poverty Levels, Cost of Living Adjustments, and Spousal Impoverishment Standards
Filing number:	**2015-252**
Effective date:	Varied effective dates
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The State of Maine administers the MaineCare program pursuant to a State Plan, which requires that the State rules reflect prevailing federal standards and arithmetical values.

Basis statement:

The Department is mandated to incorporate the following changes, per federal law. The Department expects that the changes will positively affect beneficiaries, because the majority of the changes will either increase the income limits of all MaineCare coverage groups and State Funded Assistance Programs, or allow a nursing facility resident's community spouse to have more monthly income to pay for basic expenses, such as food, housing, and heat. Where a limited number of recipients will experience a slight adverse effect due to retroactive changes to the Spousal Living Allowance, the effect will be obviated by direct reimbursement.

This rule makes certain retroactive changes with effective dates of July 1, 2014, January 1, 2015, and also makes changes with an effective date of July 1, 2015. Specifically:

- This rule updates the *MaineCare Eligibility Manual* with the Federal Poverty Level (FPL) amounts that were determined by the U.S. Department of Health and Human Services and published in the Federal Register on January 22, 2015. This change will be retroactive to January 1, 2015.
- This rule applies the SSI Cost of Living Allowance (COLA) for 2015 as required by federal law. The SSI COLA increase of 1.7% increases the Categorically Needy Nursing Care Status Income Limits to $2,199.00, and raises the SSI Countable Income Limit and Maximum Benefit to $733.00. The income limit for Adult Family Care Homes increases to $4,512. The maximum spousal allowance for Home and Community Based Waivers increases to $733. Also, the amount of protected assets for a community spouse of a nursing home applicant increases to $119,220, and the maximum monthly income to a community spouse of a nursing home resident increases to $2,981. These changes will be retroactive to January 1, 2015.
- This rule also changes the minimum monthly income standard to $1,967 and the monthly excess shelter standard to $590. Both of these changes will be retroactive to July 1, 2014, and will be effective through June 30,2015. Thereafter, effective July 1, 2015, those standards will be increased to $1,991 and $597, respectively.

Fiscal impact:

There will be a fiscal impact due to increased eligibility for some recipients, however, the amount cannot be determined.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 254-D, 3173
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manual, **Rule #275A**: **Part 2 Section 13**, Eligibility Periods / Reviews
Filing number:	**2015-257**
Effective date:	December 30, 2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule change adds a liquid asset test that is consistent with the Medicare Savings Program (MSP), changes the review period from 24 to 12 months, and requires that financial changes be reported within 10 days. This rule ensures consistent asset testing and early detection of changes in members' financial circumstances.

Basis statement:

The reference to DEL having a 24 month eligibility period in the *MaineCare Eligibility Manual*, Part 2 Section 13, "Eligibility Periods / Reviews", has been removed. This change is being made in order to stay consistent with the eligibility period and review requirements of the Medicare Savings Program (MSP) and to ensure the Department receives timely notice of changes in members' financial circumstances that could impact eligibility. This rule change is being made under the authority provided to the Department by 22 MRS §§ 42(1), 254-D, 3173.

In a single rule filing, the Department initially proposed changes to two separate and distinct state regulations, 10-144 CMR ch. 333 (the DEL rule) and 10-144 CMR ch. 332 (the *MaineCare Eligibility Manual*). In order to ensure at the time of adoption appropriate separation of the changes made to the two regulations, separate MAPA documents have been created for each regulation.

Fiscal impact:

It is anticipated that the state will save $709,310 in State Fiscal Year (SFY) 2016 ($30,883 from the General Fund and $678,427 from the Fund for a Healthy Maine) and $851,173 in SFY 2017 ($37,060 in General Fund dollars and $814,113 from the Fund for a Healthy Maine).

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	5 MRS §8054; PL 2015 Ch. 267, Parts TT, UU; 22 MRS §§ 42(1), 254-D, 3173
Chapter number/title:	**Ch. 333**, Low-Cost Drugs for the Elderly and Disabled (DEL)
Filing number:	**2015-182**
Effective date:	October 1, 2014
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

This rule implements a provision from the State FY2016 and FY2017 Biennial Budget (P.L. 2015 Ch. 267). Adoption of this emergency rule without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety or general welfare is pursuant to Part UU of the State FY2016 and FY2017 Biennial Budget (P.L. 2015 Ch. 267).

In this rule-making, the Department made changes to Section 2.1 and Section 3 of the Low Cost Drugs for the Elderly and Disabled Eligibility regulations in order to comply with Part TT of P.L. 2015, Ch. 267 and 22 MRS §254-D(4)(B)(5).

Effective October 1, 2015, these emergency rules will add to the requirements of eligibility for the DEL Program that an individual must not have more than $50,000 individually or more than $75,000 per couple in liquid assets. The definition of "liquid assets" can be found in the *MaineCare Eligibility Manual*, Part 16.5.

Basis statement:

This emergency rule will implement provisions from Part TT of the State FY2016 and FY2017 Biennial Budget (P.L. 2015 Ch. 267) that establishes a limitation on the amount of liquid assets an individual may possess in order to receive benefits from the Low Cost Drugs for the Elderly and Disabled (DEL) Program. Pursuant to MRS Title 5 §8054, the Department of Health and Human Services is authorized to adopt emergency rules as necessary to implement provisions of P.L. 2015 Ch. 267 without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety or general welfare.

Effective October 1, 2015, these emergency rules will add to the requirements of eligibility for the DEL Program that an individual must not have more than $50,000 individually or more than $75,000 per couple in liquid assets. The definition of "liquid assets" can be found in the MaineCare Eligibility Manual, Part 16.5.

In this rule-making, the Department is making changes to the following DEL Eligibility regulations in order to comport with the Biennial Budget requirements: Section 2.1 and Section 3.

Fiscal impact of rule:

It is anticipated that the state will save $709,310 in State Fiscal Year (SFY) 2016 ($30,883 from the General Fund and $678,427 from the Fund for a Healthy Maine) and $851,173 in SFY 2017 ($37,060 in General Fund dollars and $814,113 from the Fund for a Healthy Maine).

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 254-D, 3173; PL 2015 ch. 267, Parts TT, UU
Chapter number/title:	**Ch. 333**, Low-Cost Drugs for the Elderly and Disabled (DEL)
Filing number:	**2015-258**
Effective date:	December 30, 2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule change adds a liquid asset test that is consistent with the Medicare Savings Program (MSP), changes the review period from 24 to 12 months, and requires that financial changes be reported within 10 days. This rule ensures consistent asset testing and early detection of changes in members' financial circumstances.

Basis statement / summary:

The Maine Drugs for the Elderly Benefit, also referred to as the Maine Low Cost Drugs for the Elderly or Disabled (DEL) Program, is authorized by, and these regulations are issued under, the authority of 22 MSRA §254-D. The responsibility for implementing this legislation is with the Department of Health and Human Services. This benefit uses state funds only, and is not a Medicaid program.

Fiscal impact of rule:

It is anticipated that the state will save $709,310 in State Fiscal Year (SFY) 2016 ($30,883 from the General Fund and $678,427 from the Fund for a Healthy Maine) and $851,173 in SFY 2017 ($37,060 in General Fund dollars and $814,113 from the Fund for a Healthy Maine).

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §3104; 7 CFR §273.7 & 7 U.S.C. 2015(d)(4)
Chapter number/title:	**Ch. 609**, Food Supplement - Employment and Training (FSET) Program Rules, **Rule #3A** (*formerly* OFI ASPIRE/JET)
Filing number:	**2015-042**
Effective date:	4/1/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule updates the Food Supplement Employment and Training program for Federal Fiscal Year (FFY) 2015, contingent upon approval by the United States Department of Agriculture- Food and Nutrition Services.

DHHS Office for Family Independence (OFI) will partner with the Maine Department of Labor to expand Food Supplement Employment and Training (FSET) services for able bodied adults without dependents (ABAWDs). FSET services will be available in Augusta, Bangor, Lewiston and Portland. FSET will provide employment assistance, training on job search skills, support job search activities, and provide work related case management services. The FSET Competitive Skills Scholarship Program (FSET-CSSP) will also be established, which will assist some participants to get training through certificate and degree programs for approved high wage in-demand jobs.

The changes will make FSET participation mandatory for Food Supplement ABAWDs not meeting work requirements residing in counties (Androscoggin, Cumberland, Kennebec, and Penobscot) and within 30 miles of Career Center FSET locations (Augusta, Bangor, Lewiston and Portland). FSET participation will count towards up to half of an ABA WD's work

Basis statement:

This rule change updates the Food Supplement Employment and Training (FSET) program for Federal Fiscal Year (FFY) 2015, approved by the United States Department of Agriculture- Food and Nutrition Services.

DHHS Office for Family Independence (OFI) will partner with the Maine Department of Labor to expand FSET services for Able Bodied Adults Without Dependents (ABAWDs). FSET services will be available in Augusta, Bangor, Lewiston and Portland CareerCenters. FSET will provide employment assistance, training on job search skills, support job search activities, and provide work related case management services. Able Bodied Adults without Dependents who are subject to Food Supplement work requirements will be able to apply up to 9.75 hours per week of FSET job search activities toward their weekly 20 hour work requirement, and will receive up to $50 per month assistance with transportation costs to attend FSET approved activities. The FSET Competitive Skills Scholarship Program (FSET-CSSP) will be established, which will support up to 75 participants in certificate and degree programs for approved high wage and in-demand jobs.

In the final rule, in response to concerns raised by commenters, the Department withdrew its proposal to make participation mandatory, and will maintain FSET participation as voluntary. The Department also made several other changes to clarify language throughout the rule, consistent with what was proposed. All of these changes are identified in the Department's Summary and Responses to Comments and List of Changes to Final Rule.

Finally, this rule amendment will change the title of 10-144 CMR ch. 609 from "ASPIRE/JET" to "Food Supplement Employment and Training (FSET) Program Rules." The Department made this change to more accurately reflect the targeted population and the source of program funding.

Fiscal impact:

The total estimated cost is $485,000 in federal funds and a state cost of $100,000. DHHS will collaborate with the Maine DOL to provide Employment and Training services. DOL will be paying up to $50,000 towards travel, training, and support services for participants.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health & Human Services (DHHS), Maine Center for Disease Control and Prevention, **Division of Population Health - Children with Special Health Needs**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §1532
Chapter number/title:	**Ch. 709**, Critical Congenital Heart Defects Screening
Filing number:	**2015-146**
Effective date:	9/1/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

To implement CCHD screening as required by 2013 PL 397 and to define the responsibilities of hospital administration and staff, physicians and other health care providers, midwives and other "principal birthing attendants," and others, with regard to the screening of newborn infants for critical congenital heart defects which if left untreated could cause critical incidents or death. These rules address the designation of a contact person in each hospital, timing and method of CCHD screening, parental refusal of tests, types of records to be maintained, responsibilities for follow-up and reporting or data collection.

Basis statement:

These rules define responsibilities to assure that all infants born in Maine are screened for critical congenital heart defects (CCHD) (unless the infant's parent(s) object on religious grounds) in time to allow for treatment to prevent critical incidents and death. These rules address the designation of a contact person in each hospital, timing and method of CCHD screening, parental refusal of tests, types of records to be maintained, responsibilities for follow-up and reporting or data collection.

Fiscal impact:

No adverse fiscal impact on municipalities, counties or small businesses

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health & Human Services, **Maine Center for Disease Control and Prevention**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1); 22-A MRS §205(2); 22 MRS §1242
Chapter number/title:	**Ch. 720**, Rules Governing the Implementation of Expedited Partner Therapy
Filing number:	**2015-205**
Effective date:	11/4/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

Pursuant to 22 MRS ch. 251, sub-c. 3, art. 5 §1242, "An Act to Enable Expedited Partner Therapy", the statute requires the Maine Center for Disease Control and Prevention (Maine CDC) to adopt routine technical rules to implement statutory provisions governing the practice of expedited partner counseling and identifies the parameters of Expedited Partner Therapy. These parameters include the designation of sexually transmitted diseases appropriate for Expedited Partner Therapy, and the recommended protocol, materials, information and counseling required to implement Expedited Partner Therapy.

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Basis statement:

In March 2010, the Maine State Legislature enacted 22 MRS §§ 1241-1242 (2010), which require the Department to adopt routine technical rules to implement Expedited Partner Therapy ("EPT"). EPT is a public health prevention and treatment strategy to reduce the burden of sexually transmitted diseases ("STDs") by prescribing, dispensing, furnishing, or otherwise providing prescription antibiotic drugs to the sexual partner(s) of persons clinically diagnosed with STDs. Pursuant to the statues, this rule includes the designation of STDs appropriate for EPT, and the recommended protocol, materials, information and counseling required to implement EPT in Maine.

Maine's EPT rule is based on scientific evidence, the recommendations of the U.S. Centers for Disease Control and Prevention, and other nationally-recognized medical authorities. For example, during the Department's development of this rule, it reviewed EPT articles and reports from the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American Medical Association. In addition, it researched EPT guidelines and regulations from states such as Washington, Illinois, Minnesota, California and New York. EPT has been approved for practice in 36 states as a method of controlling the spread of STDs. Based on this research, the Maine Center for Disease Control and Prevention has limited Expedited Partner Therapy to be used for the treatment and prevention of infection with chlamydia (*Chalmydia trachomatis*) and gonorrhea (*Neisseria gonorrhoeae*).

These rules establish the requirements for Expedited Partner Therapy, including guidelines, criteria for eligibility, counseling messages, materials, protocol, and related administrative policies. These rules are intended to complement other public health and clinical methods for preventing and treating sexually transmitted infections, reducing the burden of disease among the residents of Maine.

As a result of the review and advice of the Office of Attorney General, and pursuant to 5 MRS §8052(5)(B), the Department found that various changes were required for the final EPT rule to be adopted. Changes included removing and reorganizing sections to remove unnecessary sections, and to make the rules more clear, concise, and consistent

with the statute. Certain technical changes were also made to correct typographical and grammatical errors.

Fiscal impact:

No adverse fiscal impact on small business, municipalities, and counties.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of Child and Family Services**
Umbrella-Unit:	**10-148**
Statutory authority:	22 MRS §42
Chapter number/title:	**Ch. 6**, Child Care Subsidy Program Rules
Filing number:	**2015-074**
Effective date:	4/21/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The rule clarifies program definitions and program eligibility standards.

Basis statement:

The Department of Health and Human Services (DHHS) is designated as the lead agency with primary responsibilities for the planning and administration of child care subsidies funded with the Child Care Development Fund.

The *Child Care and Development Fund (CCDF) Block Grant Act of 1990* requires the Lead Agency to "administer, directly, or through other governmental or non-governmental agencies" the funds received. The regulations at 45 CFR 98.11 provide that, in addition to retaining "overall responsibilities" for the administration of the program, the Lead Agency must also (among other things) promulgate all rules and regulations governing the overall administration of the CCDF program.

The adopted rules implement the regulations at 45 CFR 98.11. The rules incorporate changes and current best practices in the operation of a child care subsidy program. The major amended provisions include clarification on 1.13 Educational Program, 1.19 Hobby, clarification on 1.20 Homeless Children, clarification on1.22 In-Home Child Care Provider, clarification on 3.02 Ages of Children, eligibility for 4.08 Job Search, eligibility for 4.08 Medical Leave, eligibility determination for 4.07 One Parent with Disability, clarification on 6.00 Parent Fees, clarification on 9.05.4 Excused hours, clarification on 11.02.2 time frame to return a renewal agreement and clarification on 11.05.4 Good Standing. The rules also include various technical, non-substantive changes relating to section numbering, intra-Departmental agency name changes, spelling, and usage.

Fiscal impact:

This rule will not have a fiscal impact.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of Child and Family Services**
Umbrella-Unit:	**10-148**
Statutory authority:	22 MRS §4010-C
Chapter number/title:	**Ch. 577**, Alumni Transition Grant Program Rules
Filing number:	**2015-145**
Effective date:	8/12/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

As a result of recent state legislation, these rules establish the Alumni Transition Grant Program (ATGP), which provides financial support and navigator services to youth, who were formerly in Maine's foster care system and who meet certain eligibility criteria, in order to support their post-secondary education. The ATGP also establishes an Advisory Committee.

Basis statement:

As a result of recent state legislation, these rules establish the Alumni Transition Grant Program (ATGP), which provides financial support and navigator services to youth, who were formerly in Maine's foster care system and who meet certain eligibility criteria, in order to support their post-secondary education. The ATGP also establishes an Advisory Committee.

ATGP Eligibility

An individual who aged out of Maine's foster care system at age 18, *and* who exited Maine's Voluntary Extended Care and Support (V9) Agreement under Title 22 MRS §4037-A at age 21, *and* who is enrolled in a post-secondary education program making satisfactory progress, *and* who has not yet attained his or her 27th birthday.

ATGP Level of Support

A maximum of 40 grants will be awarded at any one time on a first come, first served basis through an application process. The level of support provided to ATGP recipients will be equivalent to the current Voluntary Extended Care and Support (V9) Program.

Financial support will be provided to eligible individuals up to the completion of an undergraduate degree, and not to exceed 6 years for the completion of a 4-year Bachelor's Degree; 4 years for the completion of a 2-year Associate's Degree; or 4 years for the completion of an eligible training program.

ATGP Navigator Services

An ATGP Navigator will provide education support to ATGP recipients as coordinated with the individual and within the parameters of the ATGP.

ATGP Advisory Committee

An ATGP Advisory Committee is established comprised of various relevant stakeholders, appointed by the Director of the Office of Child and Family Services, to oversee ATGP implementation and outcomes; to advise the OCFS Director regarding program improvements, and to provide an annual report to the Maine's Legislative Health and Human Services Committee.

Fiscal impact:

The estimated fiscal impact assumes an annual grant cost of $5,000 per child and initially 20 grants will be awarded in the first year, with an effective start date of January 1, 2015. There is an estimated annual general fund cost of $200,000 beginning in State fiscal year (SFY) 2016.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of Substance Abuse and Mental Health Services**
Umbrella-Unit:	**14-118**
Statutory authority:	22 MRS §7249, §7252
Chapter number/title:	**Ch. 11**, Rules Governing the Controlled Substances Prescription Monitoring Program
Filing number:	**2015-108**
Effective date:	7/11/2015
Type of rule:	Major substantive
Emergency rule:	No

Principal reason or purpose for rule:

The purpose for this change is to support more informed prescribing for all healthcare providers and will assist to improve detection of activity that may signal drug diversion and/or misuse.

Basis statement:

This major substantive rule change will replace a requirement to report to the Prescription Monitoring Program the filling of controlled substances within seven (7) days to not later than the close of business on the next business day of the controlled substance after it has been dispensed (both filled and delivered). The information required to be filed has been expanded to include the date the prescription was delivered (issued). By reducing the dispenser reporting timeframe, the rule change supports more informed prescribing for all healthcare providers and will improve detection of questionable activity that may signal drug diversion and/or misuse.

This change also aligns the rule with statutory definitions in 32 MRS §13702-A for dispensing and delivery. Reporting of the date the medication is delivered along with the date the prescription was filled will provide more accurate data to all PMP end users.

Fiscal impact of rule:

There will be an annual enhancement cost as quoted by Health Information Designs, the PMP vendor, of $7,800 for the 24-hour reporting feature. The cost will be paid out of a federal grant specifically for PMP. This cost will not be passed on to the pharmacies/uploaders. Depending on the database used by pharmacies/uploaders for submitting dispensed controlled substances data, there may be a minimal cost associated with minor upgrades to the pharmacy uploader database system. There are no additional costs associated with activating an already existing field to accommodate the date the medication was delivered to the patient.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2015 to December 31, 2015
Prepared by the Secretary of State, pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of Aging and Disability Services**
Umbrella-Unit:	**14-197**
Statutory authority:	34-B MRS §5604(3)
Chapter number/title:	**Ch. 8**, Rule Describing Grievance Process for Persons with Intellectual Disabilities and Autism
Filing number:	**2015-005**
Effective date:	1/14/2015
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
The Department is adopting changes to its existing Grievance Rule that will, as of January 14, 2015, extend the time frames for respondents to attempt to resolve grievances by, or on behalf of, persons eligible for Developmental Disability Services; limit the maintenance of services during the pendency of a grievance to appeals filed within specified timelines; align the definition of a correspondent to statute; and eliminate out-dated organizational references not reflective of Departmental and Office mergers occurring since publication of the existing rule.

These modest extensions in time frames will allow case managers and supervisors to more thoughtfully respond to, and attempt to resolve, grievances at the lowest possible level without premature engagement of the next level in the grievance process. The current definition of correspondent in the existing rule does not conform to the definition in statute. The titles of positions and the organizational structure referenced in the existing rule are out-of-date and do not reflect the post-consolidation structure of either the Department of Health and Human Services or the Office of Aging & Disability Services.

The grievance process is a flexible mechanism to allow persons eligible for Developmental Disability Services, and persons acting on their behalf, an opportunity to be heard regarding, and object to, any action or inaction by any individual or organization, public or private, providing services to a person eligible for Developmental Services. The amendments retain the existing rule's broad opportunity to be heard. The Department added a process to follow for the continuation of services during the pendency of a grievance, which services may continue in some instances, pursuant to the requirements set forth in the rule.

The amendments will have no economic impact on small businesses or municipalities.

Fiscal impact of rule:
No anticipated impact; potential for some minimal savings.