

**DHHS - Office of MaineCare Services**  
**Rule, State Plan Amendment, and Waiver Status Report**  
**January 2014**

**In APA Process\***

**Chapter III, Section 45, Hospital Services**

On November 15, 2013, the Department adopted an emergency rule which increased the MaineCare hospital supplemental pool for Acute Care Non-Critical Access hospitals, hospitals reclassified to a wage area outside Maine and rehabilitation hospitals, to \$65.321 million, because the Legislature appropriated an additional \$10.472 for this purpose. P.L. 2013, ch. 368, PART A, Sec. A-34. This rulemaking proposes to make the changes in the November 15, 2013 Emergency Rule permanent.

Proposed: November 26  
Staff: Rachel Thomas

Public Hearing: December 23  
Comment Deadline: January 2, 2014

**Chapters II and III, Section 92, Behavioral Health Homes**

This proposed rulemaking seeks to create Behavioral Health Homes (BHH), effective April 1, 2014, which will provide comprehensive system of care coordination for members with Serious Emotional Disorders (SED), and Serious and Persistent Mental Illness (SPMI). Members eligible for BHH services may also be eligible for services under Section 13 (Targeted Case Management), Section 17 (Community Integration Services) and/or Section 91 (Health Home Services); such members may not receive those services at the same time that they receive BHH services, and must choose among the different types of services for which they are eligible.

BHH services shall be provided to eligible members by a Behavioral Health Home Organization (BHHO) that partners with one or more Health Home Practices (HHPs). BHHOs and HHPs shall integrate and coordinate all primary, acute, behavioral health and long term services and supports for eligible members. BHHOs shall develop and implement a comprehensive Plan of Care for each member. BHH services are expected to result in improved physical and behavioral health outcomes for members, reduced hospital admissions and emergency room use, better transitional care, improved communication between health care providers, and the increased use of preventive services, community supports, and self-management tools.

BHHs are implemented pursuant to section 2703 of the Affordable Care Act, 42 U.S.C. § 1396w-4. The Department is seeking approval of a State Plan Amendment from the Centers for Medicare and Medicaid Services. Section 2703 provides an enhanced federal matching rate of 90% for the first eight (8) quarters following the effective date of the program.

Proposed: December 17, 2013  
Staff: Peter Kraut

Public Hearing: January 14, 2014  
Comment Deadline: January 24, 2014

**Chapters II and III, Section 25, Dental Services**

This rule is being proposed in order to update the principles of reimbursement (Chapter III) to include 2012 /2013 CDT codes. This rule change will also add Independent Practice Dental Hygienists, Dental Externs, and Dental Residents as qualified providers.

Proposed: January 21, 2014  
Staff: Peter Kraut

Public Hearing: February 19, 2014  
Comment Deadline: March 1, 2014

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**Chapter II Section 31, Federally Qualified Health Center Services**

This rule is being proposed in order to add Independent Practice Dental Hygienists, Dental Externs, and Dental Residents as qualified providers.

Proposed: January 21, 2014  
Staff: Peter Kraut

Public Hearing: February 19, 2014  
Comment Deadline: March 1, 2014

**Maine State Services Manual, Chapter 104, Section 6, Independent Practice Dental Hygienist Service for MaineCare Members**

This new rule will provide that the Department will reimburse Independent Practice Dental Hygienist (IPDHs) for providing certain services to MaineCare members from 10/1//12 through the effective date of a forthcoming State Plan Amendment to add IPDHs under Maine's State Plan. The services are: prophylaxis performed on a person who is 21 years of age or younger; topical application of fluoride performed on a person who is 21 years of age or younger; provision of oral hygiene instructions; the application of sealants; temporary fillings; and x-rays (under a temporary geographically limited pilot program overseen by the Maine Board of Dental Examiners).

Proposed: January 21, 2014  
Staff: Peter Kraut

Public Hearing: February 19, 2014  
Comment Deadline: March 1, 2014

**Chapter II, Section 13, Targeted Case Management Services**

This proposed rule seeks to permanently adopt the emergency rule effective December 20, 2013, that updates the Targeted Case Management (TCM) policy to include the Child and Adolescent Needs and Strengths (CANS) assessment as an approved TCM eligibility tool. The Department will no longer fund the Child and Adolescent Functional Assessment Scales (CAFAS) as of January 31, 2014, and must have the CANS in place to assure that providers who cannot self fund the CAFAS have an approved tool to evaluate members for TCM eligibility.

Proposed: January 14, 2014  
Staff: Ann O'Brien

Public Hearing; February 10, 2014  
Comment Deadline: February 20, 2014

**Rules Adopted or Provisionally-Adopted Since Last Status Update**

**Chapter III, Section 97 Private Non-Medical Institution Services**

This provisionally adopted major substantive rule eliminates the reimbursement rate for Private Non-Medical Institution Services (PNMI), Appendix D (Child Care Facilities), Model 3 (Intensive Mental Health Services for Infants and/or Toddlers). The Department is provisionally adopting the changes made by the major substantive rule proposed July 30, 2013. The Department eliminated intensive Mental Health Services for infants and/or toddlers through a separate rulemaking for Chapter II, Section 97. Although eligible infants and toddlers will no longer have access to PNMI Appendix D, Model 3 Intensive Mental Health services, they remain eligible for medically necessary Behavioral Health Services through Section 65, Behavioral Health Services, which services shall be reimbursed at the rates set forth in Chapter III, Section 65.

Provisional Adoption: December 19, 2013. Final adoption will be effective upon legislative approval.  
**Staff:** Ann O'Brien

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**In Draft And Governor's Office Approval Requested**

None

**In Draft (And Governor's Office Approval not yet requested)**

**Accountable Communities (no section number assigned yet)**

Through Accountable Communities, MaineCare will engage in shared savings arrangements with provider organizations that, as a group, coordinate and/or deliver care to a specified patient population. Accountable Communities that demonstrate cost savings, as well as the achievement of quality of care standards, share in savings generated under the model. This initiative will be offered statewide as a Medicaid State Plan option.

Accountable Communities will achieve the triple aim of better care for individuals, better population health, and lower cost through four overarching strategies:

1. **Shared savings based on quality performance-** Accountable Communities will benefit from a Value-Based Purchasing strategy that supports more integrated and coordinated systems of care.
2. **Practice-level transformation-** Accountable Communities will align with and build on the principles of Maine's multi-payer Patient-Centered Medical Home (PCMH) Pilot and MaineCare Health Homes Initiatives.
3. **Coordination across the continuum of care-** Accountable Communities will ensure the coordination of primary, acute, and behavioral health care, as well as long-term services and supports. This includes leveraging the Maine Department of Health and Human Services' existing investment in care coordination for members with chronic conditions, behavioral health needs, and long term services and supports needs.
4. **Community-led innovation-** Local health care needs, resources, and solutions will drive Maine's Accountable Communities. While each Accountable Community will meet baseline criteria, report on core quality measures, and be responsible for the cost of a set of core services, they will also be encouraged and afforded flexibility to structure services and solutions that fit locally-identified priorities and context.

**Staff:** Peter Kraut

**Section 67, Chapter II- Nursing Facility Services**

This rule is being proposed in order to make Nursing Facility eligibility consistent with Waiver 19 service eligibility for individuals with Brain Injury. Individuals with Brain Injury will be eligible for nursing facility services if they score 3 or higher in two items on the Mayo-Portland Adaptability Inventory and score a 0.1 or higher on the Brain Injury Health and Safety Assessment.

This rulemaking also:

Updates the Brain Injury definition to be consistent with the definition developed in Title 22 § 3086 in the definitions section (67.01-22)

Adds the word "Acquired" to Brain Injury to be consistent with Title 22 § 3086

Changes "Brain Injury" to "Acquired Brain Injury," and "BI" to "ABI" in the table of contents and on pages 4, 14, 46, 52

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Requires, for nursing facilities working with individuals with brain injury, that all staff have expertise in brain injury rehabilitation as demonstrated by achieving the Certified Brain Injury Specialist (CBIS) designation from the Academy of Certified Brain Injury Specialists, or through an approved equivalent training program

Reorganizes section 67.02-5

Corrects a numbering error in section 67.05-13

**Staff:** Rachel Thomas

**Section 67, Chapter III- Nursing Facility Services**

This rule is being adopted in order to comply with Resolve 72, L.D. 1189. The purpose of this rulemaking is to clarify the timeframe during which nursing facilities must demonstrate their compliance with the full 2% cost-of-living adjustment (COLA) for ‘front line staff’, required as of October 1, 2011. The rulemaking specifies that nursing facilities must demonstrate that this adjustment occurred between their fiscal year ending in 2008 and the first fiscal year ending after July 1, 2013. If a nursing facility is not able to demonstrate that the COLA for the average wage and benefit rate is exactly equal to or greater than the COLA specified within Chapter III, Section 67, the department will recoup the difference between the required increase and the actual wage and benefit rate.

**Staff:** Derrick Grant/Rachel Thomas

**Section TBD, Ch. II- Genetic Testing and Counseling** - This is a new policy to establish rules around when MaineCare pays for genetic testing.

**Staff:** Rachel Thomas

**Section 96, Chapter II-Private Duty Nursing and Personal Care Services**

Working to separate adults and children’s services, then pull out adult personal care services and add them into one ‘personal care’ policy.

**Staff:** Rachel Thomas

**Section 30, Ch II & III, Family Planning Services**-to add procedure codes to the Ch III and make the respective changes in Ch II

**Staff:** Rachel Thomas (Sarah Grant is putting this through the rulemaking process)

**Section 21, Chapter II- Home and Community-Based Benefits for Adults with Intellectual Disabilities or Autistic Disorder** – to update the policy to coincide with the waiver amendment.

**Staff:** Ginger Roberts-Scott

**Section 21, Chapter III- Allowances for Home and Community-Based Benefits for Adults with Intellectual Disabilities or Autistic Disorder** – to update the policy to coincide with the waiver amendment.

**Staff:** Ginger Roberts-Scott

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**Section 29, Chapter II- Support Services for Adults with Intellectual Disabilities or Autistic Disorder**-to update the policy to coincide with the waiver amendment.

**Staff:** Ginger Roberts-Scott

**Section 29, Chapter III- Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder**-to update the policy to coincide with the waiver amendment.

**Staff:** Ginger Roberts-Scott

**Section 19, Chapters II & III, Home and Community Benefits for the Elderly and for Adults with Disabilities**-Changes will be made to policy to incorporate Section 22 into this section of policy.

**Staff:** Ginger Roberts-Scott

**Section 22, Chapter II & III, Home and Community Benefits for the Physically Disabled**-This Section of policy will be repealed to coincide with the merger of Section 19.

**Staff:** Ginger Roberts-Scott

**Section 18, Chapters II & III, Home and Community Based Services for Adults with Brain Injury**-This will be a new Section of the MaineCare Benefits Manual providing for services for Adults with Brain injury. Both the Waiver application and policy is in draft.

**Staff:** Ginger Roberts-Scott

**Section 20, Chapters II & III, Section 20, Home and Community Based Services for Adults with Other Related Conditions**-The Department is proposing to clarify the definitions of Priority 1 and Priority 2 members. The Department is proposing to clarify that the rate for Community Support includes the cost of transportation and is a component of the rate paid for the service. A clarification is needed to Home Support to state a member may have some 1:1 direct care and it must be specified in the care plan.

The Department is also proposing to add clarifying language to Assistive Technology and Communication Aids to state that "Each system or device will be revised based on medical necessity, efficiency and meets compatibility with safety needs.

The Department is submitting a waiver amendment to CMS and is proposing changes to the policy to coincide with CMS approval. The following changes are dependent on CMS approval.

The Department is also proposing to increase the limit of Community Support and Work Support from 64 units each to a member may have a combination of 128 units of either service. The maximum weekly allowance for Community Support is 128 units, for an annual total of 6656 units. The maximum weekly allowance for Work Support Services is 128 units, for an annual total of 6656 units. When members use a combination of both services there is an annual limit of 6656 units on the total combined expenditures for the services.

The Department is proposing a new limit of 64 units per day from 44 per day of Home Support –Remote Support and 64 units per day from 44 per day of Home Support-Quarter hour.

The Department is proposing to change the limit of Communication Aids from \$2,000.00 to \$6,000.00 per year.

A Licensed Speech Language Pathologist (SLP) is being proposed to be added as a qualified provider of Communication Aids. Care Coordination limits to change to 400 from 144 units every year instead of just the first year.

The Department is also proposing to add clarifying language, that Consultation is limited to 64 units per each type of consultation annually.

**Staff:** Ginger Roberts-Scott

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**Chapter II, Section 90, Physician Services**

The Department is proposing numerous changes to this rule. The proposed rule will implement a CMS requirement that anesthesiology services be billed in one (1) minute rather than fifteen (15) units of value and that anesthesia administered by a Certified Registered Nurse Anesthetist (CRNA) be supervised by the operating doctor of medicine or osteopathy in accordance with 42 C.F.R. § 482.52 (a)(4).

Also, the proposed rule will delete Section 90A-04 regarding prior authorization for transplants, establish new criteria for reimbursement and require the nationally accredited United Network for Organ Sharing (UNOS) to recommend that a transplant be performed. The rule will allow In-State kidney and corneal transplants to be performed without prior authorization. When medically necessary, bone marrow or stem cell transplants are covered.

Moreover, the following changes have been proposed:

- Definitions for the terms “Face-to-Face Encounter” for Durable Medical Equipment (DME) and Home Health Services were added,
- Provider qualifications for obstetrical services have been amended
- Orthognathic surgery will only be approved where there is a medical necessity.
- Certified Nurse Midwives, Dentists (General, Orthodonture, Pedodontist) and Dental Hygienists practicing within the scope of their certification and licensures can be employed in a physician’s practice,
- Surgical services for post-operative treatment will be amended to comply with the CMS standard fee schedule for durational global surgical periods (0-10-90 days).
- Bariatric procedures must be performed at a nationally certified center recognized by the American College of Surgeons or the Surgical Review Corporation.
- In general, BRCA1 and BRCA2 testing are covered.
- Restricted services for circumcision will be covered if medically necessary and not cosmetic, except when deformities are the result of cancer, disease, trauma or birth defects.
- Disclosure requirements in Section 90.08-1 will be amended to ensure confidentiality and comply with the Health Insurance Portability and Accountability Act (HIPAA) and Privacy Rule.
- Protection of privacy when using Qualified Electronic Health Records (EHR).

Also within Sec 90 is the ACA’s Primary Care Physicians Payment Rate Increase. This mandatory ACA initiative will increase the current Medicaid Rate for certain primary care physicians to 100% of the Medicare fee schedule in calendar years 2013 and 2014. This will apply to specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. This initiative will also apply to all subspecialties related to those three specialty categories to the extent that they provide E&M services.

Eligible services provided by advance practice clinicians providing services within their scope of practice and under the supervision of an eligible physician will be eligible for higher payment; this includes those not specifically mentioned in the proposed rule such as nurse midwives; independently practicing advance practice clinicians (i.e., those *not* under the supervision of an eligible physician) are *not* eligible for increased payment.

Physicians will be required to self-attest that they are either board certified in family medicine, general internal medicine or pediatric medicine or a subspecialty within those specialties or that 60% of all Medicaid services they bill for are specified E&M or vaccine administration codes. Physicians recognized by the American board of physician specialties, the American osteopathic association and the American board of medical specialties are included. In order to receive the higher payment, qualifying physicians and advance practice clinicians must be providing services under the following pay-to/service location provider types: 35-Hospital/062-Hospital Based Professionals; 51-Physicians; and 54-Physician Group.

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**Estimated Fiscal Impact:**

The Department expects that this rulemaking will cost the Department approximately \$150,000 in SFY 2013. This Fiscal impact is the high end of the expected cost of BRCA testing. BRCA1 and BRCA2 are human gene mutations that have been linked to hereditary breast and ovarian cancer. Based on cost estimates, BRCA testing ranges from \$300 to \$3,000, depending on whether a patient has a limited test or a full test. The cost will not go higher than \$150,000, but will be much lower. Not all data required for a full analysis is available, as family history is a big factor in the determination of the need of the BRCA test. With no history in the system of this new testing, the Department is limited in the amount of data it can analyze. This proposed rulemaking will have no other impact on the regulated community.

**Staff:** Peter Kraut

**Chapter III, Section 109, Speech and Hearing Services** – Updating evaluation codes and change units to per session.

**Chapter II, Section 35, Hearing Aids & Services** – Adding language that the provider must use the State of Maine's Contractors for purchasing digital hearing aids.

**Chapter II, Section 35, Hearing Aids & Services** – Adding digital hearing codes and dispensing fees for those codes.

**Chapter II and III, Section 35, Hearing Aids & Services and Chapter II, Section 60, Durable Medical Equipment** – Repealing Section 35 and incorporating hearing aids into Section 60.

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**State Plan Amendment Status:**

**09-016 Transportation, Bus Passes** - This SPA adds bus passes as a covered service when transportation providers find this the most cost effective method to provide transportation to medically necessary services.  
**Status:** Submitted 9/30/09 "Off Clock", as CMS is reviewing a related 1915B waiver.

**10-013 Coverage of PNMI Services** - This SPA adds more detail, at request of CMS, of what is covered and who are qualified providers in PNMI facilities. No changes in coverage or benefit.  
**Status:** Submitted September 24, 2010. RAI Issued December 2010, responses submitted to CMS March 17, 2011. Additional questions received last week of April, and a conference call was held in May, 2011 to start working through CMS questions. Responses withdrawn 5/6, currently Off Clock, IMD analysis required.

**10-014 Coverage of Behavioral Health Services** - This SPA adds more detail, at the request of CMS, of what is covered and who are qualified providers for behavioral health services. No changes in coverage or benefit are made.  
**Status:** Submitted September 24, 2010. RAI issued December 2010, responses submitted to CMS March 17, 2011. Additional questions received last week of April. Withdrew responses 5/6. Currently off clock, IMD analysis required.

**10-015 Coverage of Rehabilitative Services** - This SPA adds more detail, at the request of CMS, of what is covered and who are qualified providers for rehabilitative services. No changes in coverage or benefit are made.

**Status:** Submitted September 24, 2010. RAI Issued December 2010, responses submitted to CMS March 17, 2011. Additional questions received last week of April. Responses Withdrawn 5/6, currently Off Clock, IMD analysis required.

**10-016 Coverage of Personal Care Services** - This SPA adds more detail, at the request of CMS, of what is covered and who are qualified providers for personal care services. No changes in coverage or benefit are made.

**Status:** Submitted September 24, 2010. RAI Issued December 2010, Responses submitted to CMS March 17, 2011. Additional questions received last week of April. Responses withdrawn 5/6. Currently off clock, IMD analysis required.

**12-006 Increase of limits for Chiropractic and Vision Services** - The state is requesting approval to increase the limits for Chiropractic and Vision services, pursuant to the 1<sup>st</sup> Supplemental Budget, P.L. 2011, CH. 477.

**Status:** Submitted June 29, 2012.  
Informal RAI questions received on August 8, 2012.  
Informal RAI responses submitted to CMS on September 10, 2012. Formal RAI received September 20, 2012.  
Formal RAI responses submitted December 22, 2012  
Follow Up questions received September 24, 2013  
Follow Up Responses sent October 9, 2013

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**12-007 Pharmacy Coverage and Reimbursement** - The state is requesting approval to revise and add several reimbursement methodologies for Pharmacy services. The reduction of reimbursement for brand-name drugs to AWP minus (-) 16%, the request to impose a mandatory generic substitution and eliminate coverage of smoking cessation products for all members except for pregnant women is made pursuant to the 1<sup>st</sup> and 3<sup>rd</sup> Supplemental Budgets.

**Status:** Submitted June 29, 2012.  
Informal RAI questions received on August 13, 2012.  
Informal RAI responses submitted to CMS on September 10, 2012.  
Formal RAI received September 26, 2012.  
Formal RAI extension received December 31, 2012  
Formal RAI submitted August 19, 2013  
Follow-Up Questions received September 21, 2013  
Follow-Up Questions submitted September 30, 2013  
Ongoing questions received and responded to through November 4, 2013  
Formal RAI withdrawn

**12-008 Reimbursement for Services other than Inpatient Hospital** - The state is requesting approval to decrease the rates of reimbursement for Podiatry, Occupational Therapy, Physical Therapy and Opioid Treatment pursuant to the 1<sup>st</sup> Supplemental Budget, P.L. 2011, CH. 477.

**Status:** Submitted June 29, 2012  
Informal RAI questions received on August 8, 2012.  
Informal RAI responses submitted to CMS on September 10, 2012. Formal RAI received September 20, 2012.  
Formal RAI responses submitted December 22, 2012  
Follow Up questions received September 24, 2013  
Follow Up Responses sent October 9, 2013  
Formal RAI withdrawn

**12-015 Mandatory Pharmacy Co-Pays** – this State Plan Amendment (SPA) is made to assure that Maine’s State Plan is updated to be consistent with policy changes that will need to be made to implement LD 346-An Act Regarding Pharmacy Reimbursement in MaineCare, which will implement mandatory co-payments for certain MaineCare members. In accordance with 42 CFR 447.76, the Department published notices in five (5) local papers, on the Departments website and held a public hearing regarding the proposed SPA. The Department did not receive any comments regarding the proposed SPA and there were no attendees at the public hearing.

**Status:** Submitted: 12/7/12  
Informal RAI received 1/2/13  
Informal responses submitted to CMS 1/15/13  
Formal responses submitted to CMS 6/3/13  
**Budget neutral**

**13-004 Substance Abuse Service** – The State will be requesting approval to impose MaineCare reimbursement for methadone for the treatment of addiction to opioids to a lifetime maximum of twenty four (24) months, except as permitted with prior authorization beyond twenty-four (24) months.

**Status:** Submitted 3/29/13  
Informal RAI received 05/14/13

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Informal responses submitted 6/24/13  
Formal RAI received 6/26/13  
Formal responses submitted 09/27/2013  
Additional questions received 11/1/15  
Additional questions responded 11/15/13  
Formal RAI withdrawn

**13-005 Physical Therapy services** – The State will be requesting approval to increase the limits for Physical Therapy Services to allow for up to five (5) treatment visits and one (1) evaluation within twelve (12) months, when provided pursuant to a pain management care plan.

Status: Submitted 3/29/13  
Informal RAI received 5/22/13  
Informal responses submitted 6/25/13  
Formal RAI received 6/27/13  
Formal responses submitted 09/27/2013  
Additional question received 11/7/13  
Responses to additional question submitted 11/21/13  
Approved 12/20/13

**13-006 Pharmacy Services/ Pain Management** – The State will be requesting approval for limits on opioid medication used for the treatment of pain

Status: Submitted 3/29/13  
Formal RAI received 6/20/13  
Formal Responses to be submitted 11/5/13

**13-008 Behavioral Health** -- The Maine State Legislature in P.L. 2013, Ch. 1, § A-23 (“An Act To Make Supplemental Appropriations and Allocations for the Expenditures of State Government and To Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 2013”) directed the Department to reduce reimbursement rates by 5% for LCPC and LMFT. This change in rates requires a State Plan Amendment to be approved by the Centers for Medicare and Medicaid Services (CMS); the Department will request approval of a State Plan Amendment retroactive to March 5, 2013.

Status: Submitted 3/29/13  
Informal RAI received 5/13/13  
Formal RAI received 6/28/13  
Formal responses submitted 09/27/2013  
Formal RAI withdrawn

**13-013 Excluded Drugs, Barbiturates, and Benzodiazepine** - The proposed Pharmacy Services amendment is being submitted to comply with Section 175 of the Medicare Improvement for Patient and Providers Act of 2008 which amended section 1860D-2(e)(2)(A) of the act to include Medicare Part D drug coverage of barbiturates “used in the treatment of epilepsy, cancer, or a chronic mental health disorder” and benzodiazepines for all medically accepted indications.

The State of Maine asks that this SPA be retroactive to the effective date of April 1, 2013. The Department of Health and Human (The Department) has made edits to its system to implement this change effective January 1, 2013. However, the submission of this SPA has been delayed in order to meet notice requirements.

Submitted 5/10/13  
Formal RAI received 8/7/13

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Formal responses to be submitted 11/5/13

**13-014- Inpatient Hospital Services** - the Department requested approval to pay a distinct substance abuse unit discharge rate equal to \$4,898. MaineCare will only reimburse at the distinct unit substance abuse rate when the member has spent the majority of his or her stay in the distinct unit. MaineCare will only reimburse for one (1) discharge for a single hospital for one (1) episode of care.

Status: Submitted June 28, 2013  
RAI received 9/18/13  
Informal RAI question received 11/26/13

**13-015 Inpatient Leave Days --** Payment of bed holds for a semi-private room for a short-term hospitalization of the member is proposed to change to seven (7) days (midnights) absence each fiscal year, as long as the member is expected to return to the nursing facility. Payment for these bed holds would be granted up to seven (7) days (midnights) absence during each twelve (12) month period. The Department will also, if CMS approves, increase reimbursement for a leave of absence from one (1) day in a twelve-month period to no more than twenty (20) day in leave of absence each fiscal year, and twenty (20) day of leave of absence during the twelve (12) month period each fiscal year.

Status: Submitted 6/28/13  
Formal RAI received 9/24/13

**13-002 Personal Care** - The Department will be submitting this SPA to CMS. This SPA will request approval to consolidate all personal care services including consumer directed personal care services into one part of the Medicaid State Plan. This SPA will also establish standard levels of medical eligibility and acuity for all personal care services and propose a minimum standard staffing qualification across all personal care services. Finally it will establish a standard rate for home based personal care services provided by independent providers and agency providers and Maintains a per diem case mix adjusted rate for personal care services delivered in residential care settings.

Submitted 6/25/13  
Informal RAI received 9/9/13  
Responses to informal RAI 10/21/13  
Formal RAI received 10/23/13

**Hospital Services Outpatient 13-017** – The Department will be requesting approval to reduce the outpatient Ambulatory Payment Classification (APC) rate for Acute Care Non-Critical Hospitals and Rehabilitation Hospitals from 93% to 83.7% of the adjusted Medicare APC rate for outpatient services; if multiple procedures are performed, the Department will pay 83.7% -- rather than 93% -- of Medicare's single bundled APC rate; calculations for outlier payments will follow Medicare rules and also be paid at 83.7% -- rather than 93% -- of the Medicare payment.

Submitted 9/27/13  
Informal question received 11/18/16  
Responses to informal RAI submitted 11/26/13  
Approved 12/20/13

**Behavioral Health 13-019** --Maine's Legislature directed the Department to reduce restores rates by 5% for LCPC and LMFT. This change in rates requires a State Plan Amendment to be approved by the Centers for Medicare and Medicaid Services (CMS); the Department will request approval of a State Plan Amendment retroactive to July 1, 2013.

Submitted 9/27/13  
Informal RAI received on 11/26/13  
Responses to Informal RAI submitted 12/10/13

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Formal RAI received 12/18/13

**Hospital Services Inpatient 13-020**- The Department will be requesting approval to increase the reimbursement rate per psychiatric discharge for members under 18 years of age from hospitals in the Lewiston-Auburn area to \$9,128.31.

Submitted 9/27/13

RAI not yet received

Formal RAI received 12/5/13

**Smoking Cessation Counseling for Pregnant Women 13-032** - to comply with Section 4107 of the Patient Protection and Affordable Care Act (Affordable Care Act), P.L. 111-148, which amended Title XIX (Medicaid) of the Social Security Act for pregnant women, including both counseling and pharmacotherapy, without cost sharing,

Submitted 10/21/13

Informal RAI received 11/12/13

Responses to informal RAI submitted 11/26/13

**13-035 - Dental Services**

The Department will submit a SPA adding two provider-types to the Other Licensed Providers section of our State Plan:

1. Independent Practice Dental Hygienists (to comply with 22 M.R.S. 3174-RR)
2. Independent Practice Dental Hygienists, practicing under Public Health Supervision
3. Dental; Hygienist
4. Denturists

The State Plan Amendment will also detail the provider qualifications and scope of practice. This SPA will be submitted no later than December 31, 2013.

Submitted 12/20/13

**13-037 - Pharmacy Services - Opioids**

The Department will submit a SPA requesting CMS's approval to modify the State Plan originally submitted on March 29, 2013.

These technical corrections are made pursuant to P.L. 2013, Chap. 368, Part AAAAA (L.D. 1509, "An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2013, June 30, 2014 and June 30, 2015").

The correction includes:

- Changing the term "alternative intervention treatments" to "therapeutic treatment options."
- o Adding language explaining that the Department will reimburse for an initial fifteen (15) day prescription for the treatment of a new onset of acute pain.

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- Reducing the number of days that the Department will reimburse for opioid medications for the treatment of a new onset of acute pain from forty-five (45) days per year to forty-two (42) days per year.

The Department will also clarify that the limits established for acute pain following a surgical procedure are for the treatment of post-operative care. This SPA also revises language regarding second opinions, stating that second opinions are required for the Department to reimburse for opioid drugs for a diagnosis typically known to have a poor response to opioid drug treatment. The previous language stated that second opinions are required when opioids are prescribed to a MaineCare member who has been typically known to have a poor response to opioid drugs.

Other changes to the Pharmacy Services section of the State Plan include adding language allowing exceptions to be established through the MaineCare Preferred Drugs List (PDL), and including members residing in a nursing facility. This SPA will be submitted no later than December 31, 2013.

Submitted 12/20/13

**13-036 - Supplemental Pool**

The Department will submit a SPA requesting approval to increase the MaineCare hospital supplemental pool to \$65.321 million, because the Legislature appropriated an additional \$10.472 million. This SPA will be submitted no later than December 31, 2013.

Submitted 12/20/13

**13-038 - New assessment tool for Eligibility Criteria for Children with Behavioral Health Disorders**

Targeted Care Management Services – The Department will submit a SPA requesting approval to add Child and Adolescent Needs and Strengths (CANS) as an assessment tool under the Targeted Care Management Services of the State Plan. CANS is an open domain assessment tool that addresses the mental health of children, adolescents, and their families, as well as the needs of Developmental Disabilities/Intellectual Disability. The Child and Adolescent Assessment Tool (CAFAS) is currently the approved assessment tool for eligibility for children with Behavioral Health Disorders. The provider will now have a choice of using the CANS or CAFAS to meet this requirement. The Department may also add this language to the Behavioral Health Services pages of the State Plan pending a conversation with CMS. The Department hopes to submit this SPA in December of 2013, but may submit it in January 2014.

Submitted 12/20/13

**13-040 - Hospitals and Nursing Reimbursement for Qualified Medicare Beneficiary without other Medicaid (QMB only)**

The Department will submit a SPA requesting approval to limit cost sharing payments, for the Qualified Medicare Beneficiary without other Medicaid (QMB Only) population, to hospital and nursing facility providers to the amount necessary to provide a total payment equal to the amount MaineCare would pay for these services under the State plan pursuant to P.L. 2013, c. 368, Part A-34. The Department will request an effective date of January 1, 2014.

Submitted 12/26/13

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**Vaccines Administration**

The Department will submit a SPA to reflect that the State of Maine became a Universal Purchaser State for the vaccine program under the Pediatric Immunization Program. This SPA will be submitted no later than December 31, 2013.

**Hospital Readmissions and Hospital Acquired Conditions**

The Department will submit a SPA requesting approval for the following:

1. Extend the time after discharge that a hospital can bill for the same Diagnosis Related Group (DRG) that a member was admitted under from 72 hours to 14 days.
2. Add 49 Hospital Acquired Conditions to the list of conditions that hospitals will not receive additional payment when the condition was not present on admission.

Please see the attached document for the 49 Hospital Acquired Conditions. The Department hopes to submit this State Plan in December of 2013, but may submit it in January 2014.

**Hearing Aids and Speech**

The Department will be submitting a State Plan Amendment, effective January 1, 2014, requesting approval to add digital hearing codes and to update the some speech codes.

**Hospital Readmissions**

Department will submit a SPA requesting approval to

1. Extend the time after discharge that a hospital can bill for the same DRG (Diagnosis-related Rate Group) that a member was admitted under from 72 hours to 14 days.

**Cost Of Living Adjustment**

The Department will submit a State Plan Amendment clarifying that Nursing Facilities who received funding to provide a cost of living increase from the Department must demonstrate that they have given front line staff at least a 2% COLA increase since the last COLA increase in 2008. This change will prevent the recoupment of funds from Nursing Facility providers.

**Smoking Cessation Products**

The Department will submit a State Plan Amendment requesting approval effective January 1, 2014, to allow payment for drugs used to promote smoking cessation including OTC drugs per section 2502 of the Affordable Care Act amends section 1927(d)(2) of the Social Security Act

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**Waivers**

**Waiver Amendments**

**Section 21, Home and Community-Based Benefits for Adults with Intellectual Disabilities or Autistic Disorder (CMS control # 0159) -**

The state of Maine would like to amend the waiver to clarify Shared Living and Family Centered Support as separate services from Home Support (Residential Habilitation). The state would like to add a new service called Home Support-Remote Support as part of Residential Habilitation. The state would like to separate Work Support (supported employment) into two services, individual and group. The state would also like to add two new services, Career Planning and Assistive Technology. For Communication Aids, Assistive Technology Professional and Audiologists will be added as qualified providers. For Occupational Therapy Maintenance, Occupational Therapy Assistants will be added as qualified providers.

The state would like to put limits on Consultation Services. The state would like to add a reserved capacity category for children transitioning to adult services. The state would also like to put a point in time limit in the waiver application. Appendix A.3 use of contracted entities, the state would like to add the use of contracted entities to this section. Lastly, a performance measure in Appendix D that was deleted during the last amendment has been added back in and the national core indicators used. Performance measures and Provider Qualifications have had terminology changes to update the current language.

**Staff:** Ginger Roberts-Scott

**Status:** Submitted to CMS 11/1/2013

**Section 32, Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders (CMS control # 0864) -** This amendment will update the start date of the waiver.

**Staff:** Ginger Roberts-Scott

**Status:** in draft

**Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Disorder (CMS control # 0467) -**

The state of Maine would like to amend this waiver to add six services. The state would like to add Residential Habilitation known in Maine as Home Support- 1/4 hour and Remote Support. This service will be limited to \$23,771.00. When combined with Community Support or Work Support, the combined total of the services cannot exceed \$23,771.00. The state would also like to add Assistive Technology (Assessment, Monthly Transmission and Equipment) and Career Planning.

The state would like to separate Work Support (Supported Employment) into two services, Individual and Group Work Support.

The state would also like to put a point in time limit in the waiver application.

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Appendix A.3 use of contracted entities, the state would like to add the use of contracted entities to this section.

Performance measures and Provider Qualifications have had terminology changes to update the current language.

The state would also like to add 30 funded openings as well.

Staff: Ginger Roberts-Scott

**Status: Submitted to CMS 11/1/2013**

**Section 19, Home and Community-Based Benefits for the Elderly and for Adults with Disabilities (CMS control #0276) - This amendment will merge Sections 19 and 22 together.**

Staff: Ginger Roberts-Scott

**Status: in draft-Spring 2014**

**Section 18 Home and Community Based Services for Members with Brain Injury.**

**New Brain Injury Waiver-1915 (c)**

Staff: Ginger Roberts-Scott

**Status: in draft July 2014**

**Section 20, Chapters II & III, Section 20, Home and Community Based Services for Adults with Other Related Conditions-**

The Department is submitting a waiver amendment to CMS .The Department is also proposing to increase the limit of Community Support and Work Support from 64 units each to a member may have a combination of 128 units of either service. The maximum weekly allowance for Community Support is 128 units, for an annual total of 6656 units. The maximum weekly allowance for Work Support Services is 128 units, for an annual total of 6656 units. When members use a combination of both services there is an annual limit of 6656 units on the total combined expenditures for the services.

The Department is proposing a new limit of 64 units per day from 44 per day of Home Support –Remote Support and 64 units per day from 44 per day of Home Support-Quarter hour.

The Department is proposing to change the limit of Communication Aids from \$2,000.00 to \$6,000.00 per year.

A Licensed Speech Language Pathologist (SLP) is being proposed to be added as a qualified provider of Communication Aids. Care Coordination limits to change to 400 from 144 units every year instead of just the first year.

The Department is also proposing to add clarifying language, that Consultation is limited to 64 units per each type of consultation annually.

**Staff: Ginger Roberts-Scott**

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(State Plan Amendments Only)

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\*PLEASE NOTE THAT ALL RULES ARE PROMULGATED IN COMPLIANCE WITH EXECUTIVE ORDER OF AUGUST 24, 2011 “AN ORDER TO IMPROVE REVIEW OF THE RULEMAKING PROCESS,” detailed at:

[http://www.maine.gov/tools/whatsnew/index.php?topic=Gov\\_Executive\\_Orders&id=182022&v=article2011](http://www.maine.gov/tools/whatsnew/index.php?topic=Gov_Executive_Orders&id=182022&v=article2011).