

CHAPTER 855

AID TO NEEDY PERSONS

§3172. Definitions

1. Aid. "Aid" means money payments to, or in behalf of, or medical care or any type of remedial care or any related services to needy individuals who qualify for such assistance under this chapter. [PL 1973, c. 790, §2 (NEW).]

1-A. Application. "Application" is the action by which an individual indicates in writing to the department his desire to receive or to be recertified for assistance under this chapter. An application is distinguished from an inquiry, which is simply a request for information about eligibility requirements for assistance. [PL 1977, c. 714, §1 (NEW).]

1-B. Approved Medicaid service. "Approved Medicaid service" means a medical service which will be provided to Medicaid recipients under the provisions of the United States Social Security Act, Title XIX and successors to it and related rules of the department. [PL 1981, c. 703, Pt. A, §22 (NEW).]

2. Home health care. "Home health care" means nursing services and other therapeutic services provided without a requirement that hospitalization should be an antecedent to care and provided on an intermittent visiting basis to individuals in their homes or other place of residence, excluding hospitals, extended care facilities, rehabilitation centers and skilled nursing homes. In addition to skilled nursing, these services may include physical therapy, speech therapy, occupational therapy, medical social services, home health aide services and such other services and standards of care as may be defined by the department which are pursuant to, consistent with and necessary to the administration of home health care within the intent of section 3173. [PL 1977, c. 582, §1 (NEW).]

3. Medicaid recipient. "Medicaid recipient" means an individual authorized by the department to receive services under the provisions of the United States Social Security Act, Title XIX and successors to it. [PL 1981, c. 703, Pt. A, §23 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW). PL 1977, c. 582, §1 (AMD). PL 1977, c. 714, §1 (AMD). PL 1981, c. 703, §§A22,23 (AMD).

§3172-A. Mental Health and Mental Retardation Improvement Fund

(REPEALED)

SECTION HISTORY

PL 1975, c. 757, §1 (NEW). PL 1977, c. 482, §1 (RPR). PL 1977, c. 680, §1 (RP).

§3172-B. Moneys received; credit to General Fund; unencumbered balance

(REPEALED)

SECTION HISTORY

PL 1977, c. 680, §2 (NEW). PL 1979, c. 127, §143 (AMD). PL 1979, c. 293, §B1 (AMD). PL 1981, c. 493, §2 (AMD). PL 1995, c. 560, §K82 (AMD). PL 1995, c. 560, §K83 (AFF). PL 2001,

c. 354, §3 (AMD). PL 2003, c. 689, §B6 (REV). RR 2009, c. 2, §55 (COR). PL 2011, c. 542, Pt. A, §§31, 32 (AMD). PL 2019, c. 343, Pt. AAA, §1 (RP).

§3173. Powers and duties of department

The department is authorized to administer programs of aid, medical or remedial care and services for medically indigent persons. It is empowered to employ, subject to the Civil Service Law, such assistants as may be necessary to carry out this program and to coordinate their work with that of the other work of the department. [PL 1985, c. 785, Pt. B, §91 (AMD).]

The department is authorized and empowered to make all necessary rules and regulations consistent with the laws of the State for the administration of these programs including, but not limited to, establishing conditions of eligibility and types and amounts of aid to be provided, and defining the term "medically indigent," and the type of medical care to be provided. In administering programs of aid, the department shall, among other services, emphasize developing and providing financial support for preventive health care and home health care in order to assure that a comprehensive range of health care services is available to Maine citizens. Preventive health services shall include, but need not be limited to, programs such as early periodic screening, diagnosis and treatment; public school nursing services; child and maternal health services; and dental health education services. To meet the expenses of emphasizing preventive health care and home health care, the department is authorized to expend for each type of care no less than 1.5% of the total sum of all funds available to administer medical or remedial care and services eligible for participation under the United States Social Security Act, Title XIX and amendments and successors to it. [PL 1979, c. 127, §144 (RPR).]

The department shall provide all applicants for aid under this chapter with information in written form, and verbally as appropriate or if requested, about coverage, conditions of eligibility, scope of programs, existence of related services and the rights and responsibilities of applicants for and recipients of assistance under this chapter. [PL 1979, c. 127, §144 (RPR).]

All applications for aid under this chapter shall be acted upon and a decision made as soon as possible, but in no case shall the department fail to notify the applicant of its decision within 45 days after receipt of his application. Failure of the department to meet the requirements of this 45-day time standard, except where there is documented noncooperation by the applicant or the source of his medical information, shall lead to the immediate and automatic issuance of a temporary medical card which shall be valid only until such time as the applicant receives actual notice of a departmental denial of his application or he receives a replacement medical card. Notwithstanding an applicant's appeal of a denial of his application, the validity of the temporary medical card shall cease immediately upon receipt of the notice of denial. Any benefits received by the applicant during the interim period when he has actual use of a valid, temporary medical card shall not be recoverable by the department in any legal or administrative proceeding against the applicant. [PL 1979, c. 127, §144 (RPR).]

Whenever an applicant is determined by the department to be ineligible for a program for which he has applied, he shall be immediately so notified in writing. Any notification of denial shall contain a statement of the denial action, the reasons for denial, the specific regulations supporting the denial, an explanation of the applicant's right to request a hearing and a recommendation to the applicant of any other program administered by the department for which he may be eligible. Whenever an individual's application for Temporary Assistance for Needy Families is denied by the department, the notice of this denial shall also include, in a clear and conspicuous manner, a statement that the applicant is likely to be eligible for medical assistance and shall include information about the availability of applications for the program upon request to the department either in writing or through a toll-free telephone number. [PL 1979, c. 127, §144 (RPR); PL 1997, c. 530, Pt. A, §34 (AMD).]

Any applicant for benefits under the medically needy program whose countable income exceeds the applicable state protected income level maximum shall be eligible for the program when his incurred medical expenses are found to exceed the difference between his countable income and the

applicable state maximum. Whenever the applicant incurs sufficient medical expenses to be eligible for the medically needy program and provides reasonable proof thereof to the department, a medical card shall be issued within 10 days of the presentation of proof that eligibility has been met. Failure of the department to meet the requirements of this 10-day time standard, except where there is documented noncooperation by the applicant or the source of his medical information, shall lead to the immediate and automatic issuance of a temporary medical card which shall be valid only until such time as the applicant receives actual notice of a departmental denial of his application or he receives a replacement medical card. Any benefits received by the applicant during the interim period when he has actual use of a valid temporary medical card shall not be recoverable by the department in any legal or administrative proceeding against the applicant. [PL 1979, c. 127, §144 (RPR).]

In all situations where prior authorization of the department is required before a particular medical service can be provided, the department shall authorize or deny the request for treatment within 30 days of the completion and presentation of the request to the department. The department's response to such a request shall be supplied to both the provider and the recipient. Whenever the provider is unable or unwilling to provide the service requested within a reasonable time after approval of the request by the department, the recipient shall have the right to locate another approved provider whose sole duty shall be to notify the department of his intention to provide the service subject to the original approval. It shall be the duty of the department to vigorously assist any recipient in his search for an approved provider of a necessary medical service where, through reasonable effort, the recipient has been unable to locate a provider on his own. [PL 1979, c. 127, §144 (RPR).]

No time standard established by this section shall be used as a waiting period before granting aid, or as a basis for denial of an application or for terminating assistance. [PL 1979, c. 127, §144 (RPR).]

The department shall make and enforce reasonable rules and regulations governing the custody, use and preservation of the records, papers, files and communications of the department. The use of those records, papers, files and communications by any other agency or department of government to which they may be furnished shall be limited to the purposes for which they are furnished and by the law under which they may be furnished. [PL 1979, c. 127, §144 (RPR).]

The department shall initiate and monitor ongoing efforts performed cooperatively with other public and private agencies, religious, business and civic groups, pharmacists and other medical providers, professional associations, community organizations, unions, news media and other groups, organizations and associations to inform low-income households eligible for programs under this chapter of the availability and benefits of these programs and to insure the participation of eligible households which wish to participate by providing those households with reasonable and convenient access to the programs. [PL 1979, c. 127, §144 (RPR).]

All moneys made available to fund programs authorized by this chapter shall be expended under the direction of the department, and the department is empowered to direct the expenditures therefrom of those sums which may be necessary for purposes of administration. [PL 1979, c. 127, §144 (RPR).]

Relating to the determination of eligibility for medical care to be provided to a beneficiary of state or federal supplemental income for the blind, disabled and elderly, the department may enter into an agreement with the Secretary of the United States Department of Health and Human Services, whereby the secretary shall determine eligibility on behalf of the department. [PL 1991, c. 528, Pt. E, §23 (AMD); PL 1991, c. 528, Pt. RRR (AFF); PL 1991, c. 591, Pt. E, §23 (AMD).]

The Department of Health and Human Services may establish fee schedules governing reimbursement for services provided under this chapter. In establishing the fee schedules, the department shall consult with individual providers and their representative associations. The fee schedules shall be subject to annual review. [PL 1979, c. 127, §144 (RPR); PL 2003, c. 689, Pt. B, §6 (REV).]

During the annual review of fee schedules required by this section, the department shall consult with individual providers participating in the Medical Assistance Program and their representative associations to consider, among other factors, the cost of providing specific services, the effect of inflation or other economic factors on the adequacy of the existing fee schedule and its obligation under the federal Medicaid program to ensure sufficient provider participation in the program. [PL 1981, c. 329, §1 (NEW).]

The annual review of fee schedules shall be incorporated into the annual Medicaid report established by section 3174-B. [PL 1985, c. 727 (RPR).]

The department may enter into contracts with health care servicing entities for the provision, financing, management and oversight of the delivery of health care services in order to carry out these programs. For the purposes of this section, "health care servicing entity" means a partnership, association, corporation, limited liability company or other legal entity that enters into a contract to provide or arrange for the provision of a defined set of health care services; to assume responsibility for some aspects of quality assurance, utilization review, provider credentialing and provider relations or other related network management functions; and to assume financial risk for provision of such services to recipients through capitation reimbursement or other risk-sharing arrangements. "Health care servicing entity" does not include insurers or health maintenance organizations. In all contracts with health care servicing entities, the department shall include standards, developed in consultation with the Superintendent of Insurance, to be met by the contracting entity in the areas of financial solvency, quality assurance, utilization review, network sufficiency, access to services, network performance, complaint and grievance procedures and records maintenance. Prior to contracting with any health care servicing entity, the department must have in place a memorandum of understanding with the Superintendent of Insurance for the provision of technical assistance, which must provide for the sharing of information between the department and the superintendent and the analysis of that information by the superintendent as it relates to the fiscal integrity of the contracting entity. The department may require periodic reporting by the health care servicing entity as to activities and operations of the entity, including the entity's activities undertaken pursuant to commercial contracts with licensed insurers and health maintenance organizations. The department may share with the Superintendent of Insurance all documents filed by the health care servicing entity, including documents subject to confidential treatment if that information is treated with the same degree of confidentiality as is required of the department. [PL 1997, c. 676, §1 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW). PL 1977, c. 582, §2 (AMD). PL 1977, c. 674, §20 (AMD). PL 1977, c. 696, §370 (AMD). PL 1977, c. 712, §F2 (AMD). PL 1977, c. 714, §2 (RPR). PL 1979, c. 127, §144 (RPR). PL 1981, c. 329, §§1,2 (AMD). PL 1985, c. 727 (AMD). PL 1985, c. 785, §B91 (AMD). PL 1991, c. 528, §E23 (AMD). PL 1991, c. 528, §RRR (AFF). PL 1991, c. 591, §E23 (AMD). PL 1997, c. 530, §A34 (AMD). PL 1997, c. 676, §1 (AMD). PL 2003, c. 689, §B6 (REV).

§3173-A. Reimbursement for therapy; intermediate care facilities and skilled nursing facilities

When therapy is nonreimbursable under Title XVIII of the Social Security Act (Medicare), the Department of Health and Human Services shall reimburse an intermediate care facility or skilled nursing facility directly for the costs of physical and occupational therapy to individual residents or for professional consultants, or both, to the staff of the facility in accordance with professional standards of practice. [PL 1977, c. 646 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

Reimbursement shall be included either as an allowable cost of operation in determining the per diem rate or as a separate service for which the facility bills the Medical Assistance Program, whichever method is the less costly to that program while providing adequate and timely reimbursement to the therapist. [PL 1977, c. 646 (NEW).]

In developing regulations to administer this section, the Department of Health and Human Services shall consult with the Maine Chapter of American Physical Therapists Association, the Maine Occupational Therapists Association and other groups as appropriate. The regulations shall be published within 60 days of the effective date of this section. [PL 1977, c. 646 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

SECTION HISTORY

PL 1977, c. 646 (NEW). PL 1977, c. 719, §1 (NEW). PL 1979, c. 127, §145 (RAL). PL 2003, c. 689, §B6 (REV).

§3173-B. Medically needy program; certain individuals in intermediate care facilities

In determining what types of medical care shall be provided to "medically indigent" individuals, the department shall provide that medically necessary care in an intermediate care facility shall be included under the provisions of the medically needy program. [PL 1979, c. 127, §145 (RAL).]

SECTION HISTORY

PL 1979, c. 127, §145 (RAL).

§3173-C. Copayments

1. Authorization required. The department may not require any MaineCare member to make any payment toward the cost of a MaineCare service unless that payment is specifically authorized by this section, except that any copayment or premium expressly approved by the federal Secretary of the Department of Health and Human Services as part of a waiver must be implemented. [PL 2003, c. 20, Pt. K, §5 (AMD).]

2. Prescription drug services. Except as provided in this subsection and subsections 3 and 4, a pharmacy shall charge a MaineCare member \$3.00 for each drug prescription that is an approved MaineCare service. The department shall adopt and follow procedures to ensure compliance with the requirements of 42 United States Code, Section 1396o-1. A pharmacy that has followed the procedures adopted by the department to ensure compliance with the requirements of 42 United States Code, Section 1396o-1 may refuse to dispense the drug if the copayment is not paid. Copayments must be capped at \$30 per month per member. If a member is prescribed a drug in a quantity specifically intended by the provider or pharmacist, for the recipient's health and welfare, to last less than one month, only one payment for that drug for that month is required. [PL 2011, c. 458, §1 (AMD); PL 2011, c. 458, §4 (AFF).]

3. Exemptions. No copayment may be imposed with respect to the following services:

- A. Family planning services; [PL 1983, c. 240 (NEW).]
- B. Services furnished to individuals under 21 years of age; [PL 1983, c. 240 (NEW).]
- C. Services furnished to any individual who is an inpatient in a hospital, nursing facility or other institution, if that individual is required, as a condition of receiving services in that institution, to spend for costs of care all but a minimal amount of income required for personal needs; [PL 1991, c. 780, Pt. R, §3 (AMD).]
- D. Services furnished to pregnant women, and services furnished during the post-partum phase of maternity care to the extent permitted by federal law; [PL 1983, c. 240 (NEW).]
- E. Emergency services, as defined by the department; [PL 1983, c. 240 (NEW).]
- F. Services furnished to an individual by a Health Maintenance Organization, as defined in the United States Social Security Act, Section 1903(m), in which he is enrolled; and [PL 1983, c. 240 (NEW).]

G. Any other service or services required to be exempt under the provisions of the United States Social Security Act, Title XIX and successors to it. [PL 1983, c. 240 (NEW).]
[PL 1991, c. 780, Pt. R, §3 (AMD).]

4. Persons in state custody. Any copayment imposed on a Medicaid recipient in the custody of the State is to be collected from the state agency having custody of the recipient.
[PL 1983, c. 240 (NEW).]

5. Limitation.

[PL 1993, c. 6, Pt. C, §7 (RP).]

6. Designated copayment.

[PL 1991, c. 780, Pt. R, §4 (RP); PL 1991, c. 780, Pt. R, §10 (AFF).]

7. Copayments. Notwithstanding any other provision of law, the following copayments per service per day are imposed and reimbursements are reduced, or both, to the following levels:

A. Outpatient hospital services, \$3; [PL 1993, c. 6, Pt. C, §8 (NEW).]

B. Home health services, \$3; [PL 1993, c. 6, Pt. C, §8 (NEW).]

C. Durable medical equipment services, \$3; [PL 1993, c. 6, Pt. C, §8 (NEW).]

D. Private duty nursing and personal care services, \$5 per month; [PL 1993, c. 6, Pt. C, §8 (NEW).]

E. Ambulance services, \$3; [PL 1993, c. 6, Pt. C, §8 (NEW).]

F. Physical therapy services, \$2; [PL 1993, c. 6, Pt. C, §8 (NEW).]

G. Occupational therapy services, \$2; [PL 1993, c. 6, Pt. C, §8 (NEW).]

H. Speech therapy services, \$2; [PL 1993, c. 6, Pt. C, §8 (NEW).]

I. Podiatry services, \$2; [PL 1993, c. 6, Pt. C, §8 (NEW).]

J. Psychologist services, \$2; [PL 1993, c. 410, Pt. I, §8 (AMD).]

K. Chiropractic services, \$2; [PL 1993, c. 410, Pt. I, §8 (AMD).]

L. Laboratory and x-ray services, \$1; [PL 1993, c. 410, Pt. I, §9 (NEW).]

M. Optical services, \$2; [PL 1993, c. 410, Pt. I, §9 (NEW).]

N. Optometric services, \$3; [PL 1993, c. 410, Pt. I, §9 (NEW).]

O. Mental health clinic services, \$2; [PL 1993, c. 410, Pt. I, §9 (NEW).]

P. Substance use disorder services, \$2; [PL 2017, c. 407, Pt. A, §76 (AMD).]

Q. Hospital inpatient services, \$3 per patient day; [PL 2003, c. 20, Pt. K, §7 (AMD).]

R. Federally qualified health center services, \$3 per patient day, effective July 1, 2004; and [PL 2003, c. 451, Pt. H, §1 (AMD); PL 2003, c. 451, Pt. H, §3 (AFF).]

S. Rural health center services, \$3 per patient day. [PL 2003, c. 20, Pt. K, §8 (NEW).]

The department may adopt rules to adjust the copayments set forth in this subsection. The rules may adjust amounts to ensure that copayments are deemed nominal in amount and may include monthly limits or exclusions per service category. The need to maintain provider participation in the Medicaid program to the extent required by 42 United States Code, Section 1396a(a)(30)(A) or any successor provision of law must be considered in any reduction in reimbursement to providers or imposition of copayments.

[PL 2017, c. 407, Pt. A, §76 (AMD).]

8. Notification. The department shall notify each MaineCare member who is subject to the copayment requirement in subsection 2 of the copayment requirements, any exemptions and limitations prior to coding the member's information for required copayments and shall notify the member again during annual recertification of eligibility.

[PL 2011, c. 458, §2 (NEW); PL 2011, c. 458, §4 (AFF).]

SECTION HISTORY

PL 1981, c. 703, §A24 (NEW). PL 1983, c. 240 (RPR). PL 1991, c. 528, §§P10,11 (AMD). PL 1991, c. 528, §RRR (AFF). PL 1991, c. 591, §§P10,11 (AMD). PL 1991, c. 622, §M11 (AMD). PL 1991, c. 780, §§R3,4 (AMD). PL 1991, c. 780, §R10 (AFF). PL 1993, c. 6, §§C5-8 (AMD). PL 1993, c. 410, §§I8,9 (AMD). PL 2003, c. 20, §§K5-8 (AMD). PL 2003, c. 451, §H1 (AMD). PL 2003, c. 451, §H3 (AFF). PL 2007, c. 240, Pt. GGG, §1 (AMD). PL 2009, c. 415, Pt. A, §12 (AMD). PL 2011, c. 458, §§1, 2 (AMD). PL 2011, c. 458, §4 (AFF). PL 2017, c. 407, Pt. A, §76 (AMD).

§3173-D. Reimbursement for substance use disorder treatment

The department shall provide reimbursement, to the maximum extent allowable, under the United States Social Security Act, Title XIX, for substance use disorder treatment. Treatment must include, but need not be limited to, residential treatment and outpatient care as defined in Title 24-A, section 2842. [PL 2017, c. 407, Pt. A, §77 (AMD).]

SECTION HISTORY

PL 1983, c. 752, §1 (NEW). PL 2017, c. 407, Pt. A, §77 (AMD).

§3173-E. Treatment of joint bank accounts in Medicaid eligibility determinations

When determining eligibility for Medicaid, the department shall establish ownership of joint bank accounts in accordance with Title 18-C, section 6-211, subsection 2. If the department determines that funds were withdrawn from a joint account without the consent of the applicant and the applicant owned the funds, the person to whom the funds were transferred is a liable 3rd party and the department shall pursue recovery of the funds in accordance with section 14. The department shall adopt rules to implement this section. [PL 2017, c. 402, Pt. C, §51 (AMD); PL 2019, c. 417, Pt. B, §14 (AFF).]

SECTION HISTORY

PL 1993, c. 410, §FF9 (NEW). PL 2017, c. 402, Pt. C, §51 (AMD). PL 2017, c. 402, Pt. F, §1 (AFF). PL 2019, c. 417, Pt. B, §14 (AFF).

§3173-F. Charging or increasing premiums

1. Premiums. The department may apply to the federal Centers for Medicare and Medicaid Services for a waiver or amend a pending or current waiver under the Medicaid program authorizing the department to impose cost sharing on some or all persons eligible for MaineCare under the Katie Beckett option authorized by the federal Tax Equity and Fiscal Responsibility Act of 1982. Premiums must be implemented on a sliding scale. The department must consult with stakeholders prior to implementing changes under this section and comply with applicable federal requirements regarding public participation in the development of the Katie Beckett waiver policy.

[PL 2005, c. 633, §1 (AMD).]

2. Rules. The department shall adopt rules providing for sanctions when complete, timely payment of premiums has not been made and providing grace periods applicable to such late or incomplete payments and allowing waiver of premiums for good cause. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2003, c. 20, Pt. K, §9 (NEW).]

3. Copayments. The department may request, as part of the waiver request under subsection 1, permission to charge members copayments above those allowed in current federal regulation and statute.

[PL 2003, c. 20, Pt. K, §9 (NEW).]

SECTION HISTORY

PL 2003, c. 20, §K9 (NEW). PL 2005, c. 633, §1 (AMD).

§3173-G. Medicaid coverage for reproductive health care and family planning services

1. Family planning benefit. The department shall provide for the delivery of federally approved Medicaid services to a qualified adult or adolescent whose individual income is equal to or below 209% of the nonfarm income official poverty line for reproductive health care and family planning services, as described in 42 United States Code, Section 1396d(a)(4)(C), including pregnancy prevention, testing and treatment for sexually transmitted infection or cancer and access to contraception, in accordance with the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

[PL 2019, c. 420, §1 (NEW).]

2. Presumptive eligibility. If a MaineCare provider determines that an adult or adolescent is likely to be eligible for services under this section, the provider must be reimbursed for services provided under this section until the department determines that the adult or adolescent is not eligible. The department shall implement this subsection in accordance with 42 United States Code, Section 1396r-1.

[PL 2019, c. 420, §1 (NEW).]

3. Rules. The department shall adopt routine technical rules as defined by Title 5, chapter 375, subchapter 2-A to carry out the provisions of this section.

[PL 2019, c. 420, §1 (NEW).]

SECTION HISTORY

PL 2015, c. 356, §1 (NEW). PL 2015, c. 356, §4 (AFF). PL 2019, c. 420, §1 (RPR).

§3173-H. Services delivered through telehealth

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

A. "Asynchronous encounters" means the interaction or consultation between a patient and the patient's provider or between health professionals regarding the patient through a system with the ability to store digital information, including, but not limited to, still images, video, audio and text files, and other relevant data in one location and subsequently transmit such information for interpretation at a remote site by health professionals without requiring the simultaneous presence of the patient or the health professionals. [PL 2019, c. 649, §1 (AMD).]

A-1. "Health professional" means a provider or an individual, facility or organization with whom a provider consults in order to provide care to a patient. [PL 2019, c. 649, §1 (NEW).]

A-2. "Patient" means a MaineCare member. [PL 2019, c. 649, §1 (NEW).]

A-3. "Provider" means an individual, a facility or an organization that provides services under the MaineCare program. [PL 2019, c. 649, §1 (NEW).]

B. "Store and forward transfers" means transmission of a patient's recorded health history through a secure electronic system to a health professional. [PL 2019, c. 649, §1 (AMD).]

C. "Synchronous encounters" means a real-time interaction conducted with interactive audio or video connection between a patient and the patient's provider or between health professionals regarding the patient. [PL 2019, c. 649, §1 (AMD).]

D. "Telehealth," as it pertains to the delivery of MaineCare services, means the use of interactive visual and audio or other electronic media for the purpose of consultation and education concerning and diagnosis, treatment, care management and self-management of a patient's physical and mental health and includes real-time interaction between the patient and the patient's provider, electronic consultation between health professionals regarding the patient, synchronous encounters, asynchronous encounters, store and forward transfers and remote patient monitoring. "Telehealth" includes telephonic services when interactive telehealth services are unavailable or when a telephonic service is medically appropriate for the underlying covered service. [PL 2019, c. 649, §1 (AMD).]

E. "Telemonitoring," as it pertains to the delivery of MaineCare services, means the use of information technology to remotely monitor a patient's health status via electronic means through the use of clinical data while the patient remains in a residential setting, allowing the provider to track the patient's health data over time. Telemonitoring may or may not take place in real time. [PL 2019, c. 649, §1 (AMD).]

[PL 2019, c. 649, §1 (AMD).]

2. Grants. The department may solicit, apply for and receive grants that support the development of the technology infrastructure necessary to support the delivery of MaineCare services through telehealth and that support access to equipment, technical support and education related to telehealth for providers.

[PL 2019, c. 649, §1 (AMD).]

3. Annual report. Beginning January 1, 2018 and annually thereafter, the department shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the use of telehealth in the MaineCare program, including the number of providers providing telehealth and telemonitoring services, the number of patients served by telehealth and telemonitoring services and a summary of grants applied for and received related to telehealth and telemonitoring.

[PL 2019, c. 649, §1 (AMD).]

4. Education. The department shall conduct educational outreach to providers and MaineCare members on telehealth and telemonitoring services.

[PL 2017, c. 307, §2 (NEW).]

5. Rules. The department shall adopt routine technical rules as defined by Title 5, chapter 375, subchapter 2-A to carry out the provisions of this section. Rules adopted by the department:

A. May not include any requirement that a patient have a certain number of emergency room visits or hospitalizations related to the patient's diagnosis in the criteria for a patient's eligibility for telemonitoring services; [PL 2017, c. 307, §2 (NEW).]

B. Except as provided in paragraph E, must include qualifying criteria for a patient's eligibility for telemonitoring services that include documentation in a patient's medical record that the patient is at risk of hospitalization or admission to an emergency room; [PL 2019, c. 649, §1 (AMD).]

C. Must provide that group therapy for behavioral health or addiction services covered by the MaineCare program may be delivered through telehealth; [PL 2019, c. 649, §1 (AMD).]

D. Must include requirements for providers providing telehealth and telemonitoring services; and [PL 2019, c. 649, §1 (AMD).]

E. Must allow at least some portion of case management services covered by the MaineCare program to be delivered through telehealth, without requiring qualifying criteria regarding a

patient's risk of hospitalization or admission to an emergency room. [PL 2019, c. 649, §1 (NEW).]

[PL 2019, c. 649, §1 (AMD).]

SECTION HISTORY

PL 2017, c. 307, §2 (NEW). PL 2019, c. 649, §1 (AMD).

§3173-I. Maine Telehealth and Telemonitoring Advisory Group

The Maine Telehealth and Telemonitoring Advisory Group, as established by Title 5, section 12004-I, subsection 38-A and referred to in this section as "the advisory group," is created within the department. [PL 2017, c. 307, §3 (NEW).]

1. Membership. The advisory group consists of the commissioner or the commissioner's designee and 9 other members appointed by the commissioner as follows:

A. A representative of an organization in this State that has a mission to increase access to telehealth services in rural areas; [PL 2017, c. 307, §3 (NEW).]

B. A representative from a home health agency in this State; [PL 2017, c. 307, §3 (NEW).]

C. A representative from a nonprofit advocacy organization that represents hospitals in this State; [PL 2017, c. 307, §3 (NEW).]

D. A representative from each of 2 separate health care providers of integrated medical services in this State; [PL 2017, c. 307, §3 (NEW).]

E. A representative from a behavioral health organization in this State; [PL 2017, c. 307, §3 (NEW).]

F. A representative from an entity in this State with experience in the field of pharmacy; and [PL 2017, c. 307, §3 (NEW).]

G. Two medical practitioners in this State who use telehealth or telemonitoring as part of their regular practice. [PL 2017, c. 307, §3 (NEW).]

[PL 2017, c. 307, §3 (NEW).]

2. Meetings. The advisory group shall hold at least one regular meeting each year.

[PL 2019, c. 649, §2 (AMD).]

3. Duties. The advisory group shall:

A. Evaluate technical difficulties related to telehealth and telemonitoring services; and [PL 2017, c. 307, §3 (NEW).]

B. Make recommendations to the department to improve telehealth and telemonitoring services statewide. [PL 2017, c. 307, §3 (NEW).]

[PL 2017, c. 307, §3 (NEW).]

For the purposes of this section, "telehealth" and "telemonitoring" have the same meaning as in section 3173-H, subsection 1, paragraphs D and E. [PL 2017, c. 307, §3 (NEW).]

SECTION HISTORY

PL 2017, c. 307, §3 (NEW). PL 2019, c. 649, §2 (AMD).

§3174. Eligibility

Medical indigency and eligibility for assistance under this chapter are to be defined and determined in manners consistent with the requirements for the receipt of federal matching funds under Title XIX, or its successors, of the Social Security Act. [PL 1977, c. 714, §3 (NEW).]

An applicant shall be an adult who requires care and assistance, an adult legally responsible for the care of another or an adult who is legally responsible for the care of, and is applying on behalf of, one or more dependent minor children. Applications may be made on behalf of those applicants by their legal representatives. [PL 1977, c. 714, §3 (NEW).]

The department shall review and reevaluate eligibility for all recipients of aid, assistance or benefits available through a program of medical assistance administered pursuant to this chapter no less than once every 12 months, notwithstanding any federal statute, regulation or waiver allowing for less frequent reviews. [PL 2017, c. 284, Pt. NNNNNNN, §9 (NEW).]

The income factor of eligibility is met if, after reducing all income received by or available to the applicant by the liabilities for the kinds of goods and services provided for in this section, the residual income does not exceed 100% of an amount equal to the Temporary Assistance for Needy Families payment standards applicable to the applicant in the case of a family of 2 or more, or does not exceed 100% of an amount equal to the Temporary Assistance for Needy Families full-need standard for a unit of one in the case of an individual. [RR 1991, c. 1, §29 (COR); PL 1997, c. 530, Pt. A, §34 (AMD).]

The application of any available insurance, other 3rd party liabilities or other benefits to which the applicant may be entitled or the determination of other eligibility factors shall be in accordance with federal matching requirements. [PL 1977, c. 714, §3 (NEW).]

The department, under rules and regulations established pursuant to section 3173, shall set forth conditions of eligibility for assistance under this chapter. Such conditions shall provide that aid may be granted only to any applicant who: [PL 1973, c. 790, §2 (NEW).]

1. Income. Has not sufficient income or other resources to provide a reasonable subsistence compatible with decency and health; [PL 1973, c. 790, §2 (NEW).]

2. Residence. Is living in the State at the date of the application; and [PL 1973, c. 790, §2 (NEW).]

3. Inmate. Is not an inmate of any public institution, except as a patient in a medical institution or an inmate during the month in which he becomes an inmate only to the extent permitted by federal law, but an inmate of such an institution may file application for aid and any allowance made thereon shall take effect and be paid upon his ceasing to be an inmate of such institution. [PL 1983, c. 178 (AMD).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW). PL 1977, c. 714, §3 (AMD). PL 1979, c. 566, §1 (AMD). PL 1981, c. 703, §A25 (AMD). PL 1983, c. 178 (AMD). PL 1987, c. 834, §1 (AMD). RR 1991, c. 1, §29 (COR). PL 1991, c. 528, §P12 (AMD). PL 1991, c. 528, §RRR (AFF). PL 1991, c. 591, §P12 (AMD). PL 1997, c. 530, §A34 (AMD). PL 2017, c. 284, Pt. NNNNNNN, §9 (AMD).

§3174-A. Medical coverage program for certain boarding home residents

The department shall administer a program of medical coverage for persons residing in cost reimbursement boarding homes who, but for their income, would be eligible for supplemental security income benefits on account of blindness, disability or age, and who do not have sufficient income to meet the per resident payment rate for boarding home care, including an amount for personal needs of at least \$30 a month. Notwithstanding supplemental security income eligibility regulations, the department may impose a penalty for certain transfers of assets. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter II-A. [PL 2001, c. 559, Pt. X, §5 (AMD).]

SECTION HISTORY

PL 1983, c. 749, §1 (NEW). PL 2001, c. 559, §X5 (AMD).

§3174-B. Medicaid report

1. Special report. The commissioner shall prepare an annual report detailing all receipts and expenditures in the Medicaid program for the prior year and proposals for the coming year.

A. This document shall include, but not be limited to, the following information: A listing of revenues and expenditures for every professional, institutional or other service provided in the Medicaid program. This shall include levels of service, rates of reimbursement, numbers of providers and recipients of service and shall specify areas where there is discretion on the use of these funds by the State. This report shall also list all transfers of funds between Medicaid line accounts or service reimbursements and the reasons for those transfers. [PL 1985, c. 392 (NEW).]

B. The information provided under paragraph A shall be broken into lines for both federal and state funds, as well as combined totals. [PL 1985, c. 392 (NEW).]

[PL 1985, c. 392 (NEW).]

2. Submission to Legislature. The Medicaid report prepared pursuant to subsection 1 must be submitted to the Legislature prior to January 15th of each year. The report submitted under this section must be transmitted to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs and health and human services matters.

[PL 1999, c. 731, Pt. AA, §1 (AMD).]

3. Monthly expenditure projections. The commissioner shall prepare a monthly report detailing all expenditures in the Medical Care - Payments to Providers program for each month of every fiscal year. This document must include sufficient detail, including expenditures by fund and category of service, for the month as well as historical data, fiscal year-to-date amounts and projections for the remainder of the biennium and the ensuing biennium. The report also must include monthly statistics on the number of individuals eligible for Medicaid and Cub Care benefits. The report must be submitted to the joint standing committees of the Legislature having jurisdiction over appropriations and financial affairs and health and human services matters no later than 15 days following the end of each month.

[PL 1999, c. 731, Pt. AA, §2 (NEW).]

SECTION HISTORY

PL 1985, c. 392 (NEW). PL 1999, c. 731, §§AA1,2 (AMD).

§3174-C. Coverage for inpatient hospital mental disease treatment services

Provided that the federal maintenance-of-effort requirements are satisfied, the department shall provide reimbursement, under the United States Social Security Act, Title XIX, for inpatient psychiatric facility care and treatment of patients with mental diseases. [PL 1985, c. 769, §1 (NEW).]

SECTION HISTORY

PL 1985, c. 769, §1 (NEW).

§3174-D. Medicaid coverage for services provided by the Maine Educational Center for the Deaf and Hard of Hearing and the Governor Baxter School for the Deaf

The Department of Health and Human Services may administer a program of Medicaid coverage for speech and hearing services, psychological services, occupational therapy and any other services provided by the Maine Educational Center for the Deaf and Hard of Hearing and the Governor Baxter School for the Deaf that qualify for reimbursement under the United States Social Security Act, Title XIX. The Department of Education has fiscal responsibility for providing the State's match for federal revenues acquired under this section. Any funds received as Medicaid reimbursement must be retained by the Maine Educational Center for the Deaf and Hard of Hearing and the Governor Baxter School for the Deaf. [PL 2005, c. 279, §13 (AMD).]

SECTION HISTORY

PL 1987, c. 395, §B2 (NEW). PL 1987, c. 834, §2 (NEW). PL 1989, c. 502, §A70 (RPR). PL 1989, c. 700, §A79 (AMD). PL 1995, c. 676, §9 (AMD). PL 1995, c. 676, §13 (AFF). PL 2003, c. 689, §B6 (REV). PL 2005, c. 279, §13 (AMD).

§3174-E. Interim assistance agreement

The department, with the approval of the Governor and on behalf of the State, may enter into an agreement with the United States Social Security Administration for the purpose of receiving reimbursement for interim assistance payments as provided by the United States Social Security Act. [PL 1989, c. 502, Pt. A, §71 (RPR).]

SECTION HISTORY

P&SL 1987, c. 118 (NEW). PL 1987, c. 831, §1 (NEW). PL 1987, c. 836, §§1,4 (NEW). PL 1987, c. 847, §4 (NEW). PL 1989, c. 502, §A71 (RPR).

§3174-F. Coverage for adult dental services

1. Coverage provided. The Department of Health and Human Services shall provide dental services, reimbursed under the United States Social Security Act, Title XIX, or successors to it, to individuals 21 years of age and over, limited to:

A. Acute surgical care directly related to an accident where traumatic injury has occurred. This coverage will only be provided for the first 3 months after the accident; [PL 1989, c. 502, Pt. A, §72 (NEW).]

B. Oral surgical and related medical procedures not involving the dentition and gingiva; [PL 1989, c. 502, Pt. A, §72 (NEW).]

C. Extraction of teeth that are severely decayed and pose a serious threat of infection during a major surgical procedure of the cardiovascular system, the skeletal system or during radiation therapy for a malignant tumor; [PL 1997, c. 159, §1 (AMD).]

D. Treatment necessary to relieve pain, eliminate infection or prevent imminent tooth loss; and [PL 1997, c. 159, §1 (AMD).]

E. [PL 1991, c. 528, Pt. P, §14 (RP); PL 1991, c. 528, Pt. RRR (AFF); PL 1991, c. 591, Pt. P, §14 (RP).]

F. Other dental services, including full and partial dentures, medically necessary to correct or ameliorate an underlying medical condition, if the department determines that provision of those services will be cost-effective in comparison to the provision of other covered medical services for the treatment of that condition. [PL 1997, c. 159, §2 (NEW).]

[PL 1997, c. 159, §§1, 2 (AMD); PL 2003, c. 689, Pt. B, §6 (REV).]

2. Demonstration projects. The department shall promptly take all appropriate steps to obtain necessary waivers, if necessary, from the federal Department of Health and Human Services that enable the State to provide within the limits of available funds, on a demonstration basis, comprehensive dental services to Medicaid-eligible individuals who are 21 years of age or older in public or private, nonprofit clinic settings. The department's goal in pursuing these waivers or demonstration projects not requiring waivers is to determine whether providing services in these settings promotes cost effectiveness or efficiency or promotes other objectives of the federal Social Security Act, Title XIX.

By January 15, 1992, the department shall report to the joint standing committee of the Legislature having jurisdiction over health matters regarding the progress of its efforts under this subsection. The report must outline the department's progress and recommend further action required in pursuit of any demonstration project under this subsection.

[PL 1991, c. 528, Pt. P, §15 (AMD); PL 1991, c. 528, Pt. RRR (AFF); PL 1991, c. 591, Pt. P, §15 (AMD).]

SECTION HISTORY

PL 1989, c. 502, §A72 (NEW). PL 1989, c. 904 (AMD). PL 1991, c. 528, §§P13-15 (AMD). PL 1991, c. 528, §RRR (AFF). PL 1991, c. 591, §§P13-15 (AMD). PL 1997, c. 159, §§1,2 (AMD). PL 2003, c. 689, §B6 (REV).

§3174-G. Medicaid coverage of certain elderly and disabled individuals, children and pregnant women; transitional Medicaid

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

1. Delivery of services. The department shall provide for the delivery of federally approved Medicaid services to the following persons:

A. A qualified woman during her pregnancy and up to 60 days following delivery when the woman's family income is equal to or below 200% of the nonfarm income official poverty line; [PL 1999, c. 731, Pt. OO, §1 (NEW).]

B. An infant under one year of age when the infant's family income is equal to or below 200% of the nonfarm income official poverty line, except that the department may adopt a rule that provides that infants in families with income over 185% and equal to or below 200% of the nonfarm income official poverty line who meet the eligibility requirements of the Cub Care program established under section 3174-T are eligible to participate in the Cub Care program instead of Medicaid. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A; [PL 2007, c. 695, Pt. C, §9 (RPR).]

C. A qualified elderly or disabled person when the person's family income is equal to or below 100% of the nonfarm income official poverty line; [PL 2005, c. 3, Pt. M, §1 (RPR); PL 2005, c. 3, Pt. M, §2 (AFF).]

D. A child one year of age or older and under 19 years of age when the child's family income is equal to or below 200% of the nonfarm income official poverty line, except that the department may adopt a rule that provides that children described in this paragraph in families with income over 150% and equal to or below 200% of the nonfarm income official poverty line who meet the eligibility requirements of the Cub Care program established under section 3174-T are eligible to participate in the Cub Care program instead of Medicaid. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A; [PL 2007, c. 695, Pt. C, §10 (RPR).]

E. **(TEXT EFFECTIVE UNTIL CONTINGENCY: See PL 2011, c. 657, Pt. Z, §2)** On or before September 30, 2012, the parent or caretaker relative of a child described in paragraph B or D when the child's family income is equal to or below 200% of the nonfarm income official poverty line, subject to adjustment by the commissioner under this paragraph and, beginning October 1, 2012, the parent or caretaker relative of a child described in paragraph B or D when the child's family income is equal to or below 133% of the nonfarm income official poverty line, subject to adjustment by the commissioner under this paragraph. Medicaid services provided under this paragraph must be provided within the limits of the program budget. Funds appropriated for services under this paragraph must include an annual inflationary adjustment equivalent to the rate of inflation in the Medicaid program. On a quarterly basis, the commissioner shall determine the fiscal status of program expenditures under this paragraph. If the commissioner determines that expenditures will exceed the funds available to provide Medicaid coverage pursuant to this paragraph, the commissioner must adjust the income eligibility limit for new applicants to the extent necessary to operate the program within the program budget. If, after an adjustment has occurred pursuant to this paragraph, expenditures fall below the program budget, the commissioner

must raise the income eligibility limit to the extent necessary to provide services to as many eligible persons as possible within the fiscal constraints of the program budget, as long as on or before September 30, 2012 the income limit does not exceed 200% of the nonfarm income official poverty line and, beginning October 1, 2012, the income limit does not exceed 133% of the nonfarm income official poverty line; [PL 2011, c. 477, Pt. Z, §1 (AMD).]

E. **(TEXT EFFECTIVE ON CONTINGENCY: See PL 2011, c. 657, Pt. Z, §2)** On or before September 30, 2012, the parent or caretaker relative of a child described in paragraph B or D when the child's family income is equal to or below 200% of the nonfarm income official poverty line, subject to adjustment by the commissioner under this paragraph and, beginning October 1, 2012, the parent or caretaker relative of a child described in paragraph B or D when the child's family income is equal to or below 100% of the nonfarm income official poverty line. Medicaid services provided under this paragraph must be provided within the limits of the program budget. Funds appropriated for services under this paragraph must include an annual inflationary adjustment equivalent to the rate of inflation in the Medicaid program. On a quarterly basis, the commissioner shall determine the fiscal status of program expenditures under this paragraph. If the commissioner determines that expenditures will exceed the funds available to provide Medicaid coverage pursuant to this paragraph, the commissioner must adjust the income eligibility limit for new applicants to the extent necessary to operate the program within the program budget. If, after an adjustment has occurred pursuant to this paragraph, expenditures fall below the program budget, the commissioner must raise the income eligibility limit to the extent necessary to provide services to as many eligible persons as possible within the fiscal constraints of the program budget, as long as on or before September 30, 2012 the income limit does not exceed 200% of the nonfarm income official poverty line; [PL 2011, c. 657, Pt. Z, §1 (AMD); PL 2011, c. 657, Pt. Z, §2 (AFF).]

F. A person 20 to 64 years of age who is not otherwise covered under paragraphs A to E when the person's family income is below or equal to 125% of the nonfarm income official poverty line, as long as the commissioner adjusts the maximum eligibility level in accordance with the requirements of the paragraph.

(2) If the commissioner reasonably anticipates the cost of the program to exceed the budget of the population described in this paragraph, the commissioner shall lower the maximum eligibility level to the extent necessary to provide coverage to as many persons as possible within the program budget.

(3) The commissioner shall give at least 30 days' notice of the proposed change in maximum eligibility level to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters; [IB 2017, c. 1, Pt. A, §1 (AMD).]

G. A person who is a noncitizen legally admitted to the United States to the extent that coverage is allowable by federal law if the person is:

(1) A woman during her pregnancy and up to 60 days following delivery; or

(2) A child under 21 years of age; and [IB 2017, c. 1, Pt. A, §2 (AMD).]

H. No later than 180 days after the effective date of this paragraph, a person under 65 years of age who is not otherwise eligible for assistance under this chapter and who qualifies for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII) when the person's income is at or below 133% plus 5% of the nonfarm income official poverty line for the applicable family size. The department shall provide such a person, at a minimum, the same scope of medical assistance as is provided to a person described in paragraph E.

Cost sharing, including copayments, for coverage established under this paragraph may not exceed the maximum allowable amounts authorized under section 3173-C, subsection 7.

No later than 90 days after the effective date of this paragraph, the department shall submit a state plan amendment to the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services ensuring MaineCare eligibility for people under 65 years of age who qualify for medical assistance pursuant to 42 United States Code, Section 1396a(a)(10)(A)(i)(VIII).

The department shall adopt rules, including emergency rules pursuant to Title 5, section 8054 if necessary, to implement this paragraph in a timely manner to ensure that the persons described in this paragraph are enrolled for and eligible to receive services no later than 180 days after the effective date of this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A. [IB 2017, c. 1, Pt. A, §3 (NEW).]

For the purposes of this subsection, the "nonfarm income official poverty line" is that applicable to a family of the size involved, as defined by the federal Department of Health and Human Services and updated annually in the Federal Register under authority of 42 United States Code, Section 9902(2). For purposes of this subsection, "program budget" means the amounts available from both federal and state sources to provide federally approved Medicaid services.

[IB 2017, c. 1, Pt. A, §§1-3 (AMD).]

1-A. Elderly prescription drug program.

[PL 2001, c. 650, §1 (RP).]

1-B. Funding. State funds necessary to implement subsection 1-C must include General Fund appropriations and Other Special Revenue allocations from the Fund for a Healthy Maine to the elderly low-cost drug program operated pursuant to section 254-D, including rebates received in that program from pharmaceutical manufacturers, that are no longer needed in that program as a result of the Medicaid waiver obtained pursuant to subsection 1-C.

[PL 2005, c. 401, Pt. C, §5 (AMD).]

1-C. Prescription drug waiver program. Except as provided in paragraph G, the department shall apply to the federal Centers for Medicare and Medicaid Services for a waiver or amend a pending or current waiver under the Medicaid program authorizing the department to use federal matching dollars to enhance the prescription drug benefits available to persons who qualify for the elderly low-cost drug program established under section 254-D. The program created pursuant to the waiver is the prescription drug waiver program, referred to in this subsection as the "program."

A. As funds permit, the department has the authority to establish income eligibility levels for the program up to and including 200% of the federal nonfarm income official poverty level, except that for individuals in households that spend at least 40% of income on unreimbursed direct medical expenses for prescription medications, the income eligibility level is increased by 25%. [PL 2001, c. 650, §3 (NEW).]

B. To the extent reasonably achievable under the federal waiver process, the program must include the full range of prescription drugs provided under the Medicaid program on the effective date of this subsection and must limit copayments and cost sharing for participants. If cost sharing above the nominal cost sharing for the Medicaid program is determined to be necessary, the department may use a sliding scale to minimize the financial burden on lower-income participants. [PL 2001, c. 650, §3 (NEW).]

C. Coverage under the program may not be less beneficial to persons who meet the qualifications of former section 254 than the coverage available under that section on September 30, 2001. [PL 2005, c. 401, Pt. C, §6 (AMD).]

D. In determining enrollee benefits under the program, to the extent possible, the department shall give equitable treatment to coverage of prescription medications for cancer, Alzheimer's disease and behavioral health. [PL 2001, c. 650, §3 (NEW).]

E. The department is authorized to provide funding for the program by using funds appropriated or allocated to provide prescription drugs under sections 254-D and 258. [PL 2005, c. 401, Pt. C, §6 (AMD).]

F. The department is authorized to amend the waiver or adjust program requirements as necessary to take advantage of enhanced federal matching funds that may become available. [PL 2001, c. 650, §3 (NEW).]

G. If, upon thorough analysis, the department determines that a waiver under this subsection is not feasible or would not significantly benefit participants in the elderly low-cost drug program, the department may decide not to pursue the waiver. Within 30 days of a decision not to proceed with a waiver and before taking action on that decision, the department shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters and shall provide a detailed analysis of the reasons for reaching that decision. [PL 2001, c. 650, §3 (NEW).]

[PL 2005, c. 401, Pt. C, §6 (AMD).]

1-D. Enrollment fee. The department may assess an annual enrollment fee of \$25 for participation in the MaineCare program for a family including a parent or caretaker relative of a child described in subsection 1, paragraph B or D when the family's income exceeds 150% of the nonfarm income official poverty line.

[PL 2007, c. 539, Pt. NNN, §1 (NEW).]

2. Resource test. The department may not apply a resource test to those children and pregnant women who are made eligible under this section, unless these persons also receive Temporary Assistance for Needy Families or United States Supplemental Security Income benefits.

[PL 1989, c. 502, Pt. A, §72 (NEW); PL 1997, c. 530, Pt. A, §34 (AMD).]

3. Benefits authorized. The scope of medical assistance to be provided within this section must be that authorized by the Federal Sixth Omnibus Budget Reconciliation Act, Public Law 99-509.

[PL 2019, c. 485, §2 (AMD).]

4. Transitional Medicaid. The department shall administer a program of transitional Medicaid to families receiving benefits under Section 1931 of the federal Social Security Act in accordance with 42 United States Code, Section 1396r-6 and this subsection. The amount, duration and scope of services provided under this subsection must be the same as that provided to a parent or caretaker relative of a child described in subsection 1, paragraph B or D.

A. The department shall provide transitional Medicaid for a 12-month extension period in accordance with 42 United States Code, Section 1396r-6, Subsection (a), Paragraph (5) to families whose eligibility for Medicaid assistance terminated due to an increase in earned income, an increase in hours of employment or a loss of a time-limited earnings disregard. [PL 2019, c. 485, §2 (NEW).]

B. The department shall provide transitional Medicaid for 4 months to families whose eligibility for Medicaid assistance terminated due to an increase in the amount of child support received by the family. [PL 2019, c. 485, §2 (NEW).]

[PL 2019, c. 485, §2 (NEW).]

SECTION HISTORY

PL 1989, c. 502, §A72 (NEW). PL 1997, c. 530, §A34 (AMD). PL 1997, c. 643, §RR4 (AMD). PL 1997, c. 777, §A1 (AMD). PL 1999, c. 401, §§KKK2,3 (AMD). PL 1999, c. 401, §KKK10 (AFF). PL 1999, c. 531, §F2 (AFF). PL 1999, c. 731, §§KK1,OO1 (AMD). PL 1999, c. 790, §A25 (AMD). PL 2001, c. 450, §§A1,2 (AMD). PL 2001, c. 650, §§1-3 (AMD). PL 2003, c. 469, §A5 (AMD). PL 2003, c. 469, §A11 (AFF). PL 2003, c. 673, §§Y1,2 (AMD). PL 2003, c. 673, §Y3 (AFF). PL 2005, c. 3, §M1 (AMD). PL 2005, c. 3, §M2 (AFF). PL 2005, c. 401, §C5,6

(AMD). PL 2007, c. 539, Pt. NNN, §1 (AMD). PL 2007, c. 695, Pt. C, §§9, 10 (AMD). PL 2011, c. 380, Pt. KK, §§2, 3 (AMD). PL 2011, c. 477, Pt. Z, §1 (AMD). PL 2011, c. 657, Pt. Z, §1 (AMD). PL 2011, c. 657, Pt. Z, §2 (AFF). IB 2017, c. 1, Pt. A, §§1-3 (AMD). PL 2019, c. 485, §2 (AMD).

§3174-H. Availability of income between married couples in determination of eligibility

Notwithstanding this chapter, for the purpose of determining medical indigency and eligibility for assistance for an individual residing or about to reside in an institution eligible for Medicaid participation under this section, there shall be a presumption, rebuttable by either spouse, that each spouse has a marital property interest in 1/2 of the total monthly income of both spouses at the time of application for medical assistance. Only the 1/2 interest of the applicant spouse shall be considered available to the spouse in determining eligibility for medical indigency and eligibility for assistance. [PL 1989, c. 502, Pt. A, §72 (NEW).]

The marital property interest of the applicant spouse in the income of both spouses may be rebutted upon a showing of one of the following: [PL 1989, c. 502, Pt. A, §72 (NEW).]

1. Court order. A court order allocating marital income pursuant to alimony, spousal support, equitable division of marital property or disposition of marital property; [PL 1989, c. 502, Pt. A, §72 (NEW).]

2. Individual ownership. The establishing of sole individual ownership of income from current active employment; or [PL 1989, c. 502, Pt. A, §72 (NEW).]

3. Supplementary allocation of spousal income. By applying to the Department of Health and Human Services for a supplementary allocation of spousal income pursuant to this section. [PL 1989, c. 502, Pt. A, §72 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

The Department of Health and Human Services shall establish standards for the reasonable and adequate support of the community spouse and the community residence of the couple. The standards shall consider the cost of housing payments, property taxes, property insurance, utilities, food, medical expenses, transportation, other personal necessities and the presence of other dependent persons in the home. [PL 1989, c. 502, Pt. A, §72 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

The community spouse may apply to the Department of Health and Human Services for a determination pursuant to the standards that the community spouse requires a larger portion of the marital income. Therefore, a smaller portion of the marital income will be available to the applicant spouse in determining medical indigency and eligibility for assistance. [PL 1989, c. 502, Pt. A, §72 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

As soon as authorized by federal law, the department shall implement this section. [PL 1989, c. 502, Pt. A, §72 (NEW).]

SECTION HISTORY

PL 1989, c. 502, §A72 (NEW). PL 2003, c. 689, §B6 (REV).

§3174-I. Medicaid eligibility determinations for applicants to nursing homes

1. Needs assessment. In order to determine the most cost-effective and clinically appropriate level of long-term care services, the department or its designee shall assess the medical and social needs of each applicant to a nursing facility. If the department chooses a designee to carry out assessments under this section, it shall ensure that the assessments are comprehensive and objective.

A. The assessment must be completed prior to admission or, if necessary for reasons of the person's health or safety, as soon after admission as possible. [PL 1993, c. 410, Pt. FF, §10 (AMD); PL 1993, c. 410, Pt. FF, §19 (AFF).]

B. The department shall determine whether the services provided by the facility are medically and socially necessary and appropriate for the applicant and, if not, what other services, such as home and community-based services, would be more clinically appropriate and cost effective. [PL 1993, c. 410, Pt. FF, §10 (AMD); PL 1993, c. 410, Pt. FF, §19 (AFF).]

B-1. For persons with severe cognitive impairments who have been assessed and found ineligible for nursing facility level care, the department, through its community options unit, shall review the assessment and provide case management to assist consumers and caregivers to receive appropriate services. [PL 2011, c. 657, Pt. BB, §2 (AMD).]

B-2. The department shall establish additional assessment practices and related policies for persons with Alzheimer's disease and other dementias as follows.

(1) For persons who have been assessed using the department's primary assessment instrument and found to have cognitive or behavioral difficulties but who do not require nursing intervention with the frequency necessary to qualify for nursing facility level of care, the department shall administer a supplemental dementia assessment for those persons with cognitive and behavioral impairments. By May 1, 1996, the criteria reflected in this supplemental dementia assessment and the scoring mechanism must be incorporated into rules adopted by the department in consultation with consumers, providers and other interested parties. The assessment criteria proposed in the rulemaking must consider, but are not limited to, the following: orientation, memory, receptive communication, expressive communication, wandering, behavioral demands on others, danger to self or others and awareness of needs.

(2) The department shall reimburse a nursing facility for individuals who are eligible for care based on the supplemental dementia assessment only if the nursing facility demonstrates a program of training in the care of persons with Alzheimer's disease and other dementias for all staff responsible for the care of persons with these conditions. The department, in consultation with consumers, providers and interested parties, shall develop the requirements for training and adopt rules containing those requirements. By July 1, 1997, the department, in consultation with consumers, providers and interested parties, shall adopt rules establishing the standards for treatments, services and settings to meet the needs of individuals who have Alzheimer's disease and other dementias. These standards must apply to all levels of care available to such individuals.

(3) No later than January 15, 1997, the department shall report to the joint standing committee of the Legislature having jurisdiction over health and human service matters on the extent to which the use of the supplemental dementia assessment has expanded medical eligibility for nursing facility care to include persons with Alzheimer's disease or other dementias.

(4) Rules adopted pursuant to this subsection are major substantive rules as defined by Title 5, chapter 375, subchapter II-A. [PL 1995, c. 687, §1 (NEW).]

C. The department shall inform both the applicant and the administrator of the nursing facility of the department's determination of the services needed by the applicant and shall provide information and assistance to the applicant in accordance with subsection 1-A. [PL 1993, c. 410, Pt. FF, §10 (AMD); PL 1993, c. 410, Pt. FF, §19 (AFF).]

D. [PL 1995, c. 170, §2 (RP).]

E. The department shall perform a reassessment of the individual's medical needs when the individual becomes financially eligible for Medicaid benefits.

(1) If the individual, at both the admission assessment and any reassessment, is determined not to be medically eligible for the services provided by the nursing facility, and is determined not to be medically eligible at the time of the determination of financial eligibility, the nursing facility is responsible for providing services at no cost to the individual until such time as a

placement at the appropriate level of care becomes available. After a placement becomes available at an appropriate level of care, the nursing facility may resume billing the individual for the cost of services.

(2) If the individual is initially assessed as needing the nursing facility's services under the assessment criteria and process in effect at the time of admission or is admitted as covered by Medicare for nursing facility services, but is reassessed as not needing those services at the time the individual is found financially eligible, then the department shall reimburse the nursing facility for services it provides to the individual in accordance with the principles of reimbursement for residential care facilities adopted by the department pursuant to section 3173. In calculating the fixed-cost component of per diem rates for nursing facility services, the department shall exclude days of service for which reimbursement is provided under this subparagraph. [PL 1995, c. 696, Pt. B, §1 (AMD).]

F. Prior to performing assessments under this section, the department shall develop and disseminate to all nursing facilities and the public the specific standards the department will use to determine the medical eligibility of an applicant for admission to the nursing facility. A copy of the standards must be provided to each person for whom an assessment is conducted. In designing and phasing in the preadmission assessment under this section, the department shall collaborate with interested parties, including but not limited to consumers, nursing facility operators, hospital operators and home and community-based care providers. [PL 1995, c. 170, §2 (AMD).]

G. A determination of medical eligibility under this section is final agency action for purposes of the Maine Administrative Procedure Act, Title 5, chapter 375. [PL 1989, c. 498 (NEW).]
[PL 2011, c. 657, Pt. BB, §2 (AMD).]

1-A. Information and assistance. If the assessment performed pursuant to subsection 1 finds the level of nursing facility care clinically appropriate, the department shall determine whether the applicant also could live appropriately and cost-effectively at home or in some other community-based setting if home-based or community-based services were available to the applicant. If the department determines that a home or other community-based setting is clinically appropriate and cost-effective, the department shall:

A. Advise the applicant that a home or other community-based setting is appropriate; [PL 1993, c. 410, Pt. FF, §11 (NEW); PL 1993, c. 410, Pt. FF, §19 (AFF).]

B. Provide a proposed care plan and inform the applicant regarding the degree to which the services in the care plan are available at home or in some other community-based setting and explain the relative cost to the applicant of choosing community-based care rather than nursing facility care; and [PL 1993, c. 410, Pt. FF, §11 (NEW); PL 1993, c. 410, Pt. FF, §19 (AFF).]

C. Offer a care plan and case management services to the applicant on a sliding scale basis if the applicant chooses a home-based or community-based alternative to nursing facility care. [PL 1993, c. 410, Pt. FF, §11 (NEW); PL 1993, c. 410, Pt. FF, §19 (AFF).]

The department may provide the services described in this subsection directly or through private agencies.

[PL 1995, c. 170, §3 (AMD).]

1-B. Notification by hospitals. Whenever a hospital determines that a patient will require long-term care services upon discharge from the hospital, the hospital shall notify the department prior to discharge that long-term care services are indicated and that a preadmission assessment must be performed under this section.

[PL 1995, c. 170, §3 (AMD).]

2. Assessment for mental illness, intellectual disability, autism or related conditions. The department shall assess every applicant to a nursing facility to screen for mental illness, intellectual

disability, autism or other related conditions in accordance with the federal Nursing Home Reform Act, Public Law 100-203, Section 4211, 42 United States Code, Section 1396r. Such assessments are intended to increase the probability that any individual who has an intellectual disability, autism or other related condition or a mental illness will receive active treatment for that individual's condition. [PL 2011, c. 542, Pt. A, §33 (AMD).]

3. Rules. The Department of Health and Human Services shall adopt rules in accordance with the Maine Administrative Procedure Act, Title 5, chapter 375, to implement this section. [PL 1989, c. 498 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

SECTION HISTORY

PL 1989, c. 498 (NEW). PL 1993, c. 410, §§FF10-12 (AMD). PL 1993, c. 410, §FF19 (AFF). PL 1995, c. 170, §§2,3 (AMD). PL 1995, c. 687, §1 (AMD). PL 1995, c. 696, §B1 (AMD). PL 2003, c. 689, §B6 (REV). PL 2011, c. 542, Pt. A, §33 (AMD). PL 2011, c. 657, Pt. BB, §2 (AMD).

§3174-J. Medicaid drug formulary

(REPEALED)

SECTION HISTORY

PL 1989, c. 875, §E35 (NEW). MRSA T. 22 §3174-J, sub-§4 (RP).

§3174-K. Counseling for certain children

By October 1, 1992, the department shall adopt rules to provide Medicaid coverage for crisis counseling for children up to 21 years of age who are in crisis as a result of their removal or imminent removal from their parents' homes. The rules must allow the counseling to be provided by licensed clinical social workers. [PL 1991, c. 882, §1 (NEW).]

SECTION HISTORY

PL 1991, c. 882, §1 (NEW).

§3174-L. Parity among counselors

1. Licensed clinical social workers and licensed clinical professional counselors. Licensed clinical social workers must be eligible to receive Medicaid reimbursement for counseling services whenever licensed clinical professional counselors are eligible to be reimbursed for those services. Licensed clinical professional counselors must be eligible to receive Medicaid reimbursement for counseling services whenever licensed clinical social workers are eligible to be reimbursed for those services.

[PL 1993, c. 393, §1 (NEW).]

2. Licensed master social workers and licensed professional counselors. Licensed master social workers must be eligible to receive Medicaid reimbursement for counseling services whenever licensed professional counselors are eligible to be reimbursed for those services. Licensed professional counselors must be eligible to receive Medicaid reimbursement for counseling services whenever licensed master social workers are eligible to be reimbursed for those services.

[PL 1993, c. 393, §1 (NEW).]

3. Licensed clinical professional counselors. A licensed clinical professional counselor, as defined in Title 32, section 13851, subsection 2, must be eligible to receive MaineCare reimbursement for counseling services at the same rate as a licensed clinical social worker, as defined in Title 32, section 7001-A, subsection 6.

[PL 2017, c. 265, §1 (NEW).]

SECTION HISTORY

RR 1993, c. 1, §53 (COR). PL 1993, c. 393, §1 (NEW). PL 1993, c. 410, §110 (NEW). PL 2017, c. 265, §1 (AMD).

§3174-M. Medicaid drug formulary

1. Authority. The department has the authority to determine which prescription and over-the-counter drugs are subject to reimbursement and coverage under the Medicaid program.

[PL 1993, c. 410, Pt. I, §10 (NEW).]

1-A. Formulary standards. Any formulary established by the department must:

A. Conform to nationally accepted standards for a sound and adequate drug formulary system that promotes rational, clinically appropriate and safe access to medically necessary prescription drugs, ensures that members have timely and appropriate access to these drugs and does not discriminate based on disease or condition; [PL 2005, c. 386, Pt. X, §1 (NEW).]

B. Be structured to maintain at least the same therapeutic categories and pharmacological classes of drugs provided on the MaineCare preferred drug list in effect on July 1, 2005; and [PL 2005, c. 386, Pt. X, §1 (NEW).]

C. With respect to atypical antipsychotic drugs:

(1) Ensure that atypical antipsychotic drugs remain available in the same manner as on July 1, 2005;

(2) Adopt any clinical edits approved by the department's psychiatric work group; and

(3) Conform to national standards for the prescribing of atypical antipsychotic drugs. [PL 2005, c. 386, Pt. X, §1 (NEW).]

[PL 2005, c. 386, Pt. X, §1 (NEW).]

2. Drug formulary committee.

[PL 2005, c. 386, Pt. X, §2 (RP).]

2-A. Drug formulary committee. As authorized by Section 1927 (d) (4) (A) of the federal Social Security Act, 42 United States Code, Section 1396r-8, the department may develop a formulary using the department's MaineCare drug utilization review committee, except that the membership of the formulary committee must include pharmacists who are expert in pharmacotherapy for pediatric, geriatric and psychiatric populations.

A. A vote of 2/3 of the members of the department's MaineCare drug utilization review committee present is required to add or delete a drug from the list of drugs that are subject to reimbursement and coverage under the MaineCare program. [PL 2005, c. 386, Pt. X, §3 (NEW).]

B. A determination under rules adopted pursuant to subsection 3 that a drug or category of drug is not covered by the MaineCare program is a final agency action subject to review under the Maine Administrative Procedure Act. [PL 2005, c. 386, Pt. X, §3 (NEW).]

[PL 2005, c. 519, Pt. DDDD, §1 (AMD); PL 2005, c. 519, Pt. DDDD, §3 (AFF).]

3. Emergency supply. The department shall adopt routine technical rules as necessary that provide for a pharmacy to dispense, in accordance with applicable licensing standards and professional judgment, a one-time supply for 10 days of the prescribed drug. The rules must allow the department to authorize refills of the drug on a case-by-case basis at the end of the 10-day period if the prescribing provider has not submitted the required information at that time or the department determines that an additional refill is necessary.

The rules must provide that receipt of a 10-day supply under this subsection does not relieve the prescribing provider of the duty to submit all required information. The provision of the 10-day supply does not entitle the MaineCare member to receive benefits pending appeal in the event that a request

for prior authorization is ultimately denied, except when the member was receiving the drug for which the 10-day supply was provided immediately prior to the provision of that supply.

Any drug provided under this emergency procedure is considered a Medicaid-covered service pending departmental actions.

[PL 2005, c. 386, Pt. X, §4 (RPR).]

4. Rulemaking. Rules adopted pursuant to section 3174-J prior to its repeal are effective as of the effective date of this chapter without the taking of any action pursuant to the Maine Administrative Procedure Act.

[PL 1993, c. 410, Pt. I, §10 (NEW).]

5. Expedited review process. The department shall provide an independent review process whenever a MaineCare member has written certification from the member's physician that:

A. Delay in the provision of the requested drug may severely jeopardize the life or health of the MaineCare member or cause a severe functional decline in the member; or [PL 2005, c. 386, Pt. X, §5 (NEW).]

B. A preferred drug, if provided, would impose a serious risk to the life or health of the MaineCare member. [PL 2005, c. 386, Pt. X, §5 (NEW).]

The independent review process must ensure a decision within 72 hours of the time that the request is filed, unless the parties otherwise agree that the 72-hour period may be extended. The independent review process must ensure that coverage decisions based upon lack of medical necessity are conducted by a physician or pharmacist. The physician need not in all cases be of the same specialty or subspecialty as the prescribing physician.

[PL 2005, c. 386, Pt. X, §5 (NEW).]

SECTION HISTORY

RR 1993, c. 1, §53 (RNU). PL 1993, c. 410, §110 (NEW). PL 2005, c. 386, §§X1-5 (AMD). PL 2005, c. 519, §DDDD1 (AMD). PL 2005, c. 519, §DDDD3 (AFF).

§3174-N. Authorization to pursue federal waivers to develop Medicaid managed-care program

The department is authorized to seek all necessary approvals to establish a Medicaid managed-care demonstration project pursuant to 42 United States Code, Social Security Act, Section 1115. [PL 1993, c. 707, Pt. I, §2 (NEW).]

SECTION HISTORY

PL 1993, c. 707, §12 (NEW).

§3174-O. Establish rules

The department shall establish rules recognizing the Medicaid hospital assessment as a reimbursable cost to providers participating in the State's medical assistance program. [PL 1995, c. 368, Pt. W, §5 (NEW).]

SECTION HISTORY

PL 1995, c. 368, §W5 (NEW).

§3174-P. Prescription processing service fee

(REPEALED)

SECTION HISTORY

PL 1995, c. 665, §EE1 (NEW). PL 1995, c. 665, §EE3 (AFF). PL 1997, c. 795, §6 (RP).

§3174-Q. Medicaid stability

1. Legislative authorization. Except as provided in subsection 2, the department, in its administration of the Medicaid program and the federal State Children's Health Insurance Program or any successor program, shall obtain authorization from the Legislature by proper enactment of law before:

A. Implementing changes in eligibility for the Medicaid program that are reasonably likely to cause a decrease in excess of 10% in the percentages of enrollment in any covered group during any year or over any 5-year period unless individuals losing eligibility in a covered group are eligible in any other covered group with substantially similar or greater coverage; [PL 2019, c. 266, §1 (NEW).]

B. Eliminating, having the effect of significantly limiting or significantly reducing eligibility for a category of service covered under the Medicaid program or the federal State Children's Health Insurance Program without comparable service provided in its place; [PL 2019, c. 266, §1 (NEW).]

C. Accepting a block grant or any other fundamental alteration in the method of federal funding for the Medicaid program that could result in a substantial decrease in total funding for the program; or [PL 2019, c. 266, §1 (NEW).]

D. Applying for or amending a waiver, including a waiver pursuant to Section 1115 of the Social Security Act, or adopting a state plan amendment that could significantly reduce the scope of services of or eligibility for the Medicaid program or the federal State Children's Health Insurance Program. [PL 2019, c. 266, §1 (NEW).]

[PL 2019, c. 266, §1 (RPR).]

2. Exceptions in the event of federal law changes. If an action must be taken by the department to comply with federal law and obtaining authorization from the Legislature cannot be achieved timely to comply with federal requirements, the department may act only to the extent necessary to achieve compliance with federal law, pending further action of the Legislature under this section.

[PL 2019, c. 266, §1 (RPR).]

3. Failure to comply. A person may not be denied eligibility for the Medicaid program or the federal State Children's Health Insurance Program as the result of a change to those programs as described in subsections 1 and 2 if the department failed to comply with this section.

[PL 2019, c. 266, §1 (NEW).]

SECTION HISTORY

PL 1995, c. 696, §B2 (NEW). PL 2009, c. 571, Pt. PPP, §1 (AMD). PL 2019, c. 266, §1 (RPR).

§3174-R. Medicaid drug rebate program

The department shall enter into a drug rebate agreement with each manufacturer of prescription drugs under the Medicaid program, in accordance with the federal Social Security Act, Section 1927, as long as the agreements are consistent with state and federal law and result in a net increase in rebate revenue available to the Maine Medicaid Program. Individual rebate agreements may vary. [PL 2005, c. 397, Pt. A, §20 (RPR).]

REVISOR'S NOTE: §3174-R. Access to dental services for children under Medicaid (As enacted by PL 1997, c. 667, §1 is REALLOCATED TO TITLE 22, SECTION 3174-S)

REVISOR'S NOTE: §3174-R. Cub Care program (As enacted by PL 1997, c. 777, Pt. A, §2 is REALLOCATED TO TITLE 22, SECTION 3174-T)

SECTION HISTORY

RR 1997, c. 2, §§45,46 (RAL). PL 1997, c. 643, §RR5 (NEW). PL 1997, c. 667, §1 (NEW). PL 1997, c. 777, §A2 (NEW). PL 2003, c. 510, §A17 (AMD). PL 2003, c. 611, §2 (AMD). PL 2005, c. 397, §A20 (RPR).

**§3174-S. Access to dental services for children under Medicaid
(REALLOCATED FROM TITLE 22, SECTION 3174-R)**

The department shall increase access to comprehensive dental care for children under the Medicaid program so that services are received on a timely basis in the regions of the State in which they live, in accordance with this section. [RR 1997, c. 2, §45 (RAL).]

1. Telephone referral service. By April 1, 1998, the department shall establish a toll-free telephone referral service to provide individuals with information on dental services and assistance in accessing dental services. The telephone service must provide persons calling about dental services with oral notice of the availability of assistance in arranging for appointments for dental screening and necessary corrective treatment, transportation to dental appointments and other services necessary to ensure access.

[RR 1997, c. 2, §45 (RAL).]

2. Increasing providers. The department shall work with a statewide dental association and dentists in the State to increase the number of providers of dental care and the number participating in the Medicaid program.

[RR 1997, c. 2, §45 (RAL).]

3. Goal. It is the goal of the Legislature that children enrolled in the Medicaid program in all regions of the State have the same access to dental care as children enrolled in private dental insurance programs.

[RR 1997, c. 2, §45 (RAL).]

4. Annual report. By February 15, 1999 and annually thereafter, the department shall submit to the joint standing committee of the Legislature having jurisdiction over health and human services matters an annual report containing information related to the progress of the department in meeting the goal stated in subsection 3 and an action plan to increase access to dental care. The report must include an analysis of the progress being made in increasing access, the problems incurred within the prior year and corrective action to be taken. The action plan must consider the following strategies to increase access: nonprofit clinics; purchase of practice clinics; enhanced reimbursement for dentists serving a large number of children under the Medicaid program; and contracts with dental clinics and health centers to provide dental care.

[RR 1997, c. 2, §45 (RAL).]

SECTION HISTORY

RR 1997, c. 2, §45 (RAL).

§3174-T. Cub Care program

(REALLOCATED FROM TITLE 22, SECTION 3174-R)

1. Program established. The Cub Care program is established to provide health coverage for low-income children who are ineligible for benefits under the Medicaid program and who meet the requirements of subsection 2. The purpose of the Cub Care program is to provide health coverage to as many children as possible within the fiscal constraints of the program budget and without forfeiting any federal funding that is available to the State for the State Children's Health Insurance Program through the federal Balanced Budget Act of 1997, Public Law 105-33, 111 Stat. 251, referred to in this section as the Balanced Budget Act of 1997.

[RR 1997, c. 2, §46 (RAL).]

2. Eligibility; enrollment. Health coverage under the Cub Care program is available to children under 19 years of age whose family income is above the eligibility level for Medicaid under section 3174-G and below the maximum eligibility level established under paragraphs A and B, who meet the requirements set forth in paragraph C and for whom premiums are paid under subsection 5.

- A. The maximum eligibility level, subject to adjustment by the commissioner under paragraph B, is 200% of the nonfarm income official poverty line. [PL 1999, c. 401, Pt. QQ, §1 (AMD); PL 1999, c. 401, Pt. QQ, §5 (AFF).]
- B. If the commissioner has determined the fiscal status of the Cub Care program under subsection 8 and has determined that an adjustment in the maximum eligibility level is required under this paragraph, the commissioner shall adjust the maximum eligibility level in accordance with the requirements of this paragraph.
- (1) The adjustment must accomplish the purposes of the Cub Care program set forth in subsection 1.
 - (2) If Cub Care program expenditures are reasonably anticipated to exceed the program budget, the commissioner shall lower the maximum eligibility level set in paragraph A to the extent necessary to bring the program within the program budget.
 - (3) If Cub Care program expenditures are reasonably anticipated to fall below the program budget, the commissioner shall raise the maximum eligibility level set in paragraph A to the extent necessary to provide coverage to as many children as possible within the fiscal constraints of the program budget.
 - (4) The commissioner shall give at least 30 days' notice of the proposed change in maximum eligibility level to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters. [RR 1997, c. 2, §46 (RAL).]
- C. All children resident in the State are eligible except a child who:
- (1) Is eligible for coverage under the Medicaid program;
 - (2) Is covered under a group health insurance plan or under health insurance, as defined in Section 2791 of the federal Public Health Service Act, 42 United States Code, Section 300gg(c) (Supp. 1997);
 - (4) Is an inmate in a public institution or a patient in an institution for mental diseases; or
 - (5) Within the 3 months prior to application for coverage under the Cub Care program, was insured or otherwise provided coverage under an employer-based health plan for which the employer paid 50% or more of the cost for the child's coverage, except that this subparagraph does not apply if:
 - (a) The cost to the employee of coverage for the family exceeds 10% of the family's income;
 - (b) The parent lost coverage for the child because of a change in employment, termination of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, COBRA, of the Employee Retirement Income Security Act of 1974, as amended, 29 United States Code, Sections 1161 to 1168 (Supp. 1997) or termination for a reason not in the control of the employee; or
 - (c) The department has determined that grounds exist for a good-cause exception. [PL 2017, c. 284, Pt. SSSSSS, §1 (AMD).]
- D. Notwithstanding changes in the maximum eligibility level determined under paragraph B, the following requirements apply to enrollment and eligibility:
- (1) Children must be enrolled for 12-month enrollment periods. Prior to the end of each 12-month enrollment period the department shall redetermine eligibility for continuing coverage; and

(2) Children of higher family income may not be covered unless children of lower family income are also covered. This subparagraph may not be applied to disqualify a child during the 12-month enrollment period. Children of higher income may be disqualified at the end of the 12-month enrollment period if the commissioner has lowered the maximum eligibility level under paragraph B. [PL 2001, c. 450, Pt. A, §3 (AMD).]

E. Coverage under the Cub Care program may be purchased for children described in subparagraphs (1) and (2) for a period of up to 18 months as provided in this paragraph at a premium level that is revenue neutral and that covers the cost of the benefit and a contribution toward administrative costs no greater than the maximum level allowable under COBRA. The department shall adopt rules to implement this paragraph. The following children are eligible to enroll under this paragraph:

(1) A child who is enrolled under paragraph A or B and whose family income at the end of the child's 12-month enrollment term exceeds the maximum allowable income set in that paragraph; and

(2) A child who is enrolled in the Medicaid program and whose family income exceeds the limits of that program. The department shall terminate Medicaid coverage for a child who enrolls in the Cub Care program under this subparagraph. [PL 2001, c. 450, Pt. A, §3 (AMD).]

[PL 2017, c. 284, Pt. SSSSSS, §1 (AMD).]

3. Program administration; benefit design. With the exception of premium payments under subsection 5 and any other requirements imposed under this section, the Cub Care program must be integrated with the Medicaid program and administered with it in one administrative structure within the department, with the same enrollment and eligibility processes, benefit package and outreach and in compliance with the same laws and policies as the Medicaid program, except when those laws and policies are inconsistent with this section and the Balanced Budget Act of 1997. The department shall adopt and promote a simplified eligibility form and eligibility process. [RR 1997, c. 2, §46 (RAL).]

4. Benefit delivery. The Cub Care program must use, but is not limited to, the same benefit delivery system as the Medicaid program, providing benefits through the same health plans, contracting process and providers. Copayments and deductibles may not be charged for benefits provided under the program. [RR 1997, c. 2, §46 (RAL).]

5. Premium payments. Premiums must be paid in accordance with this subsection.

A. Premiums must be paid at the beginning of each month for coverage for that month according to the following scale:

(1) Families with incomes between 150% and 160% of the federal nonfarm income official poverty line pay premiums of 5% of the benefit cost per child, but not more than 5% of the cost for 2 children;

(2) Families with incomes between 160% and 170% of the federal nonfarm income official poverty line pay premiums of 10% of the benefit cost per child, but not more than 10% of the cost for 2 children;

(3) Families with incomes between 170% and 185% of the federal nonfarm income official poverty line must pay premiums of 15% of the benefit cost per child, but not more than 15% of the cost for 2 children; and

(4) Families with incomes between 185% and 200% of the federal nonfarm income official poverty line must pay premiums of 20% of the benefit cost per child, but not more than 20%

of the cost for 2 children. [PL 2003, c. 673, Pt. TTT, §1 (RPR); PL 2003, c. 673, Pt. TTT, §§3, 5 (AFF).]

B. When a premium is not paid at the beginning of a month, the department shall give notice of nonpayment at that time and again at the beginning of the 6th month of the 6-month enrollment period if the premium is still unpaid, and the department shall provide an opportunity for a hearing and a grace period in which the premium may be paid and no penalty will apply for the late payment. If a premium is not paid by the end of the grace period, coverage must be terminated unless the department has determined that waiver of premium is appropriate under paragraph D. The grace period is determined according to this paragraph.

(1) If nonpayment is for the first, 2nd, 3rd, 4th or 5th month of the 6-month enrollment period, the grace period is equal to the remainder of the 6-month enrollment period.

(2) If nonpayment is for the 6th month of the 6-month enrollment period, the grace period is equal to 6 weeks. [RR 1997, c. 2, §46 (RAL).]

C. A child whose coverage under the Cub Care program has been terminated for nonpayment of premium and who has received coverage for a month or longer without premium payment may not reenroll until after a waiting period that equals the number of months of coverage under the Cub Care program without premium payment, not to exceed 3 months. [RR 1997, c. 2, §46 (RAL).]

D. The department shall adopt rules allowing waiver of premiums for good cause. [RR 1997, c. 2, §46 (RAL).]

[PL 2003, c. 673, Pt. TTT, §1 (RPR); PL 2003, c. 673, Pt. TTT, §§3, 5 (AFF).]

6. Incentives. In the contracting process for the Cub Care program and the Medicaid program, the department shall create incentives to reward health plans that contract with school-based clinics, community health centers and other community-based programs. [RR 1997, c. 2, §46 (RAL).]

7. Administrative costs. The department shall budget 2% of the costs of the Cub Care program for outreach activities. After the first 6 months of the program and to the extent that the program budget allows, the department may expend up to 3% of the program budget on activities to increase access to health care. Administrative costs must include the cost of staff with experience in health policy administration equal to one full-time equivalent position. [RR 1997, c. 2, §46 (RAL).]

8. Quarterly determination of fiscal status; reports. On a quarterly basis, the commissioner shall determine the fiscal status of the Cub Care program, determine whether an adjustment in maximum eligibility level is required under subsection 2, paragraph B and report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters on the following matters:

A. Enrollment approvals, denials, terminations, reenrollments, levels and projections. With regard to denials, the department shall gather data from a statistically significant sample and provide information on the income levels of children who are denied eligibility due to family income level; [RR 1997, c. 2, §46 (RAL).]

B. Cub Care program expenditures, expenditure projections and fiscal status; [RR 1997, c. 2, §46 (RAL).]

C. Proposals for increasing or decreasing enrollment consistent with subsection 2, paragraph B; [RR 1997, c. 2, §46 (RAL).]

D. Proposals for enhancing the Cub Care program; [RR 1997, c. 2, §46 (RAL).]

E. Any information the department has from the Cub Care program or from the Bureau of Insurance or the Department of Labor on employer health coverage and insurance coverage for low-income children; [RR 1997, c. 2, §46 (RAL).]

F. The use of and experience with the purchase option under subsection 2, paragraph D; and [RR 1997, c. 2, §46 (RAL).]

G. Cub Care program administrative costs. [RR 1997, c. 2, §46 (RAL).]
[RR 1997, c. 2, §46 (RAL).]

9. Provisions applicable to federally recognized Indian tribes. After consultation with federally recognized Indian nations, tribes or bands of Indians in the State, the commissioner shall adopt rules regarding eligibility and participation of children who are members of a nation, tribe or band, consistent with Title 30, section 6211, in order to best achieve the goal of providing access to health care for all qualifying children within program requirements, while using all available federal funds. [RR 1997, c. 2, §46 (RAL).]

10. Rulemaking. The department shall adopt rules in accordance with Title 5, chapter 375 as required to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter II-A. [RR 1997, c. 2, §46 (RAL).]

11. Cub Care drug rebate program. Effective October 1, 1999, the department shall enter into a drug rebate agreement with each manufacturer of prescription drugs that results in a rebate equal to that which would be achieved under the federal Social Security Act, Section 1927.

A. [PL 1999, c. 522, §1 (RP); PL 1999, c. 522, §2 (AFF).]
[PL 2005, c. 683, Pt. A, §34 (AMD).]

12. Premium rate review; adjustment. Effective July 1, 2004, the department shall periodically evaluate the amount of premiums charged under this section to ensure that the premiums charged reflect the most current benefit cost per child. The commissioner shall adjust the premiums by rule. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2003, c. 673, Pt. TTT, §2 (NEW).]

SECTION HISTORY

RR 1997, c. 2, §46 (RAL). PL 1999, c. 401, §§QQ1,2 (AMD). PL 1999, c. 401, §QQ5 (AFF). PL 1999, c. 522, §1 (AMD). PL 1999, c. 731, §§PP1,2 (AMD). PL 1999, c. 790, §A61 (AFF). PL 2001, c. 450, §A3 (AMD). PL 2003, c. 20, §K10 (AFF). PL 2003, c. 673, §§TTT1,2 (AMD). PL 2003, c. 673, §§TTT3,5 (AFF). PL 2005, c. 683, §A34 (AMD). PL 2017, c. 284, Pt. SSSSSS, §1 (AMD).

§3174-U. Medicaid reimbursement for dental services

The department shall conduct an annual review of the adequacy of reimbursement rates for dental services for dentists who provide care for a disproportionate number of patients whose care is reimbursed through the Medicaid program and the Cub Care program established in section 3174-T. By December 31, 1999, the department shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the results of the study, including the costs in General Fund and other money. [PL 1999, c. 301, §1 (NEW).]

REVISOR'S NOTE: §3174-U. Procedure for home health care changes (As enacted by PL 1999, c. 329, §1 is REALLOCATED TO TITLE 22, SECTION 3174-W)

SECTION HISTORY

RR 1999, c. 1, §28 (RAL). PL 1999, c. 301, §1 (NEW). PL 1999, c. 329, §1 (NEW).

§3174-V. Federally qualified health center reimbursements

Beginning in fiscal year 2003-04, the reimbursement requirements listed in subsections 1 and 2 apply to payments for certain federally qualified health centers as defined in 42 United States Code, Section 1395x, subsection(aa)(1993). [PL 2003, c. 20, Pt. K, §11 (AMD).]

1. Services furnished by center. The department shall reimburse a federally qualified health center no less than 100% of reasonable costs, reduced by the total copayments for which members are responsible, for services furnished by the center within the scope of service approved by the federal Health Resources and Services Administration or the commissioner if that center:

A. Is receiving a grant under Section 330 of the federal Public Health Services Act; or [PL 1999, c. 401, Pt. T, §1 (NEW).]

B. Is receiving funding under contract with the recipient of a grant under Section 330 of the federal Public Health Services Act, is identified as a subrecipient in the Section 330 grantee's approved scope of work and meets the requirements to receive a grant under Section 330 of that Act. [PL 1999, c. 401, Pt. T, §1 (NEW).]
[PL 2003, c. 20, Pt. K, §11 (AMD).]

2. Contracted services. When a federally qualified health center otherwise meeting the requirements of subsection 1 contracts with a managed care plan or the Dirigo Health Program for the provision of MaineCare services, the department shall reimburse that center the difference between the payment received by the center from the managed care plan or the Dirigo Health Program and 100% of the reasonable cost, reduced by the total copayments for which members are responsible, incurred in providing services within the scope of service approved by the federal Health Resources and Services Administration or the commissioner. Any such managed care contract must provide payments for the services of a center that are not less than the level and amount of payment that the managed care plan or the Dirigo Health Program would make for services provided by an entity not defined as a federally qualified health center.

[PL 2005, c. 400, Pt. C, §1 (AMD).]

SECTION HISTORY

PL 1999, c. 401, §T1 (NEW). PL 2003, c. 20, §K11 (AMD). PL 2003, c. 469, §A7 (AMD). PL 2005, c. 400, §C1 (AMD).

§3174-W. Procedure for home health care changes**(REALLOCATED FROM TITLE 22, SECTION 3174-U)**

Rules adopted by the department regarding access to home health care under the Medicaid program are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A. [RR 2003, c. 2, §73 (COR).]

SECTION HISTORY

RR 1999, c. 1, §28 (RAL). PL 2001, c. 354, §3 (AMD). RR 2003, c. 2, §73 (COR).

§3174-X. Contracted ombudsman services

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

A. "Children's health insurance program" means the state children's health insurance program under Title XXI of the Social Security Act. "Children's health insurance program" includes the Cub Care program, which is established in section 3174-T, the federal Children's Health Insurance Program, or CHIP, and the federal State Children's Health Insurance Program, or S-CHIP. [PL 2015, c. 511, §1 (NEW).]

B. "Eligible member" means a person who is eligible to participate as a member or beneficiary of the MaineCare program or the children's health insurance program. [PL 2015, c. 511, §1 (NEW).]

C. "Ombudsman" means the director of the program and persons employed or volunteering to perform the work of the program. [PL 2015, c. 511, §1 (NEW).]

D. "Outreach and education" includes, but is not limited to, work site and community-based training and workshops for members, eligible members and health care providers, social service providers and health insurance navigators, brokers and agents; outreach at events such as town fairs, expositions and health fairs; development of mailings about coverage options, open enrollment periods and other important updates; information hotline response, including providing information and referrals to members and eligible members who call; and screening for eligibility for coverage programs, including programs other than Medicaid programs such as, but not limited to, prescription assistance programs. [PL 2015, c. 511, §1 (NEW).]

E. "Program" means the ombudsman program established under this section. [PL 2015, c. 511, §1 (NEW).]
[PL 2015, c. 511, §1 (NEW).]

2. Program established. The ombudsman program is established as an independent program to provide ombudsman services to the Medicaid population regarding Medicaid services provided by the department and the department's office for family independence and office of MaineCare services. The program shall consider and promote the best interests of the Medicaid and children's health insurance program populations, answer inquiries and investigate, advise and work toward resolution of complaints of infringement of the rights of a member or eligible member. The program shall include outreach and education to eligible members and those who serve eligible members, including health care providers, social service providers and health insurance navigators, brokers, agents and other enrollment professionals. The program shall function through the staff of the program, subcontractors and any volunteers recruited and trained to assist in the duties of the program. If members or eligible members described in this subsection are applying for or receiving long-term care home-based and community-based services or institutional services, ombudsman assistance for those services is provided by the long-term care ombudsman program established pursuant to section 5106, subsection 11-C. The program shall coordinate with the long-term care ombudsman program on activities, including but not limited to marketing, outreach and referral services.
[PL 2015, c. 511, §1 (NEW).]

3. Contracted services; political activity prohibited. The program shall operate by contract with a nonprofit organization that is best able to provide services on a statewide basis. The ombudsman may not be actively involved in state-level political party activities or publicly endorse, solicit funds for or make contributions to political parties on the state level or candidates for statewide elective office. The ombudsman may not be a candidate for or hold any statewide elective or appointive public office.
[PL 2015, c. 511, §1 (NEW).]

4. Program services. The first priority in the work of the program and the contract for ombudsman services under subsection 3 must be case-specific advocacy and enrollment services. In performing services under this section, the program, as it determines to be appropriate, may create and maintain records and case-specific reports. The program may:

A. Provide information to the public about the services of the program through a comprehensive outreach program. The program shall provide information through a toll-free telephone number or numbers; [PL 2015, c. 511, §1 (NEW).]

B. Answer inquiries, investigate and work toward resolution of complaints regarding the performance and services of the department and participate in conferences, meetings and studies that may improve the performance of the department; [PL 2015, c. 511, §1 (NEW).]

C. Provide services to members and eligible members to assist them in protecting their rights; [PL 2015, c. 511, §1 (NEW).]

D. Inform members and eligible members of the means of obtaining services from the department; [PL 2015, c. 511, §1 (NEW).]

E. Provide information and referral services; [PL 2015, c. 511, §1 (NEW).]

F. Analyze and provide opinions and recommendations to agencies, the Governor and the Legislature on state programs, rules, policies and laws; [PL 2015, c. 511, §1 (NEW).]

G. Determine what types of complaints and inquiries will be accepted for action by the program and adopt policies and procedures regarding communication with members and eligible members making inquiries or complaints and the department; [PL 2015, c. 511, §1 (NEW).]

H. Apply for and use grants, gifts and funds for the purpose of performing the duties of the program; and [PL 2015, c. 511, §1 (NEW).]

I. Collect and analyze records and data relevant to the duties and activities of the program and make reports as required by law or as the department considers appropriate. [PL 2015, c. 511, §1 (NEW).]

[PL 2015, c. 511, §1 (NEW).]

5. Information for members and eligible members; eligibility. The program, in consultation with appropriate interested parties, shall provide information about eligibility requirements and procedures for enrolling in MaineCare to members and eligible members, including their dependents. The providing of the information under this subsection does not constitute representation of members and eligible members. Members and eligible members may seek and receive information regardless of whether they are represented by legal counsel. The information must be provided free of charge to members and eligible members.

This subsection does not create new rights or obligations concerning the provision of legal advice or representation of members and eligible members.

[PL 2015, c. 511, §1 (NEW).]

6. Confidentiality of records. Information held by or records or case-specific reports maintained by the program are confidential. Disclosure may be made only if the ombudsman determines such disclosure is lawful and in the best interest of the member or eligible member.

[PL 2015, c. 511, §1 (NEW).]

7. Liability. Any person who in good faith submits a complaint or inquiry to the program pursuant to this section is immune from any civil or criminal liability arising from that complaint or inquiry. For the purpose of any civil or criminal proceedings, there is a rebuttable presumption that any person acting pursuant to this section did so in good faith. The ombudsman and employees and volunteers of the program are employees of the State for the purposes of the Maine Tort Claims Act.

[PL 2015, c. 511, §1 (NEW).]

8. Information. Information about the services of the program must be given to all members and eligible members who receive or are eligible to receive services from the department and from persons and entities contracting with the department for the provision of Medicaid services.

[PL 2015, c. 511, §1 (NEW).]

9. Report. The program shall report to the department according to the requirements of the program contract under subsection 3. The program shall also report annually by January 1st to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the activities and services of the program, priorities that may have been set by the program among types of inquiries and complaints, waiting lists for services and the provision of outreach services and recommendations for changes in statute, rules or policy to improve the provision of services.

[PL 2015, c. 511, §1 (NEW).]

10. Funding. The department shall contract for ombudsman services under this section as long as nonstate funding is available.

[PL 2015, c. 511, §1 (NEW).]

SECTION HISTORY

PL 1999, c. 681, §1 (NEW). PL 2015, c. 511, §1 (RPR).

§3174-Y. Prior authorization in Medicaid program

If the commissioner establishes maximum retail prices for prescription drugs pursuant to section 2693, the department shall adopt rules for the Medicaid program requiring additional prior authorization for the dispensing of drugs determined to be priced above the established maximum retail prices. The department shall adopt rules for the Medicaid program requiring additional prior authorization for the dispensing of drugs provided from manufacturers and labelers who do not enter into agreements with the department under section 2681, subsection 3. For the purposes of this section, "labeler" means an entity or person that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale and that has a labeler code from the federal Food and Drug Administration under 21 Code of Federal Regulations, 207.20 (1999). [PL 1999, c. 786, Pt. B, §3 (NEW).]

SECTION HISTORY

PL 1999, c. 786, §B3 (NEW).

§3174-Z. Private, nonmedical and board and care institutions

Rules concerning the principles for reimbursement for private, nonmedical and board and care institutions must be major substantive rules as defined in Title 5, chapter 375, subchapter II-A. [PL 2001, c. 404, §1 (NEW).]

SECTION HISTORY

PL 2001, c. 404, §1 (NEW).

§3174-AA. Asset limits

Beginning January 1, 2002, in determining eligibility for medical assistance under the Medicaid program for all individuals and families subject to an asset test, the department shall exempt from consideration all assets exempt pursuant to program rule on January 1, 2001 and shall adopt rules to exempt from consideration certain assets in amounts and under terms the department determines to be reasonable and consistent with the purposes of the Medicaid program as provided in this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. The rules must provide exemptions for the following assets: [PL 2001, c. 450, Pt. A, §4 (NEW).]

1. Second vehicle. A 2nd vehicle that is necessary for employment, to secure medical treatment or to provide transportation for essential daily activities or a vehicle that has been modified for operation by or the transportation of a person with a disability; and
[PL 2001, c. 450, Pt. A, §4 (NEW).]

2. Savings. An amount up to \$8,000 for an individual and up to \$12,000 for a household of more than one person.

[PL 2001, c. 450, Pt. A, §4 (NEW).]

REVISOR'S NOTE: §3174-AA. Mail order drugs (As amended by PL 2003, c. 451, Pt. XX, §1 is REALLOCATED TO TITLE 22, SECTION 3174-EE)

SECTION HISTORY

PL 2001, c. 450, §A4 (NEW). RR 2003, c. 1, §19 (RAL). PL 2003, c. 20, §K12 (NEW). PL 2003, c. 451, §XX1 (AMD).

§3174-BB. Enrollment periods

The department shall establish enrollment periods for medical assistance as provided in this section. Prior to the end of the enrollment period, the department shall determine continuing eligibility for the next enrollment period and notify the enrollee of the determination. [PL , c. 0, Pt. A, §4 (NEW).]

1. Children. In the Medicaid program and the Cub Care program under section 3174-T, the enrollment period for children under 19 years of age must be 12 months. [PL 2001, c. 450, Pt. A, §4 (NEW).]

2. Adults. In the Medicaid program, the enrollment period must be the longest period allowed by federal law or regulation but may not exceed 12 months. [PL 2001, c. 450, Pt. A, §4 (NEW).]

SECTION HISTORY

PL 2001, c. 450, §A4 (NEW).

§3174-CC. Medicaid eligibility during incarceration

1. Establish procedures. The department shall establish procedures to ensure that:

A. A person receiving federally approved Medicaid services prior to incarceration does not lose Medicaid eligibility as a result of that incarceration and receives assistance with reapplying for benefits if that person's Medicaid coverage expires or is terminated during the term of incarceration; and [PL 2019, c. 492, §2 (NEW).]

B. A person who is not receiving federally approved Medicaid services prior to incarceration but meets the eligibility requirements for Medicaid receives assistance with applying for federally approved Medicaid services. [PL 2019, c. 492, §2 (NEW).]

[PL 2019, c. 492, §2 (NEW).]

2. Presumptive eligibility. If a MaineCare provider determines that a person who is incarcerated who does not have Medicaid coverage is likely to be eligible for services under this section, the provider must be reimbursed for services provided under this section in accordance with 42 Code of Federal Regulations, Section 435.1101.

[PL 2019, c. 492, §2 (NEW).]

3. Memorandum of understanding. The department and the Department of Corrections shall enter into a memorandum of understanding in order to provide an incarcerated person with assistance in applying for benefits under this section and section 3104, subsection 17.

[PL 2019, c. 492, §2 (NEW).]

The provisions of this section apply even if Medicaid coverage is limited during the period of incarceration. Nothing in this section requires or permits the department to maintain an incarcerated person's Medicaid eligibility if the person no longer meets eligibility requirements. [PL 2019, c. 492, §2 (RPR).]

SECTION HISTORY

PL 2001, c. 659, §B1 (NEW). PL 2019, c. 492, §2 (RPR).

§3174-DD. Dirigo health coverage

The department may contract with one or more health insurance carriers or the Dirigo Health Self-administered Plan established pursuant to Title 24-A, section 6981 to purchase Dirigo Health Program coverage for MaineCare members who seek to enroll through their employers pursuant to Title 24-A, section 6910, subsection 4, paragraph B. A MaineCare member who enrolls in the Dirigo Health

Program as a member of an employer group receives full MaineCare benefits through the Dirigo Health Program. The benefits are delivered through the employer-based health plan, subject to nominal cost sharing as permitted by 42 United States Code, Section 1396o(2003) and additional coverage provided under contract by the department. [PL 2007, c. 447, §2 (AMD).]

SECTION HISTORY

PL 2003, c. 469, §A6 (NEW). PL 2005, c. 400, §C2 (AMD). PL 2007, c. 447, §2 (AMD).

§3174-EE. Mail order drugs

(REALLOCATED FROM TITLE 22, SECTION 3174-AA)

The department shall require MaineCare members to purchase maintenance drugs by mail order when substantial cost efficiencies can be obtained by doing so. Any savings measures implemented by the department in fiscal year 2003-04 that are of a temporary nature may remain in effect only until a permanent savings measure or measures are implemented. [RR 2003, c. 1, §19 (RAL).]

SECTION HISTORY

RR 2003, c. 1, §19 (RAL).

§3174-FF. MaineCare Basic

1. Established. The MaineCare Basic program is established to deliver medically necessary health care services to adult members of the MaineCare program. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

2. Rules. The department shall adopt rules to implement MaineCare Basic in accordance with this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

3. Services. The rules adopted pursuant to subsection 2 must provide for access to medically necessary services as provided in the federally approved Medicaid state plan. Benefits for certain services are limited as follows.

A. A member is eligible for speech therapy benefits if the member has been assessed to have rehabilitation potential or a demonstrated medical necessity for speech therapy to avoid a significant deterioration in the member's ability to communicate orally, safely swallow or masticate. In order for the member to be eligible for speech therapy benefits, a physician must document that the member has experienced a significant decline in ability to communicate orally, safely swallow or masticate or may reasonably suffer a significant deterioration in these functions if therapy is not provided. Speech therapy benefits must cover one initial evaluation of the member per provider per year and one reevaluation every 6 months per provider. Speech therapy benefits must cover outpatient therapy provided in the home, independent practitioners' offices and speech and hearing clinic sites. [PL 2007, c. 71, §1 (RPR).]

B. A member is eligible for rehabilitation services benefits for brain injury subject to levels of care determined by rule. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

C. A member is eligible for psychological services benefits for individual and group counseling. Benefits for one or both types of counseling combined are limited to a total of 16 one-hour visits per year, except that the department may increase the maximum number of visits for psychological services to 24 visits in a 12-month period as long as any cost associated with this increase is offset by savings from managing the use of these services by methods that may include prior authorization. [PL 2005, c. 680, §1 (AMD).]

D. A member is eligible for benefits for durable medical equipment, prosthetics and orthotics for one pair of shoes and one pair of inserts per year, medical supplies required to meet standard daily

needs and power wheelchairs for a member who is nonambulatory and has a significant neuromuscular disease or disorder. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

E. A member is eligible for occupational and physical therapy benefits provided by occupational and physical therapists licensed under Title 32 and who are acting within their scope of practice. Services of occupational and physical therapists may be provided in all outpatient settings, including the home. For services subject to this paragraph, the department may require a member to have that member's rehabilitation potential documented by a physician and may limit treatment to:

- (1) Treatment following an acute hospital stay for a condition affecting range of motion, muscle strength and physical functional abilities;
- (2) Treatment after a surgical procedure performed for the purpose of improving physical function; or
- (3) Treatment in those situations in which a physician has documented that the patient has in the preceding 30 days required extensive assistance in the performance of one or more of the following activities of daily living: eating, toileting, locomotion, transfer or bed mobility.

The department may limit occupational and physical therapy services benefits under this paragraph for palliative care and maintenance of function to one visit per year to design a plan of care and train the member or caretaker of the member to implement the plan or to reassess the plan of care. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

F. A member is eligible for benefits for chiropractic services provided by a chiropractor licensed under Title 32. Benefits under this paragraph may be limited by the department by requiring a member to have that member's rehabilitation potential documented by a physician. Benefits may be limited to treatment as follows:

- (1) Treatment for acute neuromuscular skeletal conditions affecting range of motion, muscle strength and physical functional abilities; or
- (2) Treatment after a surgical procedure performed for the purpose of improving physical function. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

G. A member is eligible for benefits under the private duty nursing and personal care program and waiver programs for the physically disabled or elderly as long as those benefits may be limited by reductions in units of service or by rate reductions. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

H. A member who is eligible for benefits under section 3174-G, subsection 1, paragraph F is eligible for benefits under this section subject to the provisions of paragraphs A to G and to additional rules limiting benefits as specified in this paragraph.

- (1) Benefits for inpatient hospital admissions are limited to 2 per year, except that more admissions may be approved through prior authorization by the department. This subparagraph does not limit inpatient hospital benefits for laboratory services, x-ray services, prenatal care and mental health diagnoses.
- (2) Benefits for outpatient visits to a hospital are limited to 5 per year, except that more visits may be approved through prior authorization by the department. This subparagraph does not limit benefits for visits for laboratory services, x-ray services, prenatal care and mental health diagnoses.
- (3) Benefits for brand-name prescription medications are limited to 5 medications dispensed during the same time period, except that benefits for additional brand-name medications may be approved through prior authorization by the department. In addition to the brand-name limitation, as compared to members who are eligible under other paragraphs of section 3174-G, subsection 1, prescription medication benefits for members who are eligible under paragraph

F are limited by stricter prior authorization requirements, increased review of pharmacy use and a request for federal permission to waive freedom of choice.

(4) A member who is eligible for benefits under section 3174-G, subsection 1, paragraph F begins coverage on the date that the department determines that the member is eligible. [PL 2003, c. 673, Pt. MMM, §1 (NEW).]

[PL 2007, c. 71, §1 (AMD).]

SECTION HISTORY

PL 2003, c. 673, §MMM1 (NEW). PL 2005, c. 680, §1 (AMD). PL 2007, c. 71, §1 (AMD).

§3174-GG. Long-term Care Partnership Program

There is established within the department the Long-term Care Partnership Program pursuant to Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171, 120 Stat. 4 (2006), referred to in this section as "the program," to provide incentives for persons to insure the costs of their own long-term care and to alleviate some of the costs of long-term care being paid by MaineCare. The department shall administer the program as a part of MaineCare. [PL 2009, c. 101, §1 (AMD).]

1. Eligibility. A person is eligible for the program if that person is insured under a policy of long-term care insurance qualified pursuant to the federal Deficit Reduction Act of 2005 and approved for the purpose of the program and has used the policy alone or in combination with private resources to pay for long-term care costs without resort to MaineCare coverage. In order to qualify for benefits under the program, a person must be eligible under this subsection and meet the other criteria required for long-term care benefits under the MaineCare program as provided in this chapter and in rules adopted by the department.

[PL 2009, c. 101, §2 (AMD).]

2. Benefits. The benefits of the program include coverage for long-term care services under MaineCare after the person participating in the program has used the available coverage and benefits purchased under the approved long-term care policy.

[PL 2009, c. 101, §3 (AMD).]

3. Disregard. In addition to assets disregarded or exempt under MaineCare program rules, in determining eligibility for MaineCare and the amount of MaineCare benefits and in estate recovery pursuant to section 14, subsection 2-I, the program must disregard assets of an eligible person that are disclosed to the department in the application or posteligibility process in an amount equal to the benefits paid by the approved long-term care insurance policy.

[PL 2009, c. 101, §4 (AMD).]

4. Information. In cooperation with the Department of Professional and Financial Regulation, Bureau of Insurance, the department shall provide information to the public regarding the program and approved long-term care insurance policies.

[PL 2005, c. 12, Pt. DDD, §10 (NEW).]

5. Reciprocal agreements. The department shall enter into reciprocal agreements with other states to extend the program to persons who purchased long-term care insurance policies equivalent to policies approved in this State and to extend similar programs in other states to persons who purchase approved policies in this State and who later relocate and apply for Medicaid long-term care benefits in other states.

[PL 2005, c. 12, Pt. DDD, §10 (NEW).]

6. Other laws. Eligibility for the program does not preclude enforcement of laws regarding recovery of MaineCare benefits incorrectly paid or 3rd-party liability claims by the department. The provisions of this section do not enlarge or otherwise modify medical assistance benefits under the

MaineCare program. The provisions of section 14, subsection 2-I, paragraph A, subparagraph (3) do not apply to assets disregarded under the program.

[PL 2005, c. 12, Pt. DDD, §10 (NEW).]

7. Rulemaking. The department, after consultation with the Superintendent of Insurance within the Department of Professional and Financial Regulation, shall adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2005, c. 12, Pt. DDD, §10 (NEW).]

SECTION HISTORY

PL 2005, c. 12, §DDD10 (NEW). PL 2009, c. 101, §§1-4 (AMD).

§3174-HH. Coordination of services

For the purposes of maximizing coverage for prescription drugs for members who are enrolled in the MaineCare program, the department may provide prescription drug services for MaineCare members through the elderly low-cost drug program established under section 254-D. [PL 2005, c. 401, Pt. B, §1 (NEW).]

REVISOR'S NOTE: §3174-HH. MaineCare reimbursement for ambulance services (As enacted by PL 2005, c. 386, Pt. FF, §1 is REALLOCATED TO TITLE 22, SECTION 3174-JJ)

SECTION HISTORY

RR 2005, c. 1, §6 (RAL). PL 2005, c. 386, §FF1 (NEW). PL 2005, c. 401, §B1 (NEW).

§3174-II. Relationship to federal Medicare program

1. Authorization. To the extent permitted by federal law, with regard to the Medicare Part D benefit established in the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, the department may:

A. Serve as an authorized representative for MaineCare members for the purpose of enrollment into a Medicare Part D plan; [PL 2005, c. 401, Pt. B, §1 (NEW).]

B. Apply for Medicare Part D benefits and subsidies on behalf of MaineCare members; [PL 2005, c. 401, Pt. B, §1 (NEW).]

C. Establish rules by which MaineCare members may opt out of the procedures under paragraphs A and B; [PL 2005, c. 401, Pt. B, §1 (NEW).]

D. At its discretion, file exceptions and appeals on behalf of MaineCare members who are beneficiaries under Medicare Part D. The department may identify a designee for this function; and [PL 2005, c. 401, Pt. B, §1 (NEW).]

E. Identify objective criteria for evaluating Medicare Part D plans for the purposes of assisting or enrolling MaineCare members in Medicare Part D plans. [PL 2005, c. 401, Pt. B, §1 (NEW).]

REVISOR'S NOTE: §3174-II. MaineCare Stabilization Fund (As enacted by PL 2005, c. 457, Pt. JJJ, §1 is REALLOCATED TO TITLE 22, SECTION 3174-KK)

[PL 2005, c. 401, Pt. B, §1 (NEW).]

SECTION HISTORY

RR 2005, c. 1, §7 (RAL). PL 2005, c. 401, §B1 (NEW). PL 2005, c. 457, §JJJ1 (NEW).

§3174-JJ. MaineCare reimbursement for ambulance services

(REALLOCATED FROM TITLE 22, SECTION 3174-HH)

The department shall reimburse for ambulance services under MaineCare at a level that is not less than the average allowable reimbursement rate under Medicare for such services or at the highest percent of that level that is possible within resources appropriated for those purposes. Beginning March 1, 2015, the department shall reimburse for ambulance services under MaineCare at a level that is not less than 65% of the average allowable reimbursement rate under Medicare for such services. Beginning January 1, 2020, the department shall reimburse for ambulance services under MaineCare at a level that is not less than the average allowable reimbursement rate under Medicare for such services and shall reimburse for neonatal transport services under MaineCare at the average rate for critical care transport services under Medicare. [PL 2019, c. 530, Pt. B, §1 (AMD).]

SECTION HISTORY

RR 2005, c. 1, §6 (RAL). PL 2013, c. 441, §1 (AMD). PL 2019, c. 530, Pt. B, §1 (AMD).

§3174-KK. MaineCare Stabilization Fund

(REALLOCATED FROM TITLE 22, SECTION 3174-II)

1. Fund established. The MaineCare Stabilization Fund, referred to in this section as "the fund," is established as an Other Special Revenue Funds account for the purposes specified in this section. [RR 2005, c. 1, §7 (RAL).]

2. Nonlapsing. Any unexpended balances in the fund may not lapse but must be carried forward. [RR 2005, c. 1, §7 (RAL).]

3. Fund purposes. Allocations from the fund must prevent any loss of services or increased cost of services to a MaineCare member or a person receiving benefits under the elderly low-cost drug program under section 254-D that would otherwise result from insufficient General Fund appropriations, insufficient federal matching funds or any other shortage of funds, changes in federal or state law, rule or policy or the implementation of the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003. [PL 2005, c. 683, Pt. A, §35 (AMD).]

4. Report by State Controller. The State Controller shall report at least annually on the fund on or before the 2nd Friday in November to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters. The report must summarize the status of and activity in the fund. [RR 2005, c. 1, §7 (RAL).]

SECTION HISTORY

RR 2005, c. 1, §7 (RAL). PL 2005, c. 683, §A35 (AMD).

§3174-LL. Inpatient services reimbursement based on diagnosis-related groups

Beginning April 1, 2010, the Department of Health and Human Services shall begin to phase in a system to reimburse noncritical access hospitals for inpatient services under the MaineCare program an amount per discharge that is based on diagnosis-related groups modeled on the system used by the federal Medicare program. The new diagnosis-related groups payment system must be budget neutral, based on MaineCare hospital payments for the year prior to the year of implementation. The new payment system must be implemented for each noncritical access hospital at the beginning of the hospital's first fiscal year that commences on or after April 1, 2010. The Department of Health and Human Services shall adopt rules to implement this section. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A. [PL 2009, c. 213, Pt. CC, §3 (NEW).]

SECTION HISTORY

PL 2009, c. 213, Pt. CC, §3 (NEW).

§3174-MM. Outpatient services reimbursement under the MaineCare program based on ambulatory payment classifications

Beginning April 1, 2010, the Department of Health and Human Services shall begin to phase in a system to reimburse noncritical access hospitals for outpatient services under the MaineCare program an amount per patient service based on ambulatory payment classifications modeled on the system used by the federal Medicare program. The new ambulatory payment classifications must be budget neutral based on MaineCare payments for the same services in the year prior to the year of implementation. The new payment system must be implemented for each hospital at the beginning of the hospital's first fiscal year that commences on or after April 1, 2010. The Department of Health and Human Services shall adopt rules to implement this section. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter 2-A. [PL 2009, c. 213, Pt. CC, §4 (NEW).]

SECTION HISTORY

PL 2009, c. 213, Pt. CC, §4 (NEW).

§3174-NN. Inpatient services reimbursement for critical access hospitals based on diagnosis-related groups

(REPEALED)

SECTION HISTORY

PL 2009, c. 213, Pt. CC, §5 (NEW). PL 2011, c. 657, Pt. H, §2 (RP). PL 2011, c. 657, Pt. H, §5 (AFF).

§3174-OO. Outpatient services reimbursement for critical access hospitals under the MaineCare program based on ambulatory payment classifications

(REPEALED)

SECTION HISTORY

PL 2009, c. 213, Pt. CC, §6 (NEW). PL 2011, c. 657, Pt. H, §3 (RP). PL 2011, c. 657, Pt. H, §5 (AFF).

§3174-PP. Medicaid reimbursement for eligible services provided through the Child Development Services System and school administrative units

1. Consultation. Prior to adopting or amending any rule that pertains to the administration of a program of Medicaid coverage established by the department pursuant to this chapter for services that qualify for reimbursement and are provided through the auspices of the Child Development Services System and school administrative units in accordance with the federal Individuals with Disabilities Education Act, 20 United States Code, Section 1400 et seq., the Office of MaineCare Services shall consult with the following interested parties on the proposed adoption or amendment of rules:

- A. The Commissioner of Education or the commissioner's designee; [PL 2009, c. 643, §1 (NEW).]
- B. The Executive Director of the Maine School Management Association or the executive director's designee; [PL 2009, c. 643, §1 (NEW).]
- C. The executive director of a statewide organization of administrators of services for children with disabilities or the executive director's designee; [PL 2009, c. 643, §1 (NEW).]
- D. The executive director of a statewide organization for disability rights or the executive director's designee; and [PL 2009, c. 643, §1 (NEW).]

E. The Executive Director of the Maine Developmental Disabilities Council or the executive director's designee. [PL 2009, c. 643, §1 (NEW).]
[PL 2009, c. 643, §1 (NEW).]

2. Monthly report. The Office of MaineCare Services shall prepare and submit at the beginning of each month a report that includes a detailed statement of the status of any proposed adoption or amendment of rules that pertain to the Medicaid programs specified in subsection 1 to the joint standing committee of the Legislature having jurisdiction over education matters and the joint standing committee of the Legislature having jurisdiction over health and human services matters.
[PL 2009, c. 643, §1 (NEW).]

SECTION HISTORY

PL 2009, c. 643, §1 (NEW).

§3174-QQ. Care for children with life-threatening conditions

The department shall make decisions approving or disapproving care or services for children with life-threatening conditions who are members in the MaineCare program within one working day of receiving a complete urgent request or order from the health care provider or providers for the child.
[PL 2011, c. 35, §1 (NEW).]

REVISOR'S NOTE: §3174-QQ. Dental hygienist reimbursement (Section 3174-QQ as enacted by PL 2011, c. 457, §1 is REALLOCATED TO TITLE 22, SECTION 3174-RR)

SECTION HISTORY

RR 2011, c. 1, §32 (RAL). PL 2011, c. 35, §1 (NEW). PL 2011, c. 457, §1 (NEW).

§3174-RR. Dental hygienist reimbursement

(REALLOCATED FROM TITLE 22, SECTION 3174-QQ)

1. Reimbursement. By October 1, 2012, the department shall provide for the reimbursement under the MaineCare program of independent practice dental hygienists practicing as authorized under Title 32, section 18375 for the following procedures:

- A. Prophylaxis performed on a person who is 21 years of age or younger; [RR 2011, c. 1, §32 (RAL).]
- B. Topical application of fluoride performed on a person who is 21 years of age or younger; [RR 2011, c. 1, §32 (RAL).]
- C. Provision of oral hygiene instructions; [RR 2011, c. 1, §32 (RAL).]
- D. The application of sealants; [RR 2011, c. 1, §32 (RAL).]
- E. Temporary fillings; and [RR 2011, c. 1, §32 (RAL).]
- F. X-rays. [RR 2011, c. 1, §32 (RAL).]

Reimbursement must be provided to independent practice dental hygienists directly or to a federally qualified health center pursuant to section 3174-V when an independent practice dental hygienist is employed as a core provider at the center.

[PL 2015, c. 429, §4 (AMD).]

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

[RR 2011, c. 1, §32 (RAL).]

SECTION HISTORY

RR 2011, c. 1, §32 (RAL). PL 2015, c. 429, §4 (AMD).

§3174-SS. Calculation of 24 months

(REPEALED)

SECTION HISTORY

PL 2011, c. 477, Pt. I, §1 (NEW). PL 2019, c. 4, Pt. B, §1 (RP).

§3174-TT. Limitation on reimbursement for opioids

(REPEALED)

SECTION HISTORY

PL 2011, c. 477, Pt. O, §1 (NEW). PL 2011, c. 657, Pt. O, §1 (RP).

§3174-UU. Reimbursement for opioid drugs for the treatment of pain

This section applies to reimbursement under the MaineCare program for opioid drugs for the treatment of pain. [PL 2011, c. 657, Pt. O, §2 (NEW).]

1. Treatment of a new onset of acute pain. The department shall establish limits for MaineCare reimbursement of opioid drugs that are prescribed as medically necessary in response to a new onset of acute pain. After the initial 15-day prescription, the limits established may not exceed 42 days per year without prior authorization. In order to qualify for reimbursement under this subsection, the prior authorized prescription may not provide for more than 14 days of medication and requires a face-to-face visit between the prescriber and the MaineCare member. Notwithstanding the provisions of this subsection, the department shall limit to a period of 60 days following the surgical procedure MaineCare reimbursement for opioid drugs as treatment of post-operative care prescribed following a surgical procedure for which the medical standard of care includes the use of opioids. A MaineCare member who suffers from intractable pain and for whom opioid drugs are medically necessary beyond the limits set by this subsection may qualify for opioid drugs under subsection 2 as treatment for long-term chronic pain.

[PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]

2. Treatment of long-term chronic pain. Reimbursement for opioid drugs beyond the limit set in subsection 1 is allowed by prior authorization if the MaineCare member participates in one or more therapeutic treatment options established by the department through rulemaking.

In order to qualify for reimbursement for opioid drugs under this subsection, the MaineCare member must:

- A. Have failed to have an adequate response to the prescribed therapeutic treatment options; [PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]
- B. Have completed the prescribed therapeutic treatment options in accordance with the guidelines and show signs of regression; or [PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]
- C. Have completed at least 50% of the prescribed therapeutic treatment options under this subsection, after which the prescriber recommends that adequate control of pain will not be obtained under the therapeutic treatment options. [PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]

The department shall limit reimbursement for opioids for a MaineCare member who fails to have an adequate response to the prescribed therapeutic treatment options, subject to exception based on medical necessity. The department may include in rulemaking the establishment of a daily dosing limit, subject to exception.

The department may waive the requirement of therapeutic treatment options through prior authorization when participation is not feasible and opioid treatment is medically necessary.

The department may allow a MaineCare member who is participating in a course of treatment recommended by a prescriber, including alternatives, in accordance with rules adopted by the department to obtain a prior authorization for physical therapy in excess of 2 visits to a maximum of 6 visits.

[PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]

3. Second opinion. In order for a prescription to qualify for reimbursement under this section, prior to prescribing an opioid drug for a medical diagnosis known typically to have a poor response to opioid drugs, a prescriber shall obtain an evaluation from a prescriber from outside the practice of the prescriber.

[PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]

4. Current use. The department may delay until January 1, 2013 the application of this section to the reimbursement for opioid drugs for MaineCare members who have been receiving such treatment consistently for 6 months or longer on the effective date of this section. The department may require the development of a protocol for proper, safe and effective tapering from opioid use when appropriate and may adopt exceptions to the requirements of this section based on diagnosis or condition or on the basis of daily doses.

[PL 2011, c. 657, Pt. O, §2 (NEW).]

5. Collaboration. The department shall seek input from pain specialists, addiction medicine specialists and members of the department's physician advisory committee in the development of rules governing this section.

[PL 2011, c. 657, Pt. O, §2 (NEW).]

6. Morphine equivalent dose. The department may establish and utilize a total daily morphine equivalent dose calculation when developing rules to implement this section.

[PL 2011, c. 657, Pt. O, §2 (NEW).]

7. Exceptions. This section does not apply to reimbursement for opioid drugs for the following MaineCare members as specified in rules adopted by the department or as established through the MaineCare preferred drug list:

A. A MaineCare member who is receiving opioid drugs for symptoms related to HIV, AIDS, cancer and certain other qualifying diseases and conditions, as established by department rule; [PL 2011, c. 657, Pt. O, §2 (NEW).]

B. A MaineCare member who is receiving opioid drugs during inpatient treatment in a hospital or during hospice care; [PL 2011, c. 657, Pt. O, §2 (NEW).]

C. A MaineCare member who is receiving opioid drugs at certain qualifying low doses, as established by department rule; [PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]

D. A MaineCare member for whom MaineCare reimbursement for opioid drugs for the treatment of addiction is restricted by limits applicable to methadone and buprenorphine and naloxone combination drugs; and [PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]

E. A MaineCare member who is residing in a nursing facility. [PL 2013, c. 368, Pt. AAAAA, §1 (NEW).]

[PL 2013, c. 368, Pt. AAAAA, §1 (AMD).]

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

[PL 2011, c. 657, Pt. O, §2 (NEW).]

REVISOR'S NOTE: §3174-UU. Methadone reimbursement limitations (As enacted by PL 2011, c. 657, Pt. S, §1 is REALLOCATED TO TITLE 22, SECTION 3174-VV)

SECTION HISTORY

RR 2011, c. 2, §27 (RAL). PL 2011, c. 657, Pt. O, §2 (NEW). PL 2011, c. 657, Pt. S, §1 (NEW). PL 2013, c. 368, Pt. AAAAA, §1 (AMD).

§3174-VV. Methadone reimbursement limitations

(REALLOCATED FROM TITLE 22, SECTION 3174-UU)

(REPEALED)

SECTION HISTORY

RR 2011, c. 2, §27 (RAL). PL 2017, c. 407, Pt. A, §78 (AMD). PL 2019, c. 4, Pt. C, §1 (RP).

§3174-WW. Tobacco cessation

1. Coverage. The department shall provide coverage for comprehensive tobacco cessation treatment to a MaineCare member who is 18 years of age or older or who is pregnant. Coverage must include, at a minimum:

A. Coverage for all pharmacotherapy that is approved by the federal Food and Drug Administration for tobacco dependence treatment or is recommended as effective in the United States Public Health Service clinical practice guideline on treating tobacco use and dependence; and [PL 2013, c. 444, §1 (NEW).]

B. Coverage for tobacco cessation counseling, to be available in individual and group forms. [PL 2013, c. 444, §1 (NEW).]
[PL 2013, c. 444, §1 (NEW).]

2. Conditions of coverage. Coverage under this section must be provided with no copayments or other out-of-pocket cost sharing, including deductibles. The department may not impose annual or lifetime dollar limits or annual or lifetime limits on attempts to quit and may not require a MaineCare member to participate in counseling to receive medications.

[PL 2013, c. 444, §1 (NEW).]

3. Federal reimbursement. The department shall pursue all opportunities to maximize available federal reimbursement, including available administrative Medicaid match rates for telephonic counseling services, federal pharmacology purchasing agreements or other opportunities to maximize state resources for tobacco cessation medications and services.

[PL 2013, c. 444, §1 (NEW).]

SECTION HISTORY

PL 2013, c. 444, §1 (NEW).

§3174-XX. Dental therapy reimbursement

1. Reimbursement. By October 1, 2015, the department shall provide for the reimbursement under the MaineCare program of dental therapists practicing as authorized under Title 32, section 18377 for the procedures identified in their scope of practice. Reimbursement must be provided to dental therapists directly or to a federally qualified health center pursuant to section 3174-V when a dental therapist is employed as a core provider at the center.

[PL 2019, c. 388, §1 (AMD).]

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

[PL 2013, c. 575, §1 (NEW); PL 2013, c. 575, §10 (AFF).]

SECTION HISTORY

PL 2013, c. 575, §1 (NEW). PL 2013, c. 575, §10 (AFF). PL 2015, c. 429, §5 (AMD). PL 2019, c. 388, §1 (AMD).

§3174-YY. State educational Medicaid officer

The commissioner shall designate an appropriate employee within the department as the state educational Medicaid officer to work in coordination with the Department of Education and school administrative units to maximize reimbursement for Medicaid services provided by school administrative units. [PL 2015, c. 359, §1 (NEW).]

SECTION HISTORY

PL 2015, c. 359, §1 (NEW).

§3174-ZZ. Reimbursement for hearing aids

1. Hearing aid; definition. For purposes of this section, "hearing aid" means a nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing. [PL 2017, c. 237, §1 (NEW).]

2. Required reimbursement. The department shall provide reimbursement for a hearing aid for one hearing-impaired ear of an individual enrolled in the MaineCare program in accordance with the following requirements:

- A. The hearing loss must be documented by a primary care provider or an audiologist licensed pursuant to Title 32, chapter 137; [PL 2017, c. 237, §1 (NEW).]
- B. The hearing aid must be provided by an audiologist or a hearing aid dealer licensed pursuant to Title 32, chapter 137; and [PL 2017, c. 237, §1 (NEW).]
- C. The hearing loss must meet the requirements established by the department in rule regarding the individual's severity of hearing loss. [PL 2017, c. 237, §1 (NEW).]

The department shall provide reimbursement for a hearing aid for the 2nd hearing-impaired ear of an individual enrolled in the MaineCare program if the individual meets requirements established by the department by rule regarding the individual's severity of hearing loss, enrollment in school, enrollment in vocational training, employment needs or the needs identified by a primary care provider. [PL 2017, c. 237, §1 (NEW).]

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

[PL 2017, c. 237, §1 (NEW).]

SECTION HISTORY

PL 2017, c. 237, §1 (NEW).

§3174-AAA. Reimbursement for days awaiting placement; reimbursement for hospitals other than critical access hospitals

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

(WHOLE SECTION TEXT EFFECTIVE UNTIL 12/31/23)

(WHOLE SECTION TEXT REPEALED 12/31/23)

Beginning January 1, 2019, the department shall provide reimbursement to hospitals other than critical access hospitals for each day after the 10th day that a MaineCare-eligible individual is in the care of a hospital while awaiting placement in a nursing facility. The department shall reimburse hospitals prospectively at the statewide average rate per MaineCare member day for nursing facility services. The department shall compute the statewide average rate per MaineCare member day based on the simple average of the nursing facility rate per MaineCare member day for the applicable state fiscal year or years prorated for the hospital's fiscal year. Reimbursement for days awaiting placement

pursuant to this section is limited to a maximum of \$500,000 of combined General Fund funds and federal funds for each year. For purposes of this section, "critical access hospital" has the same meaning as in section 7932, subsection 10. [PL 2017, c. 454, §1 (NEW).]

This section is repealed December 31, 2023. [PL 2017, c. 454, §1 (NEW).]

REVISOR'S NOTE: §3174-AAA. Chiropractic services reimbursement as enacted by PL 2017, c. 421, §1 is REALLOCATED TO TITLE 22, SECTION 3174-CCC

SECTION HISTORY

PL 2017, c. 454, §1 (NEW).

§3174-BBB. Coverage for parents participating in rehabilitation and reunification efforts

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

(WHOLE SECTION TEXT EFFECTIVE ON CONTINGENCY: See PL 2019, c. 130, §5)

Notwithstanding any other provision of law to the contrary, a parent receiving benefits under this chapter as a parent of one or more dependent minor children who have been removed from the home of that parent pursuant to section 4036-B continues to be eligible for benefits under this chapter until either the department discontinues rehabilitation and reunification efforts pursuant to section 4041 or parental rights have been terminated pursuant to section 4055, whichever occurs first. The department shall adopt rules to implement this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2019, c. 130, §1 (NEW); PL 2019, c. 130, §5 (AFF).]

Beginning January 1, 2021, the department shall provide annually by January 1st to the joint standing committee of the Legislature having jurisdiction over health and human services matters a report on the number of individuals and families who continue MaineCare coverage pursuant to the requirements of this section. [PL 2019, c. 130, §1 (NEW); PL 2019, c. 130, §5 (AFF).]

REVISOR'S NOTE: §3174-BBB. Coverage for conversion therapy as enacted by PL 2019, c. 165, §3 is REALLOCATED TO TITLE 22, SECTION 3174-DDD

SECTION HISTORY

PL 2019, c. 130, §1 (NEW). PL 2019, c. 130, §5 (AFF).

§3174-CCC. Chiropractic services reimbursement

(REALLOCATED FROM TITLE 22, SECTION 3174-AAA)

1. Reimbursement. The department shall reimburse under the MaineCare program for chiropractic evaluation and management examinations performed by a chiropractic doctor licensed under Title 32, chapter 9 that are within the scope of practice of chiropractic doctors. This subsection does not limit reimbursements under the MaineCare program that may be available for other chiropractic services or affect any limits that may apply to reimbursements such as limits relating to numbers of visits.

[PL 2019, c. 421, §1 (NEW); RR 2019, c. 1, Pt. A, §24 (RAL).]

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

[PL 2019, c. 421, §1 (NEW); RR 2019, c. 1, Pt. A, §24 (RAL).]

SECTION HISTORY

PL 2019, c. 421, §1 (NEW). RR 2019, c. 1, Pt. A, §24 (RAL).

§3174-DDD. Coverage for conversion therapy

(REALLOCATED FROM TITLE 22, SECTION 3174-BBB)

The department may not provide MaineCare reimbursement for conversion therapy as defined in Title 32, section 59-C, subsection 1 administered to a minor. [PL 2019, c. 165, §3 (NEW); RR 2019, c. 1, Pt. A, §25 (RAL).]

SECTION HISTORY

PL 2019, c. 165, §3 (NEW). RR 2019, c. 1, Pt. A, §25 (RAL).

§3174-EEE. Prior authorization of treatment for opioid use disorder

1. Medication-assisted treatment. For the purposes of this section, "medication-assisted treatment" means an evidence-based practice that combines pharmacological interventions with substance use disorder counseling.

[PL 2019, c. 645, §1 (NEW).]

2. Prior authorization limitation. The department may not require under the MaineCare program prior authorization for the following:

A. The prescription of at least one drug for each therapeutic class of medication used for medication-assisted treatment for opioid use disorder; or [PL 2019, c. 645, §1 (NEW).]

B. Intensive outpatient therapy services for a diagnosis of opioid use disorder. [PL 2019, c. 645, §1 (NEW).]

[PL 2019, c. 645, §1 (NEW).]

3. Prior authorization for pregnant women. In addition to the prior authorization limits imposed in subsection 2, the department may not require under the MaineCare program any prior authorization requirements with respect to a pregnant woman for medication-assisted treatment for opioid use disorder or for intensive outpatient therapy services for a diagnosis of opioid use disorder.

[PL 2019, c. 645, §1 (NEW).]

4. Dosage increases. Notwithstanding subsections 2 and 3, the department may impose prior authorization requirements under the MaineCare program for dosage increases that exceed the department's dosing criteria as identified on the department's MaineCare preferred drug list.

[PL 2019, c. 645, §1 (NEW).]

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

[PL 2019, c. 645, §1 (NEW).]

The requirements of this section must be applied in a manner that is not inconsistent with the requirements of the Medicaid drug rebate program. [PL 2019, c. 645, §1 (NEW).]

SECTION HISTORY

PL 2019, c. 645, §1 (NEW).

§3175. Acceptance of federal provisions

The department is authorized, subject to the approval of the Governor, to: [PL 1975, c. 771, §225 (AMD).]

1. Apply for assistance. Apply for federal assistance under the United States Social Security Act, as amended, and to comply with such conditions, not inconsistent with this chapter, as may be required for such assistance; and

[PL 1973, c. 790, §2 (NEW).]

2. Reports. Make such reports in such form and containing such information as the Federal Government may from time to time require and comply with such provisions as the Federal

Government may from time to time find necessary as to assure the correctness and verification of such reports.

[PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW). PL 1975, c. 771, §225 (AMD).

§3175-A. Delinquent nursing home taxes to be withheld from Medicaid payments

Whenever the commissioner receives written notice from the State Tax Assessor that a nursing home is delinquent by more than 30 days in making a health care provider tax payment required by Title 36, section 2873, the commissioner shall, upon 10 days' written notice, withhold the outstanding amount of tax, together with any applicable interest and penalties, from the nursing home's Medicaid payments. All amounts withheld by the commissioner pursuant to this section are deemed to be health care provider tax payments by the nursing home and must be transferred within 30 days to the State Tax Assessor, who shall apply the amount in question to the nursing home's tax account. [PL 2001, c. 714, Pt. CC, §1 (NEW); PL 2001, c. 714, Pt. CC, §8 (AFF).]

SECTION HISTORY

PL 2001, c. 714, §CC1 (NEW). PL 2001, c. 714, §CC8 (AFF).

§3175-B. Delinquent residential treatment facility taxes to be withheld from Medicaid payments

Whenever the commissioner receives written notice from the State Tax Assessor that a residential treatment facility is delinquent by more than 30 days in making a health care provider tax payment required by Title 36, section 2873, the commissioner shall, upon 10 days' written notice, withhold the outstanding amount of tax, together with any applicable interest and penalties, from the residential treatment facility's Medicaid payments. All amounts withheld by the commissioner pursuant to this section are deemed to be health care provider tax payments by the residential treatment facility and must be transferred within 30 days to the State Tax Assessor, who shall apply the amount in question to the residential treatment facility's tax account. [PL 2001, c. 714, Pt. CC, §1 (NEW); PL 2001, c. 714, Pt. CC, §8 (AFF).]

SECTION HISTORY

PL 2001, c. 714, §CC1 (NEW). PL 2001, c. 714, §CC8 (AFF).

§3175-C. Delinquent hospital taxes to be withheld from Medicaid payments

When the commissioner receives written notice from the State Tax Assessor that a hospital is delinquent by more than 30 days in making a health care provider tax payment required by Title 36, section 2883 or chapter 377, the commissioner shall, upon 10 days' written notice, withhold the outstanding amount of tax, together with any applicable interest and penalties, from the hospital's Medicaid payments. All amounts withheld by the commissioner pursuant to this section are deemed to be health care provider tax payments by the hospital and must be transferred within 30 days to the State Tax Assessor, who shall apply the amount in question to the hospital's tax account. [PL 2003, c. 513, Pt. CC, §1 (AMD).]

SECTION HISTORY

PL 2001, c. 714, §NN1 (NEW). PL 2003, c. 513, §CC1 (AMD).

§3175-D. Nursing facility depreciation

(CONTAINS TEXT WITH VARYING EFFECTIVE DATES)

1. Depreciation. For sales of nursing facilities, as defined in section 1812-A, that occur on or after October 1, 2009, the department shall either:

A. At the time of the sale, recapture depreciation paid by the department under the MaineCare program, from the proceeds of the sale; or [PL 2009, c. 97, §1 (NEW).]

B. At the election of the buyer and seller, waive the recapture of depreciation at the time of the sale and allow the asset to transfer at the historical cost of the seller less depreciation allowed under the MaineCare program to the buyer for reimbursement purposes. [PL 2009, c. 97, §1 (NEW).]
[PL 2009, c. 97, §1 (NEW).]

2. (TEXT EFFECTIVE ON CONTINGENCY: See PL 2013, c. 582, §5) Methodology. Beginning with the sale of a nursing facility that occurs on or after July 1, 2014, or such other date as approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, the department shall calculate depreciation recapture using a methodology that provides percentage credits for buildings, fixed equipment and moveable equipment based on the number of years of operation by the owner of the nursing facility that is consistent with the following:

A. For the purposes of determining depreciation recapture for buildings and fixed equipment, the methodology must determine the number of years of operation by reference to the date on which the owner began operating with the original license; [PL 2013, c. 582, §1 (NEW); PL 2013, c. 582, §5 (AFF).]

B. For the purposes of determining depreciation recapture for moveable equipment, the methodology must enable percentage credits to reach 100% after the first 6 years of the assigned useful life; and [PL 2013, c. 582, §1 (NEW); PL 2013, c. 582, §5 (AFF).]

C. The methodology must treat as equivalent to the owner of the nursing facility any person or entity that owns or controls the entity that owns the nursing facility and any entity that is owned or controlled by the owner of the nursing facility. [PL 2013, c. 582, §1 (NEW); PL 2013, c. 582, §5 (AFF).]

[PL 2013, c. 582, §1 (NEW); PL 2013, c. 582, §5 (AFF).]

SECTION HISTORY

PL 2009, c. 97, §1 (NEW). PL 2013, c. 582, §1 (AMD). PL 2013, c. 582, §5 (AFF).

§3176. Treasurer of State as agent

The Treasurer of State shall be the appropriate officer of the State to receive available federal grants for programs for which the department may be eligible to receive federal funding in accordance with the Federal Social Security Act and the State Controller shall authorize expenditures therefrom as approved by the department. [PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW).

§3177. Suspension of aid

Appropriations for assistance under this chapter when used in programs entitled to receive federal matching funds shall not lapse but shall be a continuing account so long and as federal grants are available to match the State's contribution. No payments matchable by federal funds shall be made out of said account if federal grants or state appropriations are withdrawn, except that medical or remedial care or services contracted for before the date of such withdrawal shall be paid. Any money left in said fund in the event of withdrawal of federal grants or state appropriations shall be divided between the State and the Federal Government in proportion to the amount contributed by each. [PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW).

§3178. Payment to conservator or guardian

If an applicant for or a recipient of aid is found by the department to be incapable of taking care of himself or his money, payment shall be made only to a legally appointed guardian or conservator for his benefit. [PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW).

§3179. Change of circumstances

If at any time during the continuance of aid the recipient thereof becomes possessed of any property or income in excess of the amount last disclosed to the department, it shall be the duty of the recipient immediately to notify the department of the receipt or possession of such property or income, and the department may, after investigation, either cancel the aid or change the amount thereof in accordance with the circumstances. [PL 1973, c. 790, §2 (NEW).]

Any recipient of aid under this chapter whose categorical assistance benefits are terminated by the department shall be sent a separate, timely and adequate notice of the effect that that termination will have on his medical assistance. The department shall develop procedures to assure the continuation, without interruption, of medical assistance to persons who, despite the termination of their categorical assistance benefits, are eligible for continuing coverage through any program under this chapter. [PL 1977, c. 714, §4 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW). PL 1977, c. 714, §4 (AMD).

§3180. Inalienability of aid

All rights to aid shall be absolutely inalienable by any assignment, execution, pledge or otherwise, and shall not pass, in case of insolvency or bankruptcy, to any trustee, assignee or creditor. [PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW).

§3181. Appeals

1. Any person who is denied aid, or who is not satisfied with the amount of aid allotted to him, or is aggrieved by a decision of the department made under this chapter, or whose application is not acted upon with reasonable promptness, shall have the right of appeal to the commissioner, who shall provide the appellant with reasonable notice and opportunity for a fair hearing. Said commissioner or a member of the department designated and authorized by him shall hear all evidence pertinent to the matter at issue and render a decision thereon within a reasonable period after the date of the hearing. Such hearing shall conform to the procedures detailed herein. Review of any action or failure to act under this chapter shall be pursuant to Title 5, chapter 375, subchapter VII. [PL 1977, c. 694, §368 (AMD).]

2. Any action relative to the grant, denial, reduction, suspension or termination of aid provided under this chapter must be communicated to the applicant or recipient in writing and shall include the specific reason or reasons for such action and shall state that the person affected has a right to a hearing. [PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW). PL 1977, c. 594 (AMD). PL 1977, c. 694, §368 (AMD).

§3182. Fraudulent representations; penalty

Any person who by means of a willfully false statement or representation, or by impersonation or other fraudulent devices, obtains or attempts to obtain, or aids or abets any person to obtain: [PL 1973, c. 790, §2 (NEW).]

1. Assistance not entitled. Aid to which he is not entitled; [PL 1973, c. 790, §2 (NEW).]

2. Larger assistance. A larger amount of aid than that to which he is entitled; or [PL 1973, c. 790, §2 (NEW).]

3. Forfeited assistance. Payment of any forfeited installment of aid; and any person who knowingly buys or aids or abets in buying or in any way disposing of property of a recipient in such a way as to constitute a fraud upon the department shall be guilty of a misdemeanor, and upon conviction thereof shall be punished by a fine of not more than \$500, or by imprisonment for not more than 11 months, or by both. [PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW).

§3183. General penalty

Any person who violates any of the provisions of this chapter for which no penalty is specifically provided shall be punished by a fine of not more than \$500, or by imprisonment for not more than 11 months, or by both. If a recipient of aid is convicted of an offense under this chapter, the department may cancel the aid. [PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW).

§3184. Recovery of illegal payments

The department may recover the amount expended for aid in a civil action from a recipient or a former recipient who has failed to disclose assets which would have rendered him ineligible had he disclosed the assets. Such actions shall be prosecuted by the Attorney General in the name of the State of Maine, and the amount recovered shall be credited to the account for aid, medical or remedial care and services for the medically indigent. [PL 1973, c. 790, §2 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW).

§3185. Medical expenses for catastrophic illness

The department shall cease accepting applications for assistance through the Catastrophic Medical Expense Fund on June 30, 1987. The Department of Health and Human Services shall continue to provide financial assistance to, or on behalf of, families or individuals residing in the State meeting eligibility requirements for the catastrophic illness program up to a period of one year after June 30, 1987. [PL 1987, c. 349, Pt. H, §13 (RPR); PL 2003, c. 689, Pt. B, §6 (REV).]

Any balance of funds in the Catastrophic Medical Expense Fund account on June 30, 1987, shall not lapse and shall be utilized to provide financial assistance to, or on behalf of, families or individuals residing in this State meeting eligibility requirements for the catastrophic illness program on June 30, 1987. [PL 1987, c. 349, Pt. H, §13 (RPR).]

SECTION HISTORY

PL 1977, c. 714, §5 (NEW). PL 1981, c. 463, §§H1-H4 (AMD). PL 1981, c. 665, §§1,2 (AMD). PL 1983, c. 460, §1 (AMD). PL 1983, c. 824, §X3 (AMD). PL 1985, c. 501, §B19 (AMD). PL 1987, c. 349, §H13 (RPR). PL 2003, c. 689, §B6 (REV).

§3186. Medical and social services referral service

The department shall establish and maintain an information and referral service for medically indigent persons who become pregnant as a result of rape, gross sexual misconduct, incest or sexual abuse. The information and referral service shall include a list of medical and social services available from state and private sources, including, but not limited to, counseling services, shelter, maternal health care, a list of physicians who have voluntarily agreed to provide to Medicaid eligible victims, pro bono, medical services not available from Medicaid and other applicable medical or social services. [PL 1987, c. 402, Pt. A, §140 (RPR).]

This information shall also be made available to rape crisis centers, family planning agencies and other appropriate organizations. [PL 1987, c. 402, Pt. A, §140 (RPR).]

In addition to the medical and social services information provided, the department shall strongly encourage and counsel each person receiving this information to report the rape, gross sexual misconduct, incest or sexual abuse to the appropriate authorities for criminal prosecution and shall assist that person in making the report, if requested. [PL 1987, c. 402, Pt. A, §140 (RPR).]

Principles of reimbursement established for intermediate care facilities for persons with intellectual disabilities must be amended to implement the recommendations of the Advisory Committee on Staff Retention. [PL 2011, c. 542, Pt. A, §34 (AMD).]

SECTION HISTORY

PL 1985, c. 375 (NEW). PL 1985, c. 486, §1 (NEW). PL 1985, c. 749, §1 (AMD). PL 1987, c. 402, §A140 (RPR). PL 1987, c. 869, §1 (AMD). PL 2011, c. 542, Pt. A, §34 (AMD).

§3187. Principles of reimbursement; rules

The department shall meet annually with providers of community-based intermediate care facilities for persons with intellectual disabilities to review current principles of reimbursement under the federal Social Security Act, Title XIX, 42 United States Code, Chapter 7 and discuss necessary and appropriate changes. [PL 2011, c. 542, Pt. A, §35 (AMD).]

Principles of reimbursement established for intermediate care facilities for persons with intellectual disabilities must ensure maximum flexibility enabling facilities to shift variable cost funds within accounts established pursuant to the principles. These principles may not set any artificial limits on specific variable cost accounts as long as facility totals are met. [PL 2011, c. 542, Pt. A, §35 (AMD).]

Rules regarding principles of reimbursement for intermediate care facilities for persons with intellectual disabilities adopted pursuant to section 3173 are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A, except that rules adopted to establish an approval process for capital expenditures to renovate or construct intermediate care facilities for persons with intellectual disabilities are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2011, c. 542, Pt. A, §35 (AMD).]

SECTION HISTORY

PL 1987, c. 402, §A141 (NEW). PL 1995, c. 462, §A43 (AMD). PL 2003, c. 684, §1 (AMD). PL 2011, c. 380, Pt. XXX, §1 (AMD). PL 2011, c. 542, Pt. A, §35 (AMD).

§3188. Maine Managed Care Insurance Plan Demonstration for uninsured individuals

1. Development of demonstration. The Department of Health and Human Services shall develop, implement and administer the Maine Managed Care Insurance Plan Demonstration for individuals without health insurance in one urban site, one rural site and one site as determined by the department. Expenditures may not be incurred relative to the development of the 3rd site unless resources other than the General Fund are received by the department for that purpose. [PL 1989, c. 905 (AMD); PL 2003, c. 689, Pt. B, §6 (REV).]

2. Targeted enrollment. The department shall target enrollment in this plan to low-income, non-Medicaid eligible individuals employed in groups of less than 15 and the self-employed. Individual or nongroup policies will not be offered through this program. Enrollment in this plan shall not be offered to any group where there has been a health plan offered at any time within the past 12 months or to any self-employed individual who has been covered by health benefits coverage at any time within the past 12 months; except that groups and individuals who were covered through the Medicaid program or who had health benefits and lost that coverage involuntarily and who otherwise would be eligible for the Maine Managed Care Insurance Plan Demonstration are eligible for enrollment.

The intent of this demonstration is to provide access to health benefits to those for whom financial barriers preclude the purchase of the coverage. Eligibility criteria for the Maine Managed Care Insurance Plan Demonstration shall be developed by the department based upon the advice of The Robert Wood Johnson Foundation's grant advisory committee.

[PL 1987, c. 888 (RPR).]

3. Report. The Department of Health and Human Services shall prepare and submit to the joint standing committees of the 114th Legislature having jurisdiction over banking and insurance; human resources; and appropriations and financial affairs, a report on the Maine Managed Care Insurance Plan Demonstration during the 3rd year of the demonstration project. This report shall include, but not be limited to, the following information.

A. An assessment of the demonstration's success in providing cost effective affordable insurance coverage for acute and primary care services for the target population; [PL 1987, c. 349, Pt. H, §14 (NEW).]

B. An assessment of whether the demonstration should be continued, expanded incrementally to additional areas of the State, made a statewide project or discontinued; and [PL 1987, c. 349, Pt. H, §14 (NEW).]

C. An assessment of plan contracting and competitive bidding options and a review of options for program structure as a fully public or semipublic entity. [PL 1987, c. 349, Pt. H, §14 (NEW).] [PL 1987, c. 349, Pt. H, §14 (NEW); PL 2003, c. 689, Pt. B, §6 (REV).]

4. Confidentiality of records. The following medical or financial information concerning applicants to the Maine Managed Care Insurance Plan Demonstration shall be considered confidential as follows.

A. All department records that contain information regarding the identity, medical status or financial resources of particular individuals applying for health insurance coverage under the Maine Managed Care Insurance Plan Demonstration are confidential and subject to release only with the written authorization of the applicant. [PL 1989, c. 175, §3 (NEW).]

B. All department records that contain information regarding the identity or financial resources of a business or business owner applying for enrollment in the Maine Managed Care Insurance Plan Demonstration are confidential and subject to release only with written authorization of an authorized representative of the applicant's business. [PL 1989, c. 175, §3 (NEW).]

[PL 1989, c. 175, §3 (NEW).]

SECTION HISTORY

PL 1987, c. 349, §H14 (NEW). PL 1987, c. 888 (AMD). PL 1989, c. 175, §3 (AMD). PL 1989, c. 905 (AMD). PL 2003, c. 689, §B6 (REV).

§3189. The Maine Health Program

(REPEALED)

SECTION HISTORY

PL 1989, c. 588, §A43 (NEW). PL 1989, c. 875, §§E36-39 (AMD). RR 1991, c. 2, §79 (COR). PL 1991, c. 9, §§N8-10 (AMD). PL 1991, c. 42, §§1-8 (AMD). PL 1991, c. 42, §11 (AFF). PL 1991, c. 528, §§GG1-9 (AMD). PL 1991, c. 528, §RRR (AFF). PL 1991, c. 591, §§GG1-9 (AMD). PL 1991, c. 622, §L9 (AMD). PL 1993, c. 410, §§FFF5-13 (AMD). PL 1993, c. 410, §FFF17 (AFF). PL 1993, c. 673, §§2-5 (AMD). PL 1993, c. 673, §10 (AFF). PL 1995, c. 560, §K82 (AMD). PL 1995, c. 560, §K83 (AFF). PL 1995, c. 696, §A37 (AMD). PL 1999, c. 668, §100 (RP).

§3189-A. Advisory Board to Privatize the Maine Health Program

(REPEALED)

SECTION HISTORY

PL 1993, c. 410, §FFF14 (NEW). PL 1993, c. 673, §6 (AMD). PL 1993, c. 673, §10 (AFF). PL 1999, c. 668, §101 (RP).

§3190. Community Health Program grants

(REPEALED)

SECTION HISTORY

PL 1989, c. 588, §A43 (NEW). PL 1989, c. 875, §E40 (AMD). PL 1993, c. 6, §C9 (RP).

§3191. Funding of the Hospital Uncompensated Care and Governmental Payment Shortfall Fund

(REPEALED)

SECTION HISTORY

PL 1989, c. 588, §A43 (NEW). PL 1989, c. 875, §E41 (AMD). PL 1993, c. 410, §FFF15 (RP).

§3192. Community Health Access Program

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

A. "Benefit design" means the health care benefits package provided through the Community Health Access Program. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

B. "Community board" means the local governing board of a community health plan corporation. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

C. "Community health plan corporation excess insurance" means insurance that protects a plan offered by a community health plan corporation against higher than expected obligations at retention levels that do not have the effect of making the plan an insured plan. The issuance of community health access program excess insurance does not constitute the business of reinsurance. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

D. "Complementary health care provider" means a health care professional, including, but not limited to, a massage therapist, naturopath, chiropractor, physical therapist or acupuncturist, who provides care or treatment to a person that complements the care or treatment provided by a primary care physician and is credentialed by a community board. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

E. "Health quality measures" means statistical data that provides information on the quality of health care outcomes for individuals and groups with similar health problems. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

F. "Medical data collection system" means the computerized, systematic collection of individual medical data, including the cost of medical care, that when analyzed provides information on the quality and costs of health care outcomes. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

G. "Micro-employer" means an employer that has an average of 4 or fewer employees eligible for health care benefits in the 12 months preceding its enrollment in a plan offered by a community health plan corporation. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

H. "Out-of-area medical services" means medical care services provided outside of the geographic region of a community health plan corporation. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

I. "Program" means the Community Health Access Program established in this section. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]
[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

2. Program established. The Community Health Access Program is established within the department to provide comprehensive health care services through local nonprofit community health plan corporations governed by community boards. The program's primary goal is to provide access to health care services to persons without health care insurance or who are underinsured for health care services. The purpose of the program is to demonstrate the economic and health care benefits of a locally managed, comprehensive health care delivery model. The program's emphasis is on preventive care, healthy lifestyle choices, primary health care and an integrated delivery of health care services supported by a medical data collection system.
[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

3. Service areas. The department may establish 2 service areas for local plans developed by community health plan corporations in different geographic regions of the State. A service area established by the department must be an area that serves residents who seek regular primary health care services in conjunction with support from a hospital located in the same geographic region.
[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

4. Eligible population. This subsection governs eligibility.

A. The following persons may enroll in plans developed by community health plan corporations:

- (1) Micro-employers and their employees;
- (2) Medicaid recipients;
- (3) Self-insured employers and their employees to the extent allowed under the federal Employee Retirement Income Security Act;
- (4) Self-employed persons; and
- (5) Individuals without health care insurance. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

B. Individuals eligible for group health care benefits through an individual's employment or spouse's employment may not enroll. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]
[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

5. Community boards. A local community health plan corporation established pursuant to this section is governed by a community board composed of community members. The board membership must include representation of primary and complementary health care providers, mental health care

providers, micro-employers and individuals enrolled in a plan offered by the community health plan corporation. The community boards shall establish bylaws and operating procedures.

[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

6. Authorized powers. A local community health plan corporation may:

A. Develop a comprehensive health care benefit package that may include, but is not limited to, primary and tertiary health care services, mental health services, complementary health care services, preventive health care services, healthy lifestyle services and pharmaceutical services; [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

B. Develop medical data collection systems that will provide the program with the information necessary to support medical management strategies and will determine the costs and quality outcomes for the services provided; [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

C. Establish a fee structure sufficient to cover the actuarially determined costs of the comprehensive health care benefit package offered; [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

D. Develop a sliding fee schedule based on income to ensure that the fees are affordable for individuals covered by a plan offered by the community health plan corporation. The corporations are further authorized to establish mandatory minimum contributions by employers; [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

E. Collect fees from enrolled individuals and employers; [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

F. Solicit and accept funds from private and public sources to subsidize the corporation; [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

G. Develop community preventive care education and wellness programs. A corporation may coordinate its community preventive care education and wellness programs with schools, employers and other community institutions; [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

H. Enter into agreements with the department to provide care for individuals covered by the department's Medical Assistance Program in its geographic region and to develop methods to share access to medical information necessary for the program's medical data collection system; and [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

I. Enter into agreements with 3rd parties to provide needed services, including, but not limited to, administration, claims processing, customer services, stop-loss insurance, education, out-of-area medical services and other related services and products. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

7. Community health plan corporation excess insurance. In order to ensure adequate financial resources to pay for medical services allowed in the benefit plans developed by community health plan corporations, a local community health plan corporation is required to enter into agreements with insurers licensed in this State to obtain community health plan corporation excess insurance and to provide coverage for those portions of the health care benefits package that expose the corporations to financial risks beyond the resources of the corporation. The department may develop rules to provide further options for community health plan corporations to maintain financial solvency. Participation in the Medicaid program satisfies the requirement of this subsection. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2003, c. 428, Pt. I, §1 (AMD).]

8. Cost-sharing agreements. A local community health plan corporation may enter into agreements with private health insurance carriers or the Medicaid program in accordance with the following.

A. A local community health plan corporation may enter into agreements with private health care insurers to cover individual medical costs associated with all or a portion of the costs resulting from the benefit plan or benefit plans offered by the community health plan corporation. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

B. A local community health plan corporation may enter into agreements with the department to access Medicaid coverage for all or a portion of the individual medical costs resulting from the benefit plan or benefit plans offered by the local community health plan corporation. [PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

C. The department may seek a waiver from the Federal Government as necessary to permit funding under the Medicaid program to be used for coverage of Medicaid-eligible individuals enrolled in a plan offered by a community health plan corporation. The department may adopt rules required to implement the waiver in accordance with this paragraph. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. [PL 2003, c. 428, Pt. I, §2 (AMD).]

[PL 2003, c. 428, Pt. I, §2 (AMD).]

9. Medical and cost data. If Medicaid-eligible individuals are enrolled in the program, the department shall provide medical and cost data to each local community health plan corporation at the community health plan corporation's request in a format usable by the community health plan corporation's medical data collection system for the analysis of health care costs and health care outcomes.

[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

10. Dissolution or sale. Upon the dissolution, sale or other distribution of assets of a local community health plan corporation, the community board may convey or transfer the assets of the corporation only to one or more domestic corporations engaged in charitable or benevolent activities substantially similar to those of the community health plan corporation.

[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

11. Annual reports. A local community health plan corporation established pursuant to this section shall submit a written report to the commissioner on or before January 21st annually. The report must address the financial feasibility, fee structure and benefit design of the plan offered by the community health plan corporation; the health quality measures, health care costs and quality of health care outcomes under the plan; and the number of persons enrolled in the plan. The commissioner may require more frequent reports and additional information. Annually, before March 15th of each year, the department must submit a report summarizing the plan's demonstrated effectiveness to the joint standing committees of the Legislature having jurisdiction over banking and insurance matters and health and human services matters.

[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

12. Not subject to Title 24 or Title 24-A. A local community health plan corporation established pursuant to this section is not subject to any provisions of Title 24 or Title 24-A.

[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

13. Confidentiality. All information in the medical data collection system maintained by a local community health plan corporation established under this section is confidential and may not be disclosed except as permitted by sections 1711-C and 1828.

[PL 2001, c. 439, Pt. BBB, §1 (NEW); PL 2001, c. 439, Pt. BBB, §3 (AFF).]

14. Rules. The department shall adopt rules establishing minimum standards for financial solvency, benefit design, enrollee protections, disclosure requirements, conditions for limiting enrollment and procedures for dissolution of a community health plan corporation. The department may also adopt any rules necessary to carry out the purposes of this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A. The department shall begin preparing the rules required under this subsection no later than January 1, 2007. [PL 2003, c. 688, Pt. K, §1 (AMD).]

REVISOR'S NOTE: §3192. Affordable Health Care Fund (As enacted by PL 2001, c. 450, Pt. B, §2 is REALLOCATED TO TITLE 22, SECTION 3193)

SECTION HISTORY

RR 2001, c. 1, §27 (RAL). PL 2001, c. 439, §BBB1 (NEW). PL 2001, c. 439, §BBB3 (AFF). PL 2001, c. 450, §B2 (NEW). PL 2003, c. 428, §§11-3 (AMD). PL 2003, c. 688, §K1 (AMD).

§3193. Affordable Health Care Fund

(REALLOCATED FROM TITLE 22, SECTION 3192)

The Affordable Health Care Fund is established to assist individuals with the costs of participation in community health access programs. The fund is a nonlapsing fund and any excess funds may be used only for the purposes of this section. The fund may be used only to subsidize the costs of community health access programs' fees. The department shall establish subsidies on a sliding scale based on income for eligible individuals enrolled in community health access programs. Individuals eligible for health coverage under the Medicaid or Medicare program are not eligible to receive a subsidy from this fund. [RR 2001, c. 1, §27 (RAL).]

SECTION HISTORY

RR 2001, c. 1, §27 (RAL).

§3194. Report on cost of dispensing medication

The Office of MaineCare Services within the department shall biennially review and report to the joint standing committee of the Legislature having jurisdiction over health and human services matters and the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs regarding the cost of dispensing a medication in the State. By July 1st of each even-numbered year, the Office of MaineCare Services shall consider adjusting, through MaineCare rule amendment, the MaineCare pharmacy professional fee to reflect the cost of dispensing a medication in the State. [PL 2007, c. 539, Pt. HH, §1 (NEW); PL 2007, c. 590, §1 (NEW).]

SECTION HISTORY

PL 2007, c. 539, Pt. HH, §1 (NEW). PL 2007, c. 590, §1 (NEW).

§3195. Compensation for care provided to persons with intellectual disabilities or autism

1. Reimbursement. The department shall reimburse services provided to MaineCare member adults with intellectual disabilities or autism under a waiver granted by the federal Centers for Medicare and Medicaid Services for home-based and community-based care on the basis of rates and a methodology established by major substantive rulemaking. The department shall, at least every 2 years, conduct a substantive review of the rates set under this section. The review must provide for public comment. This section applies to all funds, including federal funds, paid by any agency of the State to a provider for care covered by the waiver. [PL 2017, c. 459, Pt. A, §1 (NEW).]

2. Rulemaking. The department shall adopt rules providing reimbursement rates under this section that take into account the costs of providing care and services in conformity with applicable

state and federal laws, rules, regulations and quality and safety standards and local competitive wage markets.

Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

[PL 2017, c. 459, Pt. A, §1 (NEW).]

SECTION HISTORY

PL 2017, c. 459, Pt. A, §1 (NEW).

§3196. Coverage for non-Medicaid services to MaineCare members

1. Coverage. The department shall provide coverage for abortion services to a MaineCare member.

[PL 2019, c. 274, §1 (NEW).]

2. Funding. Abortion services that are not federally approved Medicaid services must be funded by state funds within existing resources.

[PL 2019, c. 274, §1 (NEW).]

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

[PL 2019, c. 274, §1 (NEW).]

SECTION HISTORY

PL 2019, c. 274, §1 (NEW).

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