Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Maine Center for Disease Control and Prevention**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 7702-B(11), 7703(6), 7704, 7707(3), 7802(7), 8301(8), 8302-A(2), 8303-A(1)
Chapter number/title:	**Ch. 33**, Family Child Care Provider Licensing Rule (*formerly* 10-148 Ch. 33, Rules for the Certification of Family Child Care Providers)
Filing number:	**2017-147**
Effective date:	9/20/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

These rule changes are intended to clarify the health and safety minimum licensing standards for family child care providers, which include adding lead drinking water testing, background checks, and standards for outdoor play areas to address specific health and safety concerns. Further, the Department intends to make the requirements easier to understand for providers to obtain and maintain a license, by clarifying evidence-based measures for child care licensing inspections. Finally, the Department is increasing transparency regarding the inspection, investigation and enforcement procedures, so that providers can more easily understand what will happen in the course of a license, or if violations occur. These changes are designed to increase the statewide access to, and availability of, family child care, and to improve the ability of licensees to comply with this rule.

Basis statement:

The Department rulemaking proposed to repeal 10-148 CMR Ch. 33, *Rules for the Certification of Family Child Care Providers*, and replace it with 10-144 CMR Ch. 33, *Family Child Care Providers Licensing Rule* on April19, 2017. A public hearing was held on May 8, 2017, and written comments were accepted through May 18, 2017.

The 10-144 CMR Ch. 33 rule contains both routine technical and major substantive provisions. In this rulemaking, the Department repealed the 10-148 CMR Ch. 33 rule (*Rules for the Certification of Family Child Care Providers*), meaning that it is no longer legally effective, as of September 20, 2017. In addition, the Department finally adopts all the routine technical provisions, and provisionally adopts all the major substantive provisions of 10-144 CMR Ch. 33 (*Family Child Care Providers Licensing Rule*) to replace the previous rule in effect.

The rule contains a NOTICE on the first and last pages of the rule, notifying the reader that the rule contains both major substantive and routine technical provisions. All major substantive portions of the rule are shaded gray, so they are easy to identify as major substantive.

These changes to the rule achieve a variety of goals, which include increasing access to family child care providers in Maine, by affording licensees a chance to grow their business and care for more children, in order to address Maine's current shortage of infant care offered. By reducing administrative and subjective requirements beyond the limited scope of 22 MRS §8302-A(2), this rule clarifies and streamlines the licensing requirements for family child care providers, while retaining important health and safety standards. This rule increases transparency of the application, licensing, inspection and enforcement processes, so that licensees more easily understand how to become licensed and stay licensed. And finally, the licensee incurs far fewer chances of losing business or subsidies with the new escalation of enforcement actions, which allows greater opportunities for licensees to collaborate with the Department, correct violations, and contest violations than the previous rule.

The Department intends to act within its authority granted in 22 MRS §8302-A(2). For example, Maine statute (22 MRS §8302-A(l)(F)) authorizes the Department to make rules for childcare facilities regarding the quality of the program, the statute for family childcare provider rules does not include quality standards. Therefore, it removed parts of the previous rule that did not focus on primary health and safety. These removed provisions, include, but are not limited to, the following:

a. How the parents and providers interact;
b. Record requirements beyond 22 MRS §8302-A(2);
c. The requirement for applicant references;
d. Specific requirements around how long a child watches TV;
e. Specific requirements for comfortable pajamas.

Fiscal impact of rule:
Counties/Municipalities: These rule changes pose no fiscal impact to counties or municipalities.
Department: The Child Care Licensing Program does not anticipate any additional costs at this time.
Small Businesses: The expected impact will vary depending upon the provider. Some providers may not be impacted at all, particularly if they already operate in a manner that complies with the proposed rules. Other providers may save money from fewer required training hours. The child care licensing program does expect that some family child care providers will face some one-time expenses for play area surfacing and fencing.

Agency name:	Department of Health and Human Services, **Maine Center for Disease Control and Prevention**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 7702-B(11), 7703(6), 7704, 7707(3), 7802(7), 8301(8), 8302-A(2), 8303-A(1)
Chapter number/title:	**Ch. 33**, Family Child Care Provider Licensing Rule (*formerly* 10-148 Ch. 33, Rules for the Certification of Family Child Care Providers)
Filing number:	**2017-148**
Effective date:	9/20/2017
Type of rule:	Major Substantive emergency adoption
Emergency rule:	Yes

Principal reason or purpose for rule:
These rule changes are intended to clarify the health and safety minimum licensing standards for family child care providers, which include adding lead drinking water testing, background checks, and standards for outdoor play areas to address specific health and safety concerns. Further, the Department intends to make the requirements easier to understand for providers to obtain and maintain a license, by clarifying evidence-based measures for child care licensing inspections. Finally, the Department is increasing transparency regarding the inspection, investigation and enforcement procedures, so that providers can more easily understand what will happen in the course of a license, or if violations occur. These changes are designed to increase the statewide access to, and availability of, family child care, and to improve the ability of licensees to comply with this rule.

Basis statement:
The Department rulemaking proposed to repeal 10-148 CMR Ch. 33, *Rules for the Certification of Family Child Care Providers*, and to replace it with 10-144 CMR Ch. 33, *Family Child Care Providers Licensing Rule*. A public hearing was held on May 8, 2017, and written comments were accepted through May 18, 2017. The 10-144 CMR Ch. 33 rule contains both routine technical and also major substantive rule provisions.

On September 15, 2017, the Department repealed 10-148 CMR Ch. 33 and also :finally adopted the routine technical rule provisions of 10-144 CMR Ch. 33, and provisionally adopted its major substantive provisions. The routine technical rule provisions of 10-144 CMR Ch. 33 are legally effective on September 20, 2017, but, pursuant to 5 MRS §8072, the provisionally adopted major substantive rule provisions have no legal effect until the Legislature authorizes adoption of the major substantive rule. The Department now adopts all Major Substantive provisions in that rule on an emergency basis.

FINDINGS OF EMERGENCY
Pursuant to 5 MRS §§ 8054 and 8073, the Department has determined that immediate adoption of this rule is necessary to avoid an immediate threat to public health, safety or general welfare. The Department's findings of emergency are as follows: Without this emergency major substantive rule, the major substantive rule provisions that were provisionally adopted by the Department would have no legal effect until they are reviewed and approved by the Maine Legislature. These provisions provide necessary protection for children, infants, and toddlers in family child care. Additionally, the Background Check Center provision is required by federal as well as state law. These major substantive provisions are both necessary for the primary health and safety of the children in family child care and are required by Maine law to be included in this rule. 22 MRS §8302-A(2). If these major

substantive provisions are not in effect, there would no workable rule in place regarding Family Child Care Providers due to the repeal of the old rule.

The rule contains a NOTICE on the first and last pages of the rule, notifying the reader that the rule contains both major substantive and routine technical provisions. All major substantive portions of the rule are shaded gray, so they are easy to identify as major substantive.

This Emergency Major Substantive rule is identical to the 10-144 CMR Ch. 33 rule the Department adopted on September 15, 2017.

Fiscal impact of rule:
Counties/Municipalities: These rule changes pose no fiscal impact to counties or municipalities.
Department: The Child Care Licensing Program does not anticipate any additional costs at this time.
Small Businesses: The expected impact will vary depending upon the provider. Some providers may not be impacted at all, particularly if they already operate in a manner that complies with the proposed rules. Other providers may save money from fewer required training hours. The child care licensing program does expect that some family child care providers will face some one-time expenses for play area surfacing and fencing.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 42(8), 3173
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 67**, Principles of Reimbursement for Nursing Facility Services
Filing number: **2017-004**
Effective date: 1/18/2017
Type of rule: Routine Technical
Emergency rule: No

Principal reason or purpose for rule:
These changes are being made in order to ensure adequate funding for Nursing Facility Services by increasing the Prospective and Final Prospective Rate to 100 percent (100%) of all calculated direct care and routine cost components effective retroactive to July 1, 2016.
The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this change.

Basis statement:
The Department of Health and Human Services (Department) adopts this rule change to Ch. III Section 67, "Principles of Reimbursement for Nursing Facility Services", to increase the Nursing Facility Services' prospective and final prospective rate to one hundred percent (100%) of all calculated direct care and routine cost components, which will increase reimbursement and continue to provide adequate funding for Nursing Facility Services effective retroactive to July 1, 2016.
The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services for this change. Pending approval, the increased rate will be effective retroactive to July 1, 2016.
The Department is authorized to adopt these changes retroactively under 22 MRS §42(8) because these changes increase reimbursement for providers, and will have no adverse impact on either MaineCare providers or members.

Fiscal impact of rule:
The Department estimates that the General Fund impact for these changes is $10,674,230 in SFY 2017 and $11,644,615 in SFY 2018, and estimates federal expenditures of $6,826,170 in SFY 2017 and $7,496,803 in SFY 2018.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173; PL 2016 ch. 83, (127th Legis. 2016), *Resolves, Directing the Department of Health and Human Services To Increase Reimbursement Rates for Home-based and Community-based Services*
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 12**, Consumer Directed ttendant Services *and* Allowances for Consumer Directed Attendant Services
Filing number:	**2017-022**
Effective date:	2/22/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The purpose of these rules is to comply with PL 2016 ch. 83, *Resolves, Directing the Department of Health and Human Services To Increase the Reimbursement Rates for Home-based and Community-based Services*, which requires the Department to amend its rules for reimbursement rates for personal care and related services provided under 10-144 CMR ch. 101, *MaineCare Benefits Manual*, Ch. II & III Section 12, “Consumer-Directed Attendant Services” and “Allowances for Consumer Directed Attendant Services”. This rulemaking adds modifiers and reimbursement rates for two person and three person member visits for attendant care services.

Ch. II, “Consumer-Directed Attendant Services”, informs providers, if a single provider is providing personal care services to more than one Section 12 member during a single visit, the two or three person procedure code and modifier shall be billed. This law went into effect on July 29, 2016, without the governor's signature.

The Department is seeking and anticipates receiving approval from the federal Center for Medicare and Medicaid Services for these changes. Pending approval, the increased reimbursement rates and modifiers will be effective retroactive to July 29, 2016. A notice of methodology change was published on July 28, 2016.

Basis statement:

The Department of Health and Human Services (Department) adopts these rule changes to Ch. II & III, “Consumer-Directed Attendant Services” and “Allowances for Consumer-Directed Attendant Services”, to increase reimbursement rates for personal care services to comply with Resolves 2015 ch. 83, *Resolve, Directing the Department of Health and Human Services To Increase the Reimbursement Rate for Home-based and Community-based Services.* This law went into effect on July 29, 2016, without the Governor’s signature.

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services (“CMS”) for these changes. Pending approval, the increased reimbursement rates will be effective retroactive to July 29, 2016. In addition, in September of 2015, the Department proposed separate reimbursement rate changes to CMS; those rates are pending approval. As such, there are separate effective dates for various rates, as set forth more specifically in Ch. III. The Department finds that changes in Ch. III were required, to make this clear for the regulated community.

These changes are consistent with Resolves 2015 ch. 83, which requires the Department to change its reimbursement rates in Section 12 to reflect 50% of the increase in rates as set forth in a final February 1, 2016 report by Burns & Associates, Inc., and approved by the Legislature. For new codes specific to multiple person visits, as identified in Ch. III, the Department shall apply them prospectively only. Following review and advice from the Office of

the Attorney General, the Department finds that changes were required to Ch. III from what was proposed to distinguish between the different effective dates.

The Department is authorized to adopt certain of these changes retroactively under 22 MRS §42(8) because these changes increase reimbursement rates for providers, and will have no adverse impact on either MaineCare providers or members.

This rulemaking also makes various clerical changes and updates in Ch. II, such as switching references from “Consumer Directed Attendant Services” to “Consumer-Directed Attendant Services”, “self direct” to “self-direct”, “mentally retarded” to “individuals with intellectual disabilities”, and updating the name of Office of Aging and Disability Services. Additionally, references to Section 22, the “Home and Community Benefits for the Physically Disabled”, have been removed, since that waiver service was merged into Section 19 effective January 1, 2015, and no longer exists.

Fiscal impact of rule:

The Department estimates that the General Fund impact for these changes is $558,139 in SFY 2017 and estimates of federal expenditures of $356,930.

This rulemaking will not impose any costs on municipal or county governments, or on small businesses employing twenty or fewer employees.

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173; PL 2016 ch. 83, (127th Legis. 2016), *Resolves, Directing the Department of Health and Human Services To Increase Reimbursement Rates for Home-based and Community-based Services*
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 96**, Private Duty Nursing and Personal Care Services
Filing number:	**2017-023**
Effective date:	2/22/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The purpose of the rule is to comply with PL 2016 ch. 83, *Resolve, Directing the Department of Health and Human Services To Increase the Reimbursement Rates for Home-based and Community-based Services*. PL 2016 ch. 83 requires the Department to amend its rules for reimbursement rates for personal care and related services provided under 10-144 CMR ch. 101, *MaineCare Benefits Manual*, Ch. II & III Section 96, "Private Duty Nursing and Personal Care Services". This rulemaking adds modifiers and reimbursement rates for two person and three person member visits for various services as identified in Ch. Ill. This law went into effect on July 29, 2016, without the governor's signature.

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services (CMS) for a State Plan Amendment for these changes. Pending approval, pursuant to 22 MRS §42(8), the increased reimbursement rates, modifiers, and level of care caps will be effective July 29, 2016. The Department published a notice of change in reimbursement methodology, pursuant to 42 CFR §447.205, on July 28, 2016.

Basis statement:

The Department of Health and Human Services (Department) adopts these rule changes to Ch. II & III Section 96, "Private Duty Nursing and Personal Care Services", to change reimbursement rates and level of care limits for personal care services and related services to comply with Resolves 2015 ch. 83, *Resolve, Directing the Department of Health and Human Services To Increase Reimbursement Rates for Home-based and Community-based Services.* This law went into effect on July 29, 2016, without the Governor's signature.

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services ("CMS") for these changes. Pending approval, the increased reimbursement rates will be effective retroactive to July 29, 2016. In addition, in September of 2015, the Department proposed separate reimbursement rate changes to CMS; those rates are pending approval. As such, there are different effective dates for various rates, as set forth more specifically in Ch. II Appendix 2, and in Ch. III. The Department finds that changes were required in Ch. II Appendix 2 as well as in Ch. III to make this clear for the regulated community.

These changes are consistent with Resolves 2015 ch. 83, which requires the Department to change its reimbursement rates in Section 96 to reflect 50% of the increase in rates as set forth in a final February 1, 2016 report by Burns & Associates, Inc. The Department notes that for certain of the Section 96 rates, there was a decrease in reimbursement; each of those rates are consistent with what was modeled in the Burns & Associates report, and approved by the Legislature. Where the reimbursement rates decrease, the Department shall apply them prospectively only. Following review and advice from the

Office of Attorney General, the Department finds that changes were required to Ch. III from what was proposed to distinguish between the different effective dates, depending on whether a rate increased or decreased.

The Department is authorized to adopt certain of these changes retroactively under 22 MRS §42(8) because the changes increase reimbursement for providers, and will have no adverse impact on either MaineCare providers or members.

This rulemaking also makes various clerical changes and updates in Ch. II, such as switching references from "authorized agent" to "authorized entity", and updating the name of the Office of Aging and Disability Services. Additionally, references to Section 22, the Home and Community Benefits for the Physically Disabled, have been removed, since that waiver service was merged into Section 19 effective January 1, 2015, and no longer exists.

Fiscal impact of rule:

The Department estimates that the General Fund impact for these changes is $2,969,225 in SFY 2017 and estimates federal expenditures of $1,898,819 in SFY 2017.

This rulemaking will not impose any costs on municipal or county governments, or on small businesses employing twenty or fewer employees.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; PL 2016 ch. 477 (eff. April 15, 2016); Resolves 2016 ch. 82 (eff. April 26, 2016)
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 17**, Community Support Services
Filing number:	**2017-027**
Effective date:	2/26/2017
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
The Department of Health and Human Services adopts these changes pursuant to Resolves 2015, ch. 82 (eff. April 26, 2016) and PL 2015, ch. 477 (eff. April 15, 2016). In addition, this rulemaking removes certain services that have been moved to Section 65, "Behavioral Health Services", and makes minor technical edits and clarifications of policy. Overall, these changes are being added to support clinical best practices and improve the quality of care for MaineCare members. Each component of the rulemaking is stated below. As a result of public comments and further review by the Department and the Office of the Attorney General, there were additional technical changes, formatting updates, and minor adjustments to align with other sections of the MBM, and changes to language for clarity.

Transition Period
Following various changes to Ch. II Section 17, "Community Support Services", adopted by the Department on March 22, 2016, certain members no longer met clinical criteria for Community Support Services. This prompted a Legislative review of the Section 17 rule changes, after which the Legislature enacted Resolves 2015 ch. 82 (eff. April 26, 2016). This Resolve requires the Department to extend the authorized service period for certain individuals who no longer meet clinical criteria for Section 17 services after the rule changes adopted on March 22, 2016. For members affected by the March 22nd rule change, the Department shall authorize a 120 day extension for the member's Section 17 services. Additionally, 90-day extensions may be granted, provided the member is able to reasonably demonstrate to the Department, or Authorized Entity, that he or she has attempted to and has been unable to access medically necessary covered services under any other section of the *MaineCare Benefits Manual*. The Ch. II changes shall be effective retroactive to April 26, 2016. The temporary transition period shall end on June 30, 2017.

Service Provider Tax
Separately, the Legislature enacted *An Act to Increase Payments to MaineCare Providers that are Subject to Maine's Service Provider Tax,* PL 2015, ch. 477 (eff. April 15, 2016). Certain MaineCare providers subject to the service provider tax have experienced an increase in the tax to 6% since January 1, 2016. The Legislature thus provided additional appropriations to certain MaineCare providers, including Section 17 providers, in an effort to offset the increase in the provider tax. The Department is seeking and anticipates Center of Medicaid Services (CMS) approval of the reimbursement changes for Section 17 providers. Pending approval, the

Department will reimburse providers under the new increased rates retroactively to July 1, 2016, pursuant to PL 2015, ch. 477 (eff. April 15, 2016).

The Department notes that on April 29, 2016, the legislature overrode the Governor's veto of LD 1696, Resolve, *To Establish a Moratorium on Rate Changes Related to Rule Chapter 101: MaineCare Benefits Manual, Sections 13, 17, 28 and 65* (Resolves 2015 ch. 88). That law imposes a moratorium on rulemaking to change reimbursement rates, including Section 17, until after a rate study has been completed and presented to the Legislature. The Department consulted with the Office of Attorney General and the Office of the Attorney General determined and has advised the Department that Resolves 2015 ch. 88 does not prevent the instant rule changes because (1) the separate law, PL 2015 ch. 477, is more specific in regard to changing reimbursement for providers impacted by the Service Provider Tax increase; and (2) these are reimbursement rate increases, thus providing a benefit to MaineCare providers.

Adult Needs and Strengths Assessment (ANSA)

This adopted rulemaking adds a standard to the policy for providers of Community Integration Services to begin using the ANSA as an assessment and treatment planning guide for members. The ANSA is a multipurpose tool that assesses the needs and strengths of adults seeking behavioral health services. The ANSA may be used to support decision making (including level of care and service planning), to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The Department believes that this assessment tool is superior to current assessments in identifying member needs and strengths, and will better aid providers in their planning and in meeting member needs. Additionally, the ANSA will allow for the State to gather reliable data on this service and the members it serves to aid in future rulemaking and resource allocation.

Hold for Service

This adopted rulemaking adds a standard to the policy for members to choose to hold for services with a provider agency, when the initial seven (7) calendar day intake meeting requirement cannot be met, given the provider offers the member information on other providers within a 25 mile radius of the servicing area. This provision allows a member choice of providers when there is not immediate capacity to serve without penalizing the provider. Additionally, this choice will allow the member to remain involved with an agency should services not be immediately available, in an effort to streamline intake when the provider has the capacity to serve.

Treatment Plan: Access to Primary and Specialized Care

This adopted rulemaking adds a standard to the policy for providers to address a member's access to primary and specialized care in the treatment planning process for Community Integration Services. The Department believes that treatment planning for medical services is important as it is often an unmet need or area of resistance for this population. Additionally, this population frequently has medical concerns that should not go unaddressed. The Department feels it is important for providers to actively engage members to ensure their medical needs are being met, and this provision will require providers to discuss access to care during initial and ninety (90) day treatment plan reviews.

Clubhouse Services

This adopted rulemaking permanently removes Clubhouse services from this section of policy. Clubhouse services have been added and adopted in Section 65, Behavioral Health Services, as of November 23, 2016, and therefore continuing to cover this service in Section 17 would be duplicative.

Certified Intentional Peer Support Specialist (CIPSS)

This adopted rulemaking updates language regarding the CIPSS role in Assertive Community Treatment for adults to reflect the current status of this credential in the process of CMS approval, and allows for the use of this credential pending approval.

Member Appeals

To conform with Federal law and Ch. I of the *MaineCare Benefits Manual*, this adopted rule modifies the language for member appeals to include that the decision to reduce, suspend, or terminate services will be provided to the member in writing.

Fiscal impact of rule:

The fiscal impact for the Section 17 change in eligibility requirements is unable to be determined because any impact would depend on utilization, and eligibility determinations that have not yet been completed.

The Department anticipates that the Ch. III rulemaking will cost approximately $152,861 in SFY 2016, including $57,063 in state dollars and $95,798 in federal dollars, and $917,163 in SFY 2017, including $330,637 in state dollars and $586,526 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 42(8), 3173; 5 MRS §8054; PL 2016 ch. 477 (eff. April 15, 2016)
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 18**, Allowances for Home and Community Based Services for Adults with Brain Injury
Filing number:	**2017-028**
Effective date:	2/27/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The Department is adopting an increase to the rates in Ch. III Section 18 in accordance with LD 1638. Effective April 15, 2016, the Legislature enacted PL 2016 ch. 477 (*An Act To Increase Payments to MaineCare Providers That Are Subject to Maine's Service Provider Tax*) providing additional appropriations to certain MaineCare providers who are subject to the service provider tax and who have experienced an increase in the tax from 5% to 6% since January 1, 2016. The Department filed these rate increases via emergency rulemaking, effective retroactive to April 15, 2016. To prevent lapse of the emergency rule changes, which are effective for ninety (90) days, the Department is now adopting these changes.

Basis statement:

The adopted rule includes rate increases to comply with PL 2015, ch. 477 (*An Act to Increase Payments to MaineCare Providers That Are Subject to Maine's Service Provider Tax*). The Legislature enacted this law to provide additional appropriations to certain MaineCare providers who are subject to the service provider tax and who have experienced an increase in the tax from 5% to 6% since January 1, 2016.

The adopted rule results in a 1% rate increase for the following services:

- T2019 U9, Employment Specialist Services (Habilitation, supported employment waiver), from $7.42 to $7.49 per ¼ hour.
- T2016 U9, Home Support (Residential Habilitation) Level II, from $298.35 to $301.39 per diem.
- T2016 U9 TG, Home Support (Residential Habilitation) Level III – Increased Neurobehavioral, from $485.00 to $489.61 per diem.
- T2017 U9, Home Support (Residential Habilitation) Level I, from $6.27 to $6.33 per ¼ hour.
- T2017 U9 QC, Home Support (Residential Habilitation)-Remote Support-Monitor Only, from $1.62 to $1.63 per ¼ hour.
- T2017 U9 GT, Home Support (Residential Habilitation)-Remote Support-Interactive Support, from $6.27 to $6.33 per ¼ hour.
- 97535 U9 Self Care/Home Management Reintegration-Individual, from $14.39 to $14.52 per ¼ hour.
- 97535 U9 HQ Self Care/Home Management Reintegration-Group, from $9.59 to $9.68 per ¼ hour.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $21,636 in SFY 2016, which includes $8,077 in state dollars and $13,559 in federal dollars, and $129,813 in SFY 2017, which includes $46,798 in state dollars and $83,016 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 42, 3173
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 20**, Home and Community Based Services for Adults with Other Related Conditions
Filing number: **2017-030**
Effective date: 3/1/2017
Type of rule: Routine Technical
Emergency rule: No

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

Basis statement:
The Department of Health and Human Services is adopting changes to Ch. II and III Section 20, "Home and Community Based Services for Adults with Other Related Conditions", that seek to expand eligibility for services, add services, clarify existing services, increase rates, and more closely align with federal requirements for waiver services. Specific changes are outlined as follows.

Chapter II
The Department has made changes to Ch. II that help move the Section 20 waiver program towards compliance with 42 CFR §431.301(c). This federal regulation, effective March 17, 2014, sets forth new provisions for Home and Community Based Services (HCBS) waiver programs, including provisions outlining the person-centered planning process and provisions outlining the qualities of HCBS settings. The federal regulation requires states to engage in transition planning with the Centers for Medicare and Medicaid Services (CMS) to assure compliance with these provisions. The Department is currently engaged in this process with CMS. For this rulemaking, the Department has incorporated changes in Sections 20.01 (Introduction), 20.04-1 (Procedures for Developing the Care Plan), 20.04-2 (Content of the Care Plan), and 20.10-19 (Requirements for Residential Settings Owned or Controlled by a Provider), that reflect some of the person-centered planning requirements and HCBS setting requirements in 42 CFR §431.301(c). The Department made additional changes to the rule as a result of public comment.

In addition, the Department has updated Ch. II to expand eligibility criteria and services for Section 20 members. The Department added Muscular Dystrophy, Huntington's, Spina Bifida or other rare developmentally based conditions to General Eligibility Criteria at Section 20.03-2. This expansion is the result of the Department's FY 2016-2017 budget initiative to cover more individuals under this waiver and corresponding appropriations. *See* PL 2015 ch. 267 part A §A-31. The Department is seeking CMS approval for this waiver change. The Department also removed the provision in Section 20.03-2 that "any other condition will be reviewed for eligibility by the Office of MaineCare Services Medical Director" to be consistent with the current review process under Section 20.04-1(G) that requires the Office of Aging and Disability Services (OADS) to prior authorize and determine eligibility for all waiver recipients. The Department is also adding Career Planning Services as a new Section 20 service for members, consistent with other developmental services waiver programs. The Department is seeking and anticipates approval from CMS for this added benefit. The Department is also seeking approval from CMS to add Licensed Audiologists to the list of qualified providers of Communication Aids services in Section 20.10-4. Although not contained in the Ch. II rule

proposal, this change is being adopted in Ch. II on the basis of additional findings by the Department that it will benefit members by expanding the number of professionals qualified to provide this service.

The Department is also making changes to Ch. II that CMS has already approved in the current waiver. These changes include clarifying the limits on the reimbursement of Assistive Technology Devices. For example, the rule clarifies that there is a combined limit of $6,000.00 annually for devices and certain services associated with leasing, purchasing, and maintaining the devices; data transmission utility costs are also covered up to $50.00 per month. Consistent with the current waiver, the adopted rule also clarifies that for Home Support Services in Section 20.05-9, an individual Personal Care Assistant, Personal Support Specialist, or Direct Support Professional shall not be reimbursed for more than forty hours per week for any one waiver member. This reimbursement provision accords with the existing limit for Personal Care Services at Section 20.05-14 and follows other developmental services waiver programs. The rule change helps ensure that individual providers are able to deliver services in a focused and safe manner.

Other changes to Ch. II include updating the Quality Reporting requirements in Section 20.14 to help ensure members are receiving quality services under this waiver.

Finally, the Department has made a number of formatting and clerical changes to Ch. II for rule clarity. These changes include replacing "Authorized Agent" with "Authorized Entity" throughout the rule for consistency within the MaineCare Benefits Manual, updating outdated citation references, and updating grammar and formatting.

Chapter III

For Ch. III, the rule adoption increases rates in accordance with PL 2015 ch. 477 (*An Act to Increase Payments to MaineCare Providers That Are Subject to Maine's Service Provider Tax*). Effective April 15, 2016, this law provides additional appropriations to certain MaineCare providers that are subject to the service provider tax and that have experienced an increase in the tax from 5% to 6% since January 1, 2016. The Department previously adopted these changes to Ch. III through emergency rulemaking effective October 5, 2016, and retroactive to April 15, 2016. The emergency rule has since lapsed. The Department now adopts these same changes, again retroactive to April 15, 2016, to ensure providers receive this increased reimbursement. This retroactive increase benefits providers and members and is permissible under 22 MRS §42(8).

Consistent with changes in Ch. II, the Ch. III rule adoption also clarifies reimbursement limits for Assistive Technology Devices. For Procedure Code T2035 U8, Assistive Technology-Transmission (Utility Services), the maximum allowance now reads "Up to $50.00 per month." For Procedure Code A9279 U8, Assistive Technology – (Monitoring feature/device, stand alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified), the maximum allowance now reads "Up to $6,000.00 annually."

The Department also added Procedure Code T2015 U8, Career Planning (Habilitation, prevocational), at $28.00 per hour. The Department inadvertently did not include this change in the filed rule proposal document, however, did notify the public in the notice documents of this change. The inclusion of the rate in Ch. III is consistent with the provisions of Ch. II and is necessary to facilitate proper billing.

Fiscal impact of rule:

The Department anticipates that for this rulemaking, the addition of Career Planning will cost approximately $10,500 in SFY 2017, which includes $3,919.65 in state dollars and $6,580.35 in federal dollars, and $14,000 in SFY 2018, including $5,046.75 in state dollars and $8,953.25 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 42, 3173
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 29**, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
Filing number: **2017-031**
Effective date: 3/4/2017
Type of rule: Routine Technical
Emergency rule: No

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

Basis statement:
The Department is adopting various changes in its rule that help move the Section 29 waiver program towards compliance with 42 CFR §431.301(c). This federal regulation, effective March 17, 2014, sets forth new provisions for Home and Community Based Services (HCBS) waiver programs, including provisions outlining the person-centered planning process and provisions outlining the qualities of HCBS settings. In addition, to protect members and increase the quality of the Covered Services, the Department is implementing various new provider requirements in Section 29.

Significant Updates and Changes to Chapter II, Section 29 include the following:
Changes were made to ensure consistency with the current version of the Diagnostic and Statistical Manual of Mental Disorders (the “DSM”), the DSM 5. Specifically, the reference in the title of this section was changed from “Autistic Disorder” to “Autism Spectrum Disorder.” In addition, throughout Section 29, the term “Mental Retardation” with the term “Intellectual Disability.”
Language was added to the Introduction, Section 29.01, to clarify the purpose of the rule and its intended impact. This change provides more detailed language than existed previously regarding the relationship of the rule to other MaineCare benefits and explains that the benefit is limited in scope.
Multiple changes were made to the Definitions, Section 29.02, including the following:

- A definition of Clinical Review Team (the “CRT”) was added at 29.02-7. The CRT is a newly formed entity that will handle Medical Add On requests. The definition describes the role of the CRT and its responsibilities.
- The definition of Direct Supports at 29.02-10 was amended to remove specific examples of particular Covered Services to preclude the interpretation that Direct Support could be utilized only for those particular Covered Services.
- A definition of Exploitation was added at 29.02-12, as this is one of the circumstances in which providers are expected to report to the Department.
- Language was added to the definition of Medical Add On at 29.02-16 in order to specify the meaning of the term and the services to which it applies, and to explain how it is determined whether to grant Medical Add On.
- Language was added to the “On Behalf Of” section at 29.02-19 in order to specify the that it is a billable activity and to remove unnecessary language.

Subpart F was removed from Section 29.03-2, General Eligibility Criteria, Subpart F had specified “lives with family or on their own,” as an eligibility requirement. The Department determined that this language was too limiting, in that people have a variety of living scenarios,

including living with unrelated roommates, or with paid staff or residing in a boarding or group home separate from the waiver.

Under Section 29.03-5, Waiting List and Offers for Funding Openings, language was added to specify that once a member receives an offer, he or she moves from the waiting list to a different status, of offer received. The intent is to clarify that such a member is no longer part of the waiting list, thereby freeing up a spot on the waiting list for placement of a new member, with the goal of getting Covered Services to more eligible members more quickly.

Under Section 29.04, Personal Plan, the language was updated to ensure that the member is driving the process and that the process is more closely aligned with 42 CFR §§ 441.301 and 441.303 (eff. March 17, 2017). Direct references to the CFR were included and the Department shall file copies of the incorporated regulations with the Secretary of State's Office pursuant to 5 MRS §8056(B)(1)-(3).

Multiple changes were made to Section 29.05, Covered Services, including,

- Under Section 29.05-2, Career Planning, quality-oriented language was added so that the Department could review plans more frequently for appropriateness for the member.
- Under Section 29.05-3, Community Support, language was added to reinforce the fact that career exploration is included as part of this Covered Service and to stress the importance of employment related activities.
- Where applicable, dollar caps were increased to reflect the reimbursement increases implemented by this rule.
- At 29.05-4, Employment Specialist Services, 29.05-11 and Work Support-Individual the limits were removed that prevented members from receiving Employment Specialist Services and Work Support Services while enrolled in high school. This will allow members in transition to begin receiving services sooner, to help them prepare for changes after high school and, ideally, attain employment.

Under Section 29.06, Non Covered Services, the provision excluding certain family members and guardians from providing direct and indirect services to members was removed. Some members receive services from family members, and the Department seeks to continue this practice, which makes services more accessible for members and offers greater member choice.

A number of changes were made to Section 29.07, Limits, including,

- At 29.07-2, Assistive Technology and Career Planning were removed from the annual dollar cap. These services are subject to separate limits as described at 29.07-14 for Assistive Technology and 29.07-15 for Career Planning.
- At 29.07-4 the limit for Home Accessibility Adaptions was increased from $5,000 in a three year period to $10,000 in a five year period. This provides more services and greater flexibility to members.
- At 29.07-10, the limit was removed that prevented members from receiving Work Support Services while enrolled in high school. This will allow members in transition to begin receiving services sooner, to help them prepare for changes after high school and, ideally, attain employment.
- At 29.07-15, the cap of 60 hours of services must be delivered within a six month period, instead of annually. The Department believes this will improve the quality and effectiveness of this Covered Service.
- At 29.07-16, language was added in order to prevent individuals living out of state from receiving MaineCare services, which is contrary to state and federal law.
- Throughout, the Department increased various dollar caps to reflect the 1% increase in reimbursement for providers.

At 29.10, Provider Qualifications and Requirements, new provisions were added to provide additional safeguards for member health and safety, improve quality of services and to increase training and the qualifications for providers. The following changes were made:

- Additional qualifications for Direct Support Professionals.
- Additional qualifications for Employment Specialist.

- Clarification of Background Check Criteria.
- Clarification of Reportable Events & Behavioral Treatment.

At 29.12, Reimbursement, language was added to ensure compliance with the MaineCare rules as regards provider billing requirements.

In Appendix I, language was added to provide details regarding the role and composition of the Clinical Review Team, the types of services that would be appropriate for Medical Add On, and the requirements for Medical Add On determinations and approvals. The Department removed authority to approve Medical Add On retroactively to the date of application because Medical Add on is effectively a prior authorization, which by its nature cannot be backdated.

A new Appendix, Appendix IV- Additional Requirements for Section 29 Providers of Community Support Services, and Employment Specialist Services was added. The Department is adding these requirements to help ensure high quality services to members.

The following is a summary of significant changes that were made to the final rule as a result of the public comments and review by the Office of the Attorney General. A complete list of all changes to the final rule is contained in the Summary of Comments and Responses document.

At Sections 29.05-10 and 29.07-2, the program dollar cap was increased from $23,771.00 to $23,985.00, which reflects the 1% increase in reimbursement and assures no effective service reduction. Also, hourly caps were removed to make clear that the Department intends only to use the dollar caps. Elimination of the hourly caps removes redundancy and potential confusion from the rule, as the monetary cap accomplishes the same purpose as hourly caps.

As a result of comments as well as review by the Office of Attorney General, changes from proposed rule were removed so as to retain the requirement that various services must be implemented within ninety (90) days of assessment. See Section 29.04 (Personal Plan), 29.05-1 (Home Support Remote Support).

At 29.04-4, the term “Guardian” was added to make it clear that a member’s guardian may also request an update to the Personal Plan.

At 29.04-2, to be consistent with Section 21, citations to 42 CFR § 441.301(c)(1) and 34-B MRSA. § 5470-B(2) were added. Also, to ensure consistency with Section 21, at 29.04-2 and 21.10-1, clarification of policy mandating that Grievance Training must take place prior to working with members was added.

At 29.05-5, the limit for adaptations was changed from $5,000 in a three year period to $10,000 in a five year period in order to allow greater flexibility for members using this benefit.

At 29.05-7, Home Support-Remote Support the restriction that “sub-contracting is not permissible under this service” was removed. This will allow providers to subcontract with entities that specialize in technology and provider greater access to Covered Services for members.
Section 29.08-4 (Provider Termination of a Member’s Service) was removed as a result of concerns raised by commenters and the Office of the Attorney General.

At 29.10-4, Background Check Criteria, the reference to “prospective” employees was removed as a result of concerns raised by commenters and the Office of Attorney General.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $38,338 in SFY 2016, which includes $14,311 state dollars and $24,026 in federal dollars and $230,027 in SFY 2017, including $82,925 in state dollars and $147,102 in federal dollars.

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; LD 1638
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 21**, Home and Community Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
Filing number:	**2017-038**
Effective date:	3/5/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This waiver renewal adopts rule changes to the Comprehensive Home and Community Based Services (HCBS) Waiver for persons with Intellectual Disabilities and Autism Spectrum Disorder. The rule includes language that will bring the Department into compliance with new requirements from the Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Services (HCBS) Settings Rule released on January 16, 2014 (see 42 CFR §441.301(c)). The Department is seeking and anticipates receiving CMS approval for this section. Ch. II Section 21 is a routine technical rule and does not require legislative approval prior to final adoption of the rule.

Basis statement:

This regulation governs a federal Medicaid home and community based federal Medicaid 1915C waiver service. In this rulemaking, the Department has made changes that help move the Section 21 waiver program towards compliance with 42 CFR §431.301(c). This federal regulation, effective March 17, 2014, sets forth new provisions for Home and Community Based services (HCBS) waiver programs. The federal regulation requires states to engage in transition planning with the Centers for Medicare and Medicaid Services (CMS) to assure compliance with these provisions. The Department is currently engaged in this process with CMS. For this rulemaking, the Department has incorporated changes regarding the Person-Centered planning process. Attached to this Basis Statement is a copy of a portion of the federal regulation, 42 CFR 431.301(c)(1), which is incorporated into this rule by reference.

Although the Department proposed changes (proposed 21.10-6 – Residential Settings Owned or Controlled by a Provider), in compliance with 42 CFR §441.301(c)(4)((vi)(B), the Department has chosen to not go forward with the proposed language. In response to the many comments the Department received complaining about the inclusion of the federal HCBS settings standards [codified in 42 CFR 441.301(c)(4)(vi)(B – F)] the Department has made the decision to remove, and not adopt, these proposed requirements in the final rule. The Department made this determination in an effort to balance the important goals of the federal HCBS settings standards regulation, and concerns of the Section 21 providers that compliance would be burdensome and expensive. According to CMS guidance, "Home and Community-Based Setting Requirements: Systemic and Site-Specific Assessments and Remediation" posted online at https://www.medicaid.gov/medicaid/hcbs/downloads/q-and-a-hcb-settings.pdf, states have until March 17, 2019 to come into full compliance with the rule. The Department intends to re-propose these requirements in a future rulemaking.

Ch. II Section 21 is a routine technical rule and does not require legislative approval prior to final adoption of the rule. The companion rule, Ch. III Section 21, is a major

substantive rule and requires legislative approval. With regard to the Ch. III rule, the Department adopted an emergency major substantive rule on September 28, 2016. The Department also went through proposed rulemaking for Ch. III, and provisionally adopted the rule on 24 February, 2017. The provisionally adopted rule will be submitted to the Maine Legislature for its approval and action.

This Ch. II proposed rule was publically noticed on September 28, 2016 and a public hearing was held on October 19, 2016 in Augusta. There were 54 people in attendance for the hearing. The Department received comments from 67 individuals until the close of the commenting period on October 29, 2016.

Changes to Ch. II Section 21 include:

- Renamed the section from Home & Community Benefits for Members with Intellectual Disabilities or Autistic Disorder to Home & Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder to be consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Throughout Section 21 to be consistent with the DSM, replaced the term “Mental Retardation” with “Intellectual Disabilities.”
- In the Definitions section:
  - In the definition of “DSM” the Department deleted the reference to the fourth edition, and substituted “current edition” so that the definition will always refer to the current edition of the DSM
  - Added clarifying language to Administrative Oversight Agency to include language that OADS needs to approve these agencies
  - Updated definition for Autism Spectrum Disorder.
  - Added Clinical Review Team as the entity to review service requests, including medical add-on services, to ensure clinical oversight.
  - Added clarifying language Correspondent, to add spectrum disorder to the term autism.
  - Removed language from Direct Supports to make the definition clearer.
  - Added clarifying language to Family-Centered Support.
  - Updated the definition of Intellectual Disability to be consistent with the Diagnostic and Statistical Manual of Mental Disorders.
  - Added the role of the CRT in reference to Medical Add On.
  - Deleted the term Mental Retardation, since that term is no longer used by DSM.
  - Clarified Prior Authorization
  - Moved language from Shared Living definition to the definition of Shared Living Provider.
- Under Determination of Eligibility, added clarifying language to Reserved Capacity
  - Updated General Eligibility Criteria added clarifying language and updated the diagnoses to be consistent with the DSM and added Rett Syndrome.
  - Under Redetermination of Eligibility added the requirement that every twelve months from the date of initial eligibility approval, the member’s case manager will need to resubmit an updated personal plan and a BMS 99. This is the codification of a current requirement.
- 21.03-5 Substituted “annual cost” for “annual budget” in order to be consistent with the hearings (Calculating the Estimated Annual Cost)
- 21.03-8. Added language regarding “Offers for funded opening” to the effect that at the time a member is offered a funded opening the member will be removed from the waiting list. The reason is that once the Department has determined an offer to

meet the members needs has been offered, then the member no longer has to wait for an offer.

- 21.03-9 (Redetermination of Eligibility). Added requirement that eligibility for the waiver for each member has to be redetermined every 12 months. This requirement ensures that the member continues to be eligible for the service.
- 21.04-2 (Plan Requirements), adds language regarding conflict-free planning to ensure that members have informed choices, which is consistent with 42 CFR 441.301(c)(1).
- 21.05 (Covered Services)/Duplicative Services, moved the introductory sentence which stated that duplicative services were not covered, to the 21.06.1 (Duplicative Services) which section elaborates on the services which would be considered duplicative.
- Under Personal Plan and also Planning Team Composition, the language was updated throughout this section to ensure that the member is driving the process and that the process is more closely aligned with the CFR §441.301 and 34-B MRSA. §5470-B(2). Direct references to the CFR were included.
- 21.04-2 (Personal Plan), added the requirement that grievance training be provided to all staff, upon hire, and retraining every thirty six months. The reason for this is because the grievance process is a very important process, and staff members need this training, which benefits members.
- In the Covered Services section:
  - Under Communication Aids, added Augmented communication services to replace Facilitated communication services as an update.
  - Under Community Supports, added language that will allow for career exploration as part of the service, and allows a member to also receive Work Support services.
  - Community Supports, the Department deleted the hour cap and replaced it with a dollar cap of $26,640.10 annually, for this service. This is not a reduction of community support services.
  - 21.05-6 (Consultation Services), the Department removed the cap on these services from this section and moved the cap to the Limit Section 21.07-7 (Consultation Services).
  - 21.05-9 (Employment Specialist Services), the Department deleted the limit that high school members could not receive this service, in order to help high school members transitioning from school to work.
  - 21.05-19 (Physical Therapy Maintenance), added new language so that this service may be provided up to three members at a time.
  - 21.05-20 (Shared living), added language to clarify that respite is not separate billable service because it is a component of the rate paid to the Administrative Oversight Agency.
- In the Limits section:
  - Added language which disallows duplicative services covered by other sections in the MaineCare Benefits Manual.
  - Under Consultation Services, added information regarding limits.
  - Definition of annual limits for: Occupational Therapy (Maintenance).
  - 21.07-2, the Department increased the limit for combined cost of Community Support, Work Support-individual and Work Support-Group.
  - Deleted 21.07-4 and moved that language to 21.07-3 (Home Accessibility Adaptations).
  - Added a new limit for Occupational Therapy.

  - 21.07-14, added new language to state that if a member was in continuous care in a hospital or a nursing facility for over six months, that member would be terminated from Section 21 waiver services. This is consistent with the Section 21 limit for duplicative services.
- In the Duration of Care Section, added requirements for Provider Termination of a Member's Services.
- 21.10 - In Provider Qualifications and Requirements, added language throughout to provide additional assurances for the health and safety of members as well as quality of services. These changes include updates to the following:
  - Requiring providers to train staff in identifying risks such as risk of abuse, neglect or exploitation;
  - Additional qualification for Direct Support Professionals.
  - Provider qualifications necessary to perform an Assistive Technology Assessment.
  - Shared Living (Foster Care, Adult), requiring that providers maintain a clean and healthy living environment for members.
  - Background Check Criteria, requiring background checks for any adult who may be providing direct or indirect services.
  - Reportable Events & Behavioral Treatment., requiring that providers provide staff with training on various Department regulations concerning reportable events, and rights of persons with intellectual disability.
- Appendix I. Clarifies that it is the CRT which reviews all increased levels of support requests. The Department also added Physician Assistants to the list of providers who can write a recommendation for medical support.
- Appendix II. Clarifies that it is the CRT that is responsible for review and approval of all Medical Add-ons. The Department also defined what medical conditions support the Medical Add on rate.
- Appendix V- Added Requirements for Section 21 Providers of Home Support Services, Community Support Services, and Employment Specialist Services. This new section of policy was added to assure the health and safety of members as well as quality of services, by placing requirements on certain providers. The requirements include requiring providers to comply with Department regulations for individuals with Intellectual Disabilities, and to comply with Department regulations regarding reporting incidents of abuse, neglect and exploitation of members with intellectual disability. Additional requirements include requiring providers to make available financial information to the Department, and include requirements of homeowners and/or rental insurance. These requirements protect Section 21 members, who are among Maine's most vulnerable citizens.

Although the Department proposed a change (21.08-4 in the proposed rule) which would have prohibited providers from terminating members without written approval of the Department, the Department has determined to not adopt this change, in light of many public comments challenging this change.

Although the Department proposed the change under 21.05-2 Career Planning which was quality oriented language, the Department has removed from the rule the language requiring that plans will need to be sent into the Department at 3 intervals as those intervals were not defined clearly in the proposed rule.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $144,502 in SFY 2016, which includes $53,943 state dollars and $90,560 in federal dollars and $867,014 in SFY 2017, including $312,559 in state dollars and $554,456 in federal dollars.

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; 5 MRS §8054; PL 2017 ch. 2 part P
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 93**, Opioid Health Home Services
Filing number:	**2017-060**
Effective date:	4/11/2017
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

The Maine 128th Legislature passed legislation, PL 2017 ch. 2, *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, 2017.* Part P (the "Supplemental Budget") grants the Department emergency rulemaking authority to create the Opioid Health Home program without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety, or general welfare under 5 MRS §8054.

Further Basis statement:

The rule establishes the MaineCare Opioid Health Home (OHH) Services program for addressing the opioid crisis in Maine. The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving the MaineCare population. In addition to providing treatment for an individual's substance abuse dependency, the OHH integrates physical, social, and emotional supports to provide holistic care. The model provides a community-based support system focused on team-based clinical care. MaineCare members diagnosed with opioid addiction and who have a second chronic condition or are at risk for having a second chronic condition are eligible for these services. The OHH services provide a multi-faceted approach and comprehensive treatment specifically targeted to the opioid dependent population. The program will increase access to treatment options, integrate health and dependency care, and promote stable recovery results. It is expected that this newly established OHH program will not only result in more individuals receiving the substance abuse treatment they need, but will also lead to improvements in the quality of care they are receiving.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $2,807,400 in SFY 2017, which includes $1,000,000 in state dollars and $1,807,400 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 19**, Home and Community Benefits for the Elderly and Adults with Disabilities
Filing number:	**2017-078**
Effective date:	6/1/2017
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
The Department is adopting changes to both Ch. II and Ch. III of Section 19, "Home and Community Benefits for the Elderly and Adults with Disabilities", that seek to add services, clarify existing services, increase rates for personal care services, adjust rates and rate methodology for other services, more closely align the rule with federal requirements for waiver services, and make various clerical and formatting updates. Specific changes are outlined as follows:

Chapter II
Ch. II Section 19 was originally promulgated to provide members with the opportunity to remain in their own homes, avoiding or delaying institutional care. In furtherance of this goal, this rule adoption adds three new services that enhance members' opportunities to access necessary supports and services within their communities: Home Delivered Meals, Living Well for Better Health, and Matter of Balance (Falls Prevention). The meals service will assist members who are unable to prepare their own meals and for whom no one else is responsible to prepare meals. The Living Well for Better Health and Matter of Balance program are evidence-based workshops available to all members that have been shown to improve quality of life for individuals with chronic disease.

In addition, the Department is moving Adult Day Health Services from Section 19 to the State Plan. This change benefits members by increasing options for services under the program cap. Services under the State Plan also do not limit members in the same manner under the Section 19 waiver in terms of scope and duration.

The Department is also increasing options for members through this adopted rule by adding a definition of "Budget Authority" to allow members under the Participant-Directed Option to determine the wages of hired Attendants. Similarly, the Department is adding a definition for "Fiscal Intermediary" so that the responsibilities of the Fiscal Management Services provider are also clear. The Fiscal Intermediary works with the member who self-directs services. In addition, the Department added language to the rule which clarifies that, under the Participant-Directed Option, the member is considered the employer of the Attendant. These changes give the member more autonomy in self-directing services under this waiver. All members are eligible to elect the Participant-Directed Option; however, some members may need the assistance of a Representative and the Department has added the definition of "Cognitive Capacity" in making this determination.

Other changes to the Ch. II rule adoption include the addition of the Person-Centered Planning definition and requirement that the Service Coordination Agency follow this model

when working with the member to develop and implement services. The adoption of these rule provisions helps move the Section 19 waiver program towards compliance with 42 CFR §431.301(c). This federal regulation sets forth new provisions for Home and Community Based Services waiver programs. The Department is currently engaged in transition planning with the Center for Medicare and Medicaid Services ("CMS") for all such waiver programs.

The Department made a number of other changes to the rule adoption to help clarity and improve upon existing processes for determining eligibility. This includes removing the requirement that the member provides a physician's letter to the Service Coordination Agency, as all services will be medically authorized by the Assessing Services Agency; adding language to the rule that emphasizes consideration of the member's needs and preferences; and updating the timeframes in which the Assessing Services Agency must complete both assessments and re-assessments, as reflected in current Departmental contracts.

As explained below, the Department is increasing several rates under Ch. III. To correspond with these rate increases, the Department is increasing the waiver cap in Ch. II.

Chapter III

Ch. III is the companion rule to Ch. II and provides billing codes and rates for the services described in Ch. II. With this rule adoption, the Department is making the following changes: (1) increasing the rates of reimbursement for personal care and related services; (2) incorporating other recommended rate changes pursuant to a rate study; (3) adding and removing rates to correspond with updates in covered services; (4) increasing the per diem rate for respite care not provided in the home; and (5) adding columns for modifiers and revenue codes.

First, the Department is adopting rate increases in accordance with Resolves 2015, ch. 83 (*Resolve, Directing the Department of Health and Human Services To Increase Reimbursement Rates for Home-based and Community-based Services*). Through this Resolve, the Legislature directed the Department to amend this rule "to reflect 50% of the increase in rates noted in the final rates modeled in the February 1, 2016 report 'Rate Review for Personal Care and Related Services: Final Rate Models' prepared for the department by Burns & Associates, Inc." Several rates are affected by this legislative directive as denoted in the adopted rule. These rate increases will be retroactive to July 29, 2016, the effective date of the Resolve, and pursuant to 22 MRS §42(8).

Second, the Department is incorporating other changes to Ch. III as a result of other recommendations in the Burns & Associates rate study. The Department has decreased the rate for three procedure codes: Skilled Nursing Visit (RN), Other Nursing (LPN), and Home Health Aide Visit – Home Health services. In addition, the Department has added new rates and procedure codes in accordance, as set forth in the study, for personal care and related services provided to two and three members simultaneously. These changes will take effect on June 1, 2017.

Next, the Department has added procedure codes and rates for the three new services added under Ch. II: Home Delivered Meals, Living Well (Chronic Disease Management), and Matter of Balance (Falls Prevention). The Department has also removed the procedure code and rate for Adult Day Health Services, as this service will now be offered to members under the State Plan. These changes are effective June 1, 2017.

The Department also increased the rate for Respite Care Services, not in the home. The reason for this increase is to match the rate under Section 19 with the current nursing facility rate that was rebased as of July 1, 2016 elsewhere in the *MaineCare Benefits Manual*. This increase will be retroactive to July 1, 2016, and pursuant to 22 MRS §42(8).

Finally, the Department is adding columns to differentiate between procedure code, modifier, and revenue code in Ch. III. Providers need to ensure that they are using the

appropriate procedure code, modifier, and revenue code for reimbursement of services. This change should assist providers in this responsibility.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $330,139.18 in SFY 2017, which includes $117,595.57 in state dollars and $212,543.60 in federal dollars, and $1,320,556.70 in SFY 2018, which includes $470,382.30 in state dollars and $850,174.40 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173; PL 2016 ch. 477; Resolves 2015 ch. 45, 2017 ch. 6
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 97**, Private Non-Medical Institution Services
Filing number:	**2017-091**
Effective date:	7/16/2017
Type of rule:	Major Substantive
Emergency rule:	No

Principal reason or purpose for rule:

These changes are being done in order to comply with:

1) PL 2016 ch. 477, *An Act to Increase Payments to MaineCare Providers That Are Subject to Maine's Service Provider Tax,* Private Non-Medical Institutions have experienced an increase in the tax since January 1, 2016. PNMIs are in need of increased funding to continue providing these services to Maine's vulnerable citizens, including children, individuals with substance use disorders, and adults with intellectual disabilities and autistic disorder. Pursuant to 22 MRS §42(8), the increased rates will be effective retroactive to July 1, 2016.

2) Ch. III Section 97 (the "Main Rule") and Ch. III Section 97 Appendix C only, the Department repeals and replaces the March 8, 2016 emergency major substantive rule, which made changes pursuant to Resolves 2015 ch. 45, Resolve, *To Require the Department of Health and Human Services to Provide Supplemental Reimbursement to Residential Care Facilities in Remote Island Locations.* Those changes are incorporated into this major substantive rulemaking.

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services (CMS) for these changes. Pending approval, the increased reimbursement rates will be effective retroactive as to July 1, 2016.

This rulemaking follows an emergency rulemaking filed on October 25, 2016, which will remain in effect for up to one year or until the Legislature approves the provisionally adopted major substantive rule.

Basis statement:

The Department of Health and Human Services finally adopts these major substantive rule changes to Ch. III Section 97, "Private Non-Medical Institution (PNMI) Services". Pursuant to 5 MRS §8072, the Department submitted its provisionally adopted rule changes to the Legislature for review and authorization for final adoption. On March 30, 2017, the Legislature enacted "*Resolve, Regarding Legislative Review of Portions of Chapter 101: MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institution Services, a Late-filed Major Substantive Rule of the Department of Health and Human Services"* (Resolves 2017, ch. 6 (effective April 19, 2017), which authorized the Department to finally adopt the provisionally adopted rule changes, as submitted (i.e., without any changes). The law included authority for the Resolve to take place immediately, given the Legislature's emergency findings, and thus it took effect upon the Governor's signature.

These rule changes effectuate a one (1) percent rate increase in the direct care component to PNMI Services providers who have experienced an increase in the Maine Service Provider Tax since January 1, 2016, pursuant to PL 2015 ch. 477, *An Act to Increase Payments to MaineCare Providers That Are Subject to Maine's Service Provider Tax*. PNMIs are in need of increased funding to continue providing these services to Maine's vulnerable citizens, including children, and individuals with intellectual disabilities and autistic disorder.

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Service (CMS) for these changes. Pending approval, the increased reimbursement rates will be effective retroactive to July 1, 2016.

In addition, in Ch. III Section 97 (the "Main Rule") and Ch. III Section 97 Appendix C only, the Department repealed and replaced the March 8, 2016 emergency major substantive rule, which made changes pursuant to Resolves 2015 ch. 45, Resolve, *To Require the Department of Health and Human Services to Provide Supplemental Reimbursement to Residential Care Facilities in Remote Island Locations.* These changes are incorporated into this final adoption rulemaking.

The Department is seeking and anticipates receiving approval from CMS for the remote island facility reimbursement increases. Pending CMS approval, those changes shall be effective retroactive to October 1, 2015.

The Department previously implemented these same changes through emergency major substantive rulemaking, effective as of October 25, 2016. The emergency major substantive rule changes shall remain in effect until the time that these finally adopted rule changes take effect, thirty days after filing with the Secretary of State's Office. 5 MRS §8072(8).

Fiscal impact of rule:

This major substantive rulemaking is estimated to cost the Department approximately $7,903,979 in SFY 2017, which includes $3,093,823 in state dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; 5 MRS §8054; PL 2017 ch. 2
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 93**, Opioid Health Home Services
Filing number:	**2017-103**
Effective date:	7/10/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
The Maine 128th Legislature passed legislation, PL 2017 ch. 2, *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, 2017*. Part P (the "Supplemental Budget") grants the Department emergency rulemaking authority to create the Opioid Health Home program without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety, or general welfare under 5 MRS §8054.

Basis Statement:
The Department adopts this rule pursuant to PL. 2017 ch. 2 part P §P-1 (Establishment of Opioid Health Home Program). On April 11, 2017, the Department adopted an emergency rule which established the Opioid Health Home Service as a MaineCare service.

This rule makes permanent the April 11, 2017 emergency rule, with some changes. The MaineCare Opioid Health Home (OHH) Services program addresses the opioid crisis in Maine. The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving the MaineCare population. In addition to providing treatment for an individual's substance abuse dependency, the OHH integrates physical, social, and emotional supports to provide holistic care. The model provides a community-based support system focused on team-based clinical care. MaineCare members diagnosed with opioid addiction and who have a second chronic condition or are at risk for having a second chronic condition are eligible for these services. The OHH services provide a multi-faceted approach and comprehensive treatment specifically targeted to the opioid dependent population. The program will increase access to treatment options, integrate health and dependency care, and promote stable recovery results. It is expected that this newly established OHH program will not only result in more individuals receiving the substance abuse treatment they need, but will also lead to improvements in the quality of care they are receiving.

The Department has submitted a State Plan Amendment (SPA) request to CMS for approval, and anticipates that CMS will approve the Opioid Health Home SPA. Pending CMS approval, covered services will be provided as described in this rule.

Fiscal impact of rule:
The Department anticipates that this rulemaking will cost approximately $2,807,400 in SFY 2017, which includes $1,000,000 in state dollars and $1,807,400 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. X Section 1**, Benefit for People Living with HIV/AIDS
Filing number:	**2017-104**
Effective date:	7/10/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule updates outdated references identifying Department agencies, *MaineCare Benefit Manual* policies and services, and outdated Internet website addresses. The rule also clarifies and lists specific non-covered services and required co-payments for certain services in a more organized, easier to understand form. Additional changes to the rule include more specifically-defined objectives that may lead to disenrollment, simplification of disenrollment protocol, clarification of appeal rights language, and minor grammar and punctuation changes.

Basis Statement:

The rule changes set out the required co-payments for certain services in a more organized, easier to understand form, and removes the non-applicable 90-day supply co-pay.

Additionally, the rule more specifically-defines actions that may lead to disenrollment, it simplifies disenrollment protocol, and clarifies the appeal rights language.

The rule also updates references in the covered and non-covered services tables to reflect the current *MaineCare Benefit Manual* policies. For certain additions and removals of services, as noted in each instance in the rule, the Department is seeking and anticipates receiving CMS approval.

For example, the category title “Early Intervention” has been changed to “Services for Children with Intellectual Disability or Autism.” The previous title was misleading in that a federal program by that name exists, but it is not related to or the same as the name used in the MaineCare policies. The new title directly correlates to the MaineCare policy.

The rule also clarifies some of the non-covered services. For instance, non-covered Section 60 services, “Durable Medical Equipment”, currently include those that were previously identified in the sections of MaineCare policy that are now repealed; specifically Sections 32, “Waiver Services for Children with Intellectual Disability or Pervasive Developmental Disorders”, and Section 35, “Hearing Aids and Services”, have been repealed. As such, the Department removes references to them in this rule. Similarly, the non-covered services table in this rule previously identified in the now-repealed Section 22, “Home and Community Benefits for the Physically Disabled”. Because Section 22 was merged with Section 19, “Home and Community Benefits for the Elderly and for Adults with Disabilities”, and the Department removed reference to Section 22. Those services remain identified herein as non-covered.

Some of the services previously identified in Section 96, “Private Duty Nursing and Personal Care Services”, Section 97, “Private Non-Medical Institution Services”, and Section102, “Rehabilitative Services”, as non-covered services have now been moved to Section 18, “Home and Community-Based Services for Adults with Brain Injury”. Accordingly, the Department added reference to Section 18 under the non-covered services table in this rule to ensure that the services that are now part of Section 18 remain identified as non-covered.

This adopted rule updates many outdated references identifying Department agencies, *MaineCare Benefit Manual* policies and services, outdated internet website addresses, and contains minor grammar and punctuation changes.

Fiscal impact of rule:
This rulemaking is estimated to have no fiscal impact.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; 5 MRS §4551 *et seq.*; 22 MRS 42(8); 42 CFR 1007; PL 2014 ch. 444 (to be codified at 22 MRS §3174-WW); 42 USC 1320a–7; 42 CFR 431.55(h)(2); 42 CFR 455.416(c)l; Public Law 111–148; Public Law 111-256; LD 1596; 22 MRS §3173-C sub-§2, as amended by PL 2011 ch. 458
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. I Section 1**, General Administrative Policies and Procedures
Filing number:	**2017-105**
Effective date:	7/5/2017
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis Statement:
This rulemaking adopts the following changes:
1. References to the "Office of Integrated Access and Support" were updated to the "Office for Family Independence." The name of this agency has changed, and the policy should reflect the name change.
2. Section 1.02-4(B), "Covered Health Care Provider" definition has been expanded to include "a provider of medical or health services and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business" to more accurately mirror federal language.
3. Section 1.02-4(G), added language to the definition of "National Provider Identifier (NPI)" to clarify that the NPI is issued by CMS.
4. Section 1.02-4(H)(3), changed the definition of "Ordering, Prescribing and Referring (OPR) provider" to "Non-Billing, Ordering, Prescribing and Referring Provider (NOPR)" to conform with current online MaineCare billing practices.
5. Section 1.03-1, change of language describing online provider enrollment. In the state of Maine, online enrollment is now the sole means through which providers enroll and update information. Therefore, language was added describing the online enrollment process through the Department's Health PAS portal. This change is being made to institute the federally mandated revalidation requirements outlined in 42 CFR §424.515.
6. Section 1.03-1(A), addition of language describing the requirement for providers to complete subsequent enrollment applications every three to five years, depending on provider type in order to institute the federally mandated revalidation requirements outlined in 42 CFR §424.515.
7. Section 1.03-1, addition language authorizing the Department to request additional information which demonstrates the provider applicant's ability to provide high-quality care, services, and supplies, and to be financially responsible. This change is being made to better help ensure MaineCare's ability to align with federally mandated revalidation requirements in 42 CFR §424.515.
8. Section 1.03-1(C), addition language describing the requirement for providers (with the exception of individual practitioners) to pay an enrollment fee for each provider site. Language was also added describing the option for providers to apply for a fee waiver, as well as the exemption from the fee for providers who have paid an enrollment fee for the site in question

during the preceding 12 months to Medicare or another Medicaid agency. This enrollment fee language is being added to comply with 42 CFR §455.460.
9. Section 1.03-B, addition of language stating that providers must obtain a National Provider Identification (NPI) or Atypical Provider Identifier (API) plus three digit service location identifier and use this number in submitting all claims for payment. This change is being made to upgrade the provider enrollment process for efficiency purposes.
10. Section 1.03-2, addition of language stating that out-of-state providers are subject to the same enrollment requirements as in-state providers to ensure all MaineCare providers properly enroll.
11. Section 1.03-3, addition of a list of factors the Department must and may consider in determining whether to enroll or deny enrollment to a provider applicant. Certain situations will trigger automatic denial of enrollment. These changes are being added to conform with 42 CFR §455.410.
12. Section 1.03-3, addition of subsections that set forth the criteria for MaineCare's denial of provider enrollment or subsequent provider enrollment applications. These changes follow the federal regulations set forth in 42 CFR §455.416.
13. Section 1.03-5, addition of language stating that providers who are terminated from MaineCare (whether involuntarily or voluntarily), have one year from the end date of enrollment to submit claims for services provided during the period of active enrollment. This change was added to be consistent with the one-year regular timely filing noted in Section 1.10-2.
14. Section 1.03-6, addition of language regarding changes of ownership, closures and disenrollment. Providers will be required to notify the Provider Enrollment Unit of any Change in Ownership (CHOW), closure, or intention to disenroll from the MaineCare program no less than thirty (30) days prior to the intended change. Providers undergoing a CHOW will be required to submit a CHOW questionnaire. These changes are being made to conform with federal regulations set forth in 42 CFR §455.104.
15. Section 1.03-7, addition of language stating that the Department will terminate the enrollment of any provider (other than NOPR providers) who has not submitted a claim within 365 days of enrollment. Such providers are eligible to re-enroll at any time. This change is being added to ensure that the MaineCare system has the most current and relevant provider information on record.
16. Section 1.03-8 (F), language was updated involving provider nondiscrimination requirements to conform with state and federal laws. The current policy contains an incomplete list of groups whom providers are barred from discriminating against. The Department has added sexual orientation, gender identity, ancestry, age and any other category protected by state and federal law.
17. Section 1.03-8(V), addition of language requiring disclosure of certain ownership or control interests. These requirements follow those of 42 CFR §§ 455.101-105.
18. Section 1.06-2 (A), addition of language stating that the Department will not reimburse for interpreter travel time to help minimize abuse of the interpreter reimbursement.
19. Section 1.06-5, addition of language stating that providers may refuse to continue to see members who have repeatedly broken appointments without prior notice. In such situations, providers must provide advanced notice of office policies concerning no-shows to members before refusing to continue to see those members. This addition is being made to allow providers to refuse to continue to see members only in accordance with the provider's standard office policies for broken appointments.
20. Section 1.07-1(C), addition of language describing Early and Periodic Screening, Diagnosis and Treatment Services. This additional information provides more detailed and clarifying language regarding the Early and Periodic Screening, Diagnosis and Treatment Services.

21. Section 1.07-3(C), addition of an exception to the requirement that providers appeal third party payer denials of services prior to billing MaineCare. The exception is when Medicare has denied services based on Local Coverage Determinations (LCDs) or National Coverage Determinations (NCDs), and also includes Licensed Marriage and Family Therapist (LMFTs), Licensed Professional Counselor (LCPCs), and Licensed Master Social Workers Clinical Conditional (LMSW-CCs) when the following criteria are met: 1) member has an established relationship with the provider; or 2) another provider is not available. This additional language is being added to allow for a more streamlined procedure for allowing for appeals because these provider types are not recognized by Medicare.
22. Section 1.09-2(J), addition of tobacco cessation products and services to the list of copayment exemptions. Copayments for tobacco cessation services are prohibited by 22 MRS §3174-WW.
23. Section 1.11-2, addition of language describing National Correct Coding Initiative (NCCI) edits, and a statement that MaineCare will reject claims not in conformity with NCCI requirements. This change is being made to mirror federal regulations set forth in National Correct Coding Initiative Policy Manual from CMS.
24. Section 1.06-2(I), removal of Private Non-Medical Institutions (PNMIs) from list of facilities that include interpreter services in their reimbursement calculations. Interpreter services are not included in the PNMI rate calculation.
25. Section 1.12-2 (D), addition of language stating that the liability for debts owed to the Department by the provider is enforceable against the provider, including any person who has an ownership or control interest in the provider, and against any officer, director or member of the provider who, in that capacity, is responsible for any control or any management of the funds or finances of the provider. Language has also been added defining "individuals or entities with an ownership or control interest." These changes are being made to clarify that individuals with management or control over the funds or finances of the provider are personally liable. This addition also corresponds to the language of the MaineCare Provider Agreement, section (D)(3)(c).
26. Section 1.14-1(A), updating of the website address for information regarding prior authorizations.
27. Sections 1.14-2(A)(1) and **1.14-2(B)(3)**, removal of language allowing for MaineCare covered services to be rendered to members within five miles of the Maine/Canadian border. This language is pursuant to Section 6505 of the Affordable Care Act amending Section 1902(a) of the Social Security Act (the Act), and requires that a state shall not provide any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States (U.S.).
28. Section 1.15, removal of language regarding Section 113 Non-Emergency Transportation (NET) of the MaineCare Benefits Manual. Section 113 sets forth the policy for non-emergency transportation, so the duplicative language was removed from Section 1.15.
29. Termination from participation language that was in **former Section 1.03-4** has been moved to **new Section 1.19** entitled "Termination from Participation in MaineCare."
30. Section 1.20(Z) & (AA), addition of two new grounds for sanctions: (1) an entity that is an HMO or is providing services under a Medicaid waiver program, and has a substantial contractual relationship with an entity that could be excluded from the Medicaid program; (2) if a provider has been convicted of a crime while performing services as a health care worker or provider. This change is being made to conform with the requirements of Section 1902 of the *Social Security Act* (42 USC 1396a).
31. Section 1.20-2(C), addition of a sanction action for limitation of services for which the provider is authorized to perform and receive payment. This change adds a sanction that may occur as a result of a grounds for sanction described in 1.20-1 (Grounds for Sanctions).

32. The Department is adopting a new provision, **Section 1.21**, entitled "Reinstatement from Termination or Exclusion." Reinstatement language that was in former Section 1.19-4(F) has been moved to this new section. The Department is also making the change that requests for reinstatement from exclusion or termination be addressed to the Manager of Program Integrity, in writing. The language also sets forth factors that will be considered by the Department when making a decision to reinstate. The adopted language, in Subparagraph 2, also sets forth minimum periods of time before reinstatement can be considered, for certain violations of law or other exclusion or termination reasons. The time period requirements are consistent with the time period requirements imposed on the Federal Secretary of HHS in the *Social Security Act* Section 1128 (as codified in 42 USC 1320a-7) (Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs).
33. Removal of references to the term "mentally retarded." This term was replaced by the term "intellectually disabled." This change follows the direction of *Rosa's Law*, Public Law 111-256, which requires the federal government to change terminology in federal statute to eliminate use of the term "mental retardation."
34. Replacement of the term "Authorized Agent" with the term "Authorized Entity." This change is being adopted across the agency in order to more accurately describe the Department's relationship with the aforementioned entities. Contractors with the state are not legal agents of the state, so the term was replaced with "entity" to avoid confusion.
35. Section 1.25, changes to the language describing the duties, role, and composition of the MaineCare Advisory Committee (MAC) in order to more closely align with federal requirements, as outlined in 42 CFR §431.12.
36. Minor grammar and punctuation edits have also been made.
Finally, as a result of public comments and further review by the Department and the Office of the Attorney General, there were additional technical changes, formatting updates, and changes to language for clarity.

Fiscal impact of rule:

The Department expects that the changes to tobacco cessation services exemptions will result in a cost to the Department. However, these costs are accounted for in rulemaking for Section 80, "Pharmacy Services". There are no other costs associated with the changes in this rulemaking.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 29**, Allowances for Support Services for Adults with Intelletual Disabilities or Autism Spectrum Disorder
Filing number:	**2017-114**
Effective date:	8/26/2017
Type of rule:	Major Substantive
Emergency rule:	No

Principal reason or purpose for rule:

This waiver renewal adopts rule changes to the Comprehensive Home and Community Based Services (HCBS) Waiver for Persons with Intellectual Disabilities and Autism Spectrum Disorder. Ch. III Section 29 is a companion to Ch. II Section 29, "Support Services for Members with Intellectual Disabilities or Autism Spectrum Disorder". Ch. III is a major substantive rule and requires legislative approval prior to final adoption of the rule.

Significant Updates and Changes to Ch. III Section 29 include renaming of the Section from "Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder" to "Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder."

The Department adopted via emergency rulemaking an increase to the rates in Ch. III in accordance with LD 1638. The legislature passed LD 1638 to authorize an increase in the service provider tax. Ch. III Section 29 lists the procedure codes, descriptions and reimbursement rates for covered services provided to members under its companion rule, Ch. II Section 29, "Support Services for Adults with Intellectual Disabilities or Autistic Disorder".

The increased rates were effective retroactive to April 15, 2016. The following services have a 1% increase as a result of LD 1638:

- T2017, Home Support-Quarter Hour, from $6.27 to $6.33.
- T2017 QC, Home Support-Remote Support-Monitor Only, from $1.62 to $1.63 per quarter hour.
- T2017 GT, Home Support-Remote Support-Interactive Support, from $6.27 to $6.33 per quarter hour.
- T2021, Community Support (day habilitation) from $5.28 to $5.33 per quarter hour.
- T2021 SC, Community Support (day habilitation) with Medical Add On from $6.51 to $6.57 per quarter hour.
- Replaced H023 HQ Work Support (supported employment) with the following modifiers below:
  - H2023 UN Work Support (supported employment-Group 2 members served, up to $3.46 per ¼ hour.
  - H2023 UP Work Support (supported employment-Group 3 members served, up to $2.30 per ¼ hour.
  - H2023 UQ Work Support (supported employment-Group 4 members served, up to $1.73 per ¼ hour.
  - H2023 UR Work Support (supported employment-Group 2 members served, up to $1.38 per ¼ hour.
  - H2023 US Work Support (supported employment-Group 2 members served, up to $1.15 per ¼ hour.

Basis Statement:

The Department finally adopts these major substantive changes to the reimbursement rates in Ch. III Section 29. Pursuant to 5 MRS §8072, the Department submitted its provisionally adopted rule changes to the Legislature for review and authorization for final adoption. On May 31, 2017 the Legislature enacted "*Resolve, Regarding Legislative Review of Portions of Chapter 101: MaineCare Benefits Manual, Chapter III, Section 29, Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder, a Late-filed Major Substantive Rule of the Department of Health and Human Services"* (Resolves 2017, Ch. 10 (effective May 31, 2017), which authorized the Department to finally adopt the provisionally adopted rule changes, as submitted (i.e., without any changes). The law included authority for the Resolve to take place immediately, given the Legislature's emergency findings, and thus it took effect upon the Governor's signature.

Most of the changes finally adopted in Section 29 were made pursuant to PL 2015 Ch. 477, *An Act to Increase Payments to MaineCare Providers That Are Subject to Maine's Service Provider Tax* (eff. April 15, 2016). Through this law, the Legislature required a 1% increase in reimbursement for certain services to offset an increase in the service provider tax, which took effect January 1, 2016.

In addition, the Department seeks to permanently adopt new codes and rates for Work Support provided to multiple members at one time. The Department is making these changes to allow for providers to bill for different group sizes.

On September 28, 2016, the Department implemented the above-described changes through emergency major substantive rulemaking. Pursuant to 5 MRS §8073, emergency major substantive rules are effective for up to 12 months, or until the Legislature has reviewed and approved of the provisionally adopted rule. In addition, pursuant to 22 MRS §42(8), these emergency rule changes are effective retroactive to April 15, 2016.

Additional changes to Ch. III Section 29 that were not deemed emergency but were part of the proposed rule and the provisionally adopted rule include:

- Updating Section 1400(3), reducing the reimbursement for respite care to provide that the amount billed for any single day cannot exceed a per diem rate of $90.00. The Department seeks to implement this change to make the rule consistent with the rates that are already in Appendix I and to be consistent with MIHMS.
- Renaming of the Section from "Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder" to "Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder." The Department seeks to implement this change as this is the current terminology used in the DSM 5.
- Various clerical and formatting changes.

These finally adopted major substantive rule changes will be effective 30 days after the rule is filed with the Secretary of State, or at a later date as specified by the Department.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $38,338 in SFY 2016, which includes $14,311 state dollars and $24,026 in federal dollars and $230,027 in SFY 2017, including $82,925 in state dollars and $147,102 in federal dollars.

The Department estimates that this rulemaking will not have any impact on municipalities or counties.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 42, 3173; LD 1638
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 21**, Allowances for Home and Community Services for Adults with Intelletual Disabilities or Autism Spectrum Disorder
Filing number: **2017-121**
Effective date: 9/6/2017
Type of rule: Major Substantive
Emergency rule: No

Principal reason or purpose for rule:

This waiver renewal proposes rule changes to the “Comprehensive Home and Community-Based Services (HCBS) Waiver for Persons with Intellectual Disabilities and Autism Spectrum Disorder”. Ch. III Section 21 is a companion to Ch. II Section 21, “Home and Community-Based Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder”. Ch. III is a major substantive rule and requires legislative approval prior to final adoption of the rule.

Significant updates and changes to Ch. III Section 21 include:

- Renaming of the Section from “Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder” to “Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autism Spectrum Disorder.”
- Removal of Calculation of the Per Diem Rate for Agency Home Supports.
- Clarification of the Average Billing Method.
- Removal of the Range in Appendix IIA and IIB.

The Department will adopt via emergency rulemaking an increase to the rates in Ch. III in accordance with LD 1638, *An Act to Increase Payments to MaineCare Providers That Are Subject to Maine’s Service Provider Tax*. The legislature passed LD 1638 to authorize an increase in the service provider tax. Ch. III Section 21 lists the procedure codes, descriptions and reimbursement rates for covered services provided to members under its companion rule, Ch. II Section 21 “Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder”.

The increased rates will be effective retroactive to April 15, 2016. The following services will have a 1% increase as a result of LD 1638:

- T2017, Home Support (habilitation, residential, waiver), from $6.27 to $6.33 per quarter hour.
- T2017 SC, Home Support (habilitation, residential, waiver)-with Medical Add On from $7.50 to $7.57 per quarter hour.
- T2017 QC, Home Support (habilitation, residential, waiver)-Remote Support-Monitor Only, from $1.62 to $1.63 per quarter hour.
- T2017 GT, Home Support (habilitation, residential, waiver)-Remote Support-Interactive Support, from $6.27 to $6.33 per quarter hour.
- T2016, Agency Home Support (habilitation, residential, waiver), from $22.43 to $22.64 per diem.
- T2016 SC, Agency Home Support (habilitation, residential, waiver) with Medical Add On, from $19.53 to $19.72 per diem.
- T2016 SC, Agency Home Support (habilitation, residential, waiver), from $27.15 to $27.41 per diem.
- S5140, Shared Living (Foster Care, adult)-Shared Living Model-One member served, from $126.19 to $127.39 per diem.
- S5140 TG, Shared Living (Foster Care, adult)-Shared Living Model-One member served-increased level of support, from $183.52 to $185.27 per diem.
- S5140 UN, Shared Living (Foster Care, adult)-Shared Living Model-Two members served, from $63.10 to $63.71 per diem.

- S5140 UN TG, Shared Living (Foster Care, adult)-Shared Living Model-Two members served-Increased level of support, from $120.42 to $121.57 per diem.
- T2016 U5, Home Support (habilitation, residential, waiver)-Family Centered Support-One member served, from $104.17 to $105.16 per diem.
- T2016 TG U5, Home Support (habilitation, residential, waiver)-Family Centered Support-One member served-Increased level of support, from $216.96 to $219.03 per diem.
- T2016 UN U5, Home Support (habilitation, residential, waiver)-Family Centered Support-Two members served, from $85.8 to $86.61 per diem.
- T2016 UN TG U5, Home Support (habilitation, residential, waiver)-Family Centered Support-Two members served-Increased level of support, from $196.78 to $198.65 per diem.
- T2016 UP U5, Home Support (habilitation, residential, waiver)-Family Centered Support-Three members served, from $73.15 to $73.85 per diem.
- T2016 UP TG U5, Home Support (habilitation, residential, waiver)-Family Centered Support-Three members served-Increased level of support, from $178.40 to $180.09 per diem.
- T2016 UQ U5, Home Support (habilitation, residential, waiver)-Family Centered Support-Four members served, from $61.99 to $62.58 per diem.
- T2016 UQ TG U5, Home Support (habilitation, residential, waiver)-Family Centered Support-Four members served-Increased level of support, from $162.16 to $163.71 per diem.
- T2016 UR U5, Home Support (habilitation, residential, waiver)-Family Centered Support-Five or members served, from $55.29 to $55.82 per diem.
- T2016 UR TG U5, Home Support (habilitation, residential, waiver)-Family Centered Support-Five or members served-Increased level of support, from $153.42 to $154.88 per diem.
- T2021, Community Support (day habilitation) from $5.28 to $5.33 per quarter hour.
- T2021 SC, Community Support (day habilitation) with Medical Add On from $6.51 to $6.57 per quarter hour.
- Replaced H023 HQ Work Support (supported employment) with the following modifiers below:
  - H2023 UN Work Support (supported employment)-Group 2 members served, up to $3.46 per ¼ hour.
  - H2023 UP Work Support (supported employment)-Group 3 members served, up to $2.30 per ¼ hour.
  - H2023 UQ Work Support (supported employment)-Group 4 members served, up to $1.73 per ¼ hour.
  - H2023 UR Work Support (supported employment)-Group 2 members served, up to $1.38 per ¼ hour.
  - H2023 US Work Support (supported employment)-Group 2 members served, up to $1.15 per ¼ hour.

Basis Statement:

This regulation governs the reimbursement for a federal Medicaid 1915(c) waiver service. This regulation is a major substantive rule.

On September 28, 2016, the Department adopted an emergency major substantive rule for Ch. III Section 21, to comply with PL 2015 ch. 477 (*An Act to Increase Payments to MaineCare Providers that are Subject to Maine's Service Provider Tax*). The Maine Legislature enacted PL 2015, Ch. 477 on an emergency basis, and therefore the legislation took effect on the date that it was signed by Governor LePage; April 15, 2016. The September 28, 2016 emergency major substantive rule increased 23 codes/services by 1%, with a retroactive effective date of April 15, 2016. Pursuant to 5 MRS §8073, the September 28, 2016, emergency major substantive rule – with the 1% rate increases - is effective for up to twelve months or until the Legislature has completed its review of the provisionally adopted rule.

Pursuant to 5 MRS §8072(1), the Department engaged in proposed rulemaking for Ch. III Section 21. On February 24, 2017, the Department provisionally adopted the Ch. III Section 21 major substantive rule. The Department submitted the provisionally adopted rule to the

Legislature, which authorized adoption of the rule with some legislative changes. Resolves 2017 Ch. 15, approved by the Governor on June 8, 2017.

This rulemaking makes the following changes, all of which were approved or initiated by the Legislature:

- To match the current terminology in the DSM 5, renamed the Section from "Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder" to "Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autism Spectrum Disorder."
- In Appendix I changed "Consultation Services" for both Psychological and Speech Therapy to "Consultative Services" to be consistent with the approved service name in the waiver application. These changes have no impact on services or billing.
- Make permanent the 1% rate increase to 23 codes/services that received a 1% rate increase in the September 28, 2016 Emergency Major Substantive rulemaking. These codes, and the increased rates, are listed in Appendix I.
- To allow different billing options for different group sizes, replaced H023 HQ Work Support (supported employment) with the following modifiers below:
  - H2023 UN Work Support (supported employment)-Group 2 members served.
  - H2023 UP Work Support (supported employment)-Group 3 members served.
  - H2023 UQ Work Support (supported employment)-Group 4 members served.
  - H2023 UR Work Support (supported employment)-Group 5 members served.
  - H2023 US Work Support (supported employment)-Group 6 members served.

When proposing the rule the Department proposed removing the range methodology in Appendix IIA and IIB. The reason for this was that it is the expectation of the Department that providers bill only for the services they provide. The range methodology was originally included in the rule to allow for fluctuations in staffing. Based on the comments received, the Department decided to not go forward with that rule change.

The Legislature, Resolves 2017 ch. 15, approved the changes listed above, and in addition made the following changes to the Final Rule:

1. §1050 the definition of per diem has been changed to remove the requirement that a provider bill only for days on which a member is receiving per diem Home Support at 11:59 p.m. The definition of per diem has been changed to clarify that there is no requirement that a provider bill only for days on which a member is physically present in the home at 11:59 p.m. and that on days when a member is transitioning between providers of home support, only the provider providing home support services at 11:59 p.m. may bill for home support.
2. §2000 (Audit of Services) the Legislature removed the proposed change in the documentation requirement for staffing schedules, so that the documentation requirement remains as it is in current rules, which require documentation showing the hours and the name of the direct staff scheduled to work at the facility.

The rule is final 30 days after it is filed with the Secretary of State.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $144,502 in SFY 2016, which includes $53,943 in state dollars and $90,560 in federal dollars and $867,014 in SFY 2017, including $312,559 in state dollars and $554,456 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 42, 3173
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 80**, Pharmacy Services
Filing number: **2017-132**
Effective date: 9/1/2017
Type of rule: Routine Technical
Emergency rule: No

Principal reason or purpose for rule:
This rulemaking increases the efficiency and effectiveness of the MaineCare Pain Management and Buprenorphine prescribing sections. This rulemaking also brings these sections into compliance with the Department's Office of Substance Abuse and Mental Health Services rules governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications. This rulemaking also aligns MaineCare policy with the CMS Covered Outpatient Drug final rule and adopts the recently completed New England States Consortium Systems Organization (NESCSO) pharmacy cost of dispensing survey into policy.

Basis Statement:
This rulemaking adopts the following changes:

1 Definitions of "Acute Pain," "Buprenorphine," "Chronic Pain," "Opioid Medication," and "Prescription Monitoring Program" have been added to Section 80.01, Definitions.

2. In Section 80.07-6, Policies and Procedures, Dispensing Practices, language has been added requiring that generic drugs must be dispensed as a ninety (90) day supply for drugs identified as maintenance drugs after the initial thirty (30) day supply, with additional language excluding opioid medications from the requirement.

3. The addition of a new section, Section 80.07-12, Prescribing Opioids for Pain Management, which aligns MaineCare with Maine statutes and the Department's Office of Substance Abuse and Mental Health Services rules governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications. The section incorporates current best practices guidelines and includes subsections on prescribing requirements for treating chronic pain; limitations and exemptions; rules regarding prior authorization for both acute and chronic pain prescriptions; and medical record documentation requirements.

4. The addition of a new section, Section 80.07-13, Buprenorphine and Buprenorphine Combination Products for Substance Use Disorder (SUD) which provides best practice guidelines for Medication-Assisted Treatment (MAT) using buprenorphine and derivatives for individuals who have been diagnosed with SUD. This sections includes subsections associated with prescriber requirements; detailed protocols; limitations on members qualified to receive the drug; and rules regarding prior authorizations. The section also outlines requirements for medical records which follow the model established by the Drug Addiction Treatment Act of 2000 (DATA).

5. Section 80.09, the reimbursement sections for retail and specialty pharmacy providers, has been amended to align MaineCare policy with the CMS Covered Outpatient Drug final rule. The change to this section also includes changing the pharmacy dispensing fee from $3.35 to $11.89 following the New England States Consortium Systems Organization (NESCSO) pharmacy cost of dispensing survey.

Finally, as a result of public comments and further review by the Department and the Office of the Attorney General, there were additional technical changes, formatting updates, and changes to language for clarity. The Summary of Public Comments and Department Responses document identifies changes that were made to the final rule.

Fiscal impact of rule:
The Department anticipates that this rulemaking will cost approximately $2,155,243 in SFY 2018, which includes $768,560 in state dollars and $1,386,683 in federal dollars, and $2,586,292 in SFY 2019, which includes $922,272 in state dollars and $1,664,020 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1) & (8), §3173; 5 MRS §8054, 8073; PL 2017 ch. 284, §§ MMMMMMM-2, TTTT-1
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 21**, Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autism Spectrum Disorder
Filing number:	**2017-156**
Effective date:	9/29/2017
Type of rule:	Major Substantive
Emergency rule:	Yes

Principal reason or purpose for rule:

The emergency adopted rule implements rate increases enacted by the Legislature in PL 2017 ch. 284 §MMMMMMM-2.

Basis Statement:

This emergency major substantive rule is adopted in accordance with PL 2017 ch. 284, §TTTT-1, which authorized the Department to adopt emergency rules as necessary to implement provisions of PL 2017 ch. 284, over which it has subject matter jurisdiction without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety or general welfare.

PL 2017 ch. 284 provides funding to increase reimbursement rates for 23 procedure codes in Ch. III Section 21. The legislation directed the Department to increase the rates for the specific procedure codes in equal proportion to the funding provided for that purpose.

In addition to the rate increases required by PL 2017 ch. 284, the Department has also increased the rate for a 24th procedure code – T2017 QC (Home Support, Habilitation, residential, waiver – Remote Support – Monitor only). In accordance with 5 MRS §8054, the Department has determined that this rate increase needs to be done in this emergency rulemaking for it is necessary to avoid an immediate threat to public health, safety or general welfare. The Department's findings of an emergency are as follows: PL 2017 ch. 284 increased every other procedure code for Home Support: Quarter Hour and Home Support: Remote Support. Increasing the rate for the procedure code that was "left out" creates consistency with the other codes, in line with the Section 21 service and reimbursement scheme. If the rate for this code is not increased, it is likely to create pressure to move members to services with higher rates for financial reimbursement reasons, rather than member need.

These increased rates will be effective retroactive to July 1, 2017. The Department determined that a retroactive rate increase to the beginning of the state fiscal year was appropriate, since the appropriation is intended for the entire fiscal year. The retroactive application of this rule comports with 22 MRS §42(8) which authorizes the Department to adopt rules with a retroactive application for a period not to exceed 8 calendar quarters and there is no adverse financial impact on any MaineCare member or provider.

The Legislature did not appropriate additional funding for these rate increases beyond June 30, 2018; therefore, rates will revert to their current levels (pre-July 1, 2017) on July 1, 2018. The Department moved to emergency rulemaking once the rates were calculated and finalized. In creating the rates for the codes shown below, the Department examined utilization of these services, and then calculated rates to ensure parity between Section 21 and Section 29, to lessen administrative complications for providers.

This emergency major substantive rule increases the following rates:

- In Section 1910, the group rates for Work Support have been increased:
    - 2 Members in Group
    - 3 Members in Group
    - 4 Members in Group
    - 5 Members in Group
    - 6 Members in Group
- In Appendix I:
    - T2017 home support
    - T2017 SC home support with medical add-on
    - T2017 GT home support – remote support
    - T2017 QC home support-remote support-monitor only
    - T2016 agency home support
    - T2016 agency home support over 168 hours
    - T2016 SC agency home support with medical add-on
    - S5140 shared living foster care, adult, one member
    - S5140 TG shared living foster care, adult, one member, increased level of support
    - S5140 UN shared living foster care, adult, 2 members
    - S5140 UN TG shared living foster care, adult, 2 members, increased level of support
    - T2021 community support
    - T2021 SC community support with medical add-on
    - T2015 career planning has been increased
    - T2019 employment specialist services
    - T2019 SC employment specialist services with medical add-on
    - H2023 work support, individual
    - H2023 SC work support with medical add-on
    - H2023 UN work support, group, 2 members
    - H2023 UP work support, group, 3 members
    - H2023 UQ work support, group, 4 members
    - H2023 UR work support, group, 5 members
    - H2023 US work support, group, 6 members
    - T2034 crisis intervention services

The Maine Legislature has designed the Ch. III Section 21 regulation as a major substantive rule. Pursuant to 5 MRS §8073, this emergency major substantive rule may be effective for up to twelve months, or until the Legislature has completed its review. The Department intends to proceed with major substantive rulemaking, which will be provisionally adopted, and then submitted to the Legislature for its review.

Fiscal impact of rule:

This rulemaking is estimated to cost approximately $33,422,308 in SFY18, which includes $9,909,714 in state dollars and $21,507,255 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §42, §3173; 5 MRS §8054; PL 2017 ch. 284
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 29**, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
Filing number: **2017-157**
Effective date: 10/1/2017
Type of rule: Routine Technical
Emergency rule: Yes

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

Basis Statement:
The Department is adopting this emergency rule to make the following changes to Ch. II Section 29: (1) an increase in the combined services cap from $23,985 to $52,425; (2) the addition of Shared Living (Foster Care, Adult) as an available covered service to members; (3) the removal of Work Support services from and the addition of Shared Living services to the combined services cap; (4) an increase in the Respite Services cap from $1,000 to $1,100; and (5) the removal of the weekly cap for Home Support-Remote Support services.

These emergency rule changes were triggered by PL 2017 ch. 284, *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, 2018 and June 30, 2019* ("Act"). part A §A-34 of the Act provides funding to increase the annual cap for combined services provided under the *MaineCare Benefits Manual*, Ch. II Section 29.07-2, from $23,771 to $47,500. The Act authorizes the Department to adopt this change on an emergency basis without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety, or general welfare. See part TTTT §TTTT-1.

The Department understands that the justification for increasing this cap to $47,500 under the Act was to enable Section 29 members to have the option to apply for residential services under this waiver program. Therefore, this emergency rulemaking also adds Shared Living (Foster Care, Adult) services to the covered benefits under Section 29. To implement these services, the Department is adding definitions of Administrative Oversight Agency, Shared Living, and Shared Living Provider in Section 29.02 (Definitions), as well as provider requirements for Shared Living (Foster Care, Adult) in Section 29.10-4. These added definitions and provider requirements are consistent with Ch. II Section 21, "Home and Community Benefits for Adults with Intellectual Disabilities or Autism Spectrum Disorder", which also offers Shared Living services. The Department is also including Shared Living in Appendix IV, which describes additional requirements for providers related to organizational structure, personnel management, operational policies and procedures, financial management, and environment, consistent with other Section 29 providers. The Department is likewise engaging in concurrent emergency rulemaking to add Shared Living services rates to Ch. III Section 29, so that eligible members can begin receiving these services. All of these changes are integral to fully implementing the new Shared Living service. These changes are immediately necessary for the safety and welfare of the vulnerable members of Section 29 who are in urgent need of the residential services the Department believes the Legislature contemplated in increasing the cap under the Act. 5 MRS §8054.

The Department also understands that the $47,500 cap increase authorized under the Act not only accounted for the addition of Shared Living services, but also accounted for the removal of Work Support services. Removing Work Support services from the cap, and including Shared Living services within the cap, as described in Section 29.07-2 (Limits), will immediately benefit members who may be eligible for residential services. Additionally, this change positively impacts members by allowing members who receive Work Support services to engage in these services with fewer restrictions. The Department asserts that these changes are necessary on an emergency basis in order to implement the Legislature's authorization to increase the cap. Absent these changes, members will be immediately and negatively impacted and restricted from receiving services the cap was intended to provide. 5 MRS §8054.

The Department has also increased the annual cap from the $47,500 in the legislation to $52,425. The Act directed the Department to increase the Shared Living services rates under Ch. III Section 21 for SFY2018 (effective July 1, 2017 through June 30, 2018). See part MMMMMMM §MMMMMMM-2(1). The Department has calculated the annual cost of the newly added Shared Living service to Section 29, at the increased rate for this service in Section 21, and has determined that the cap should be set at $52,425 (instead of $47,500) to fully benefit Section 29 members who may now be eligible for this service. Without this increase on an emergency basis, members will be harmed by not having full access to services and providers will be negatively impacted by having a disparity in rates between these Sections. 5 MRS §8054.

The addition of Shared Living services to Ch. II and the reconfiguration of which services are included under the combined services cap at Section 29.07-2 will be effective October 1, 2017, as this is the first date Shared Living services will be available to members. However, the new cap of $52,425 for combined services under Section 29.07-2 will be retroactive to July 1, 2017. The reason for having the cap retroactive is two-fold. First, the Legislature increased the cap in the Act (to $47,500) based on fiscal year calculations – i.e., starting on July 1, 2017. Second, the Act directs the Department to increase rates of reimbursement for procedure codes in Ch. III (effective July 1, 2017 to June 30, 2018), which the Department is doing through a concurrent emergency major substantive rulemaking. See part MMMMMMM, §MMMMMMM-2(2). Increasing the cap retroactive to July 1, 2017, will allow for the increased reimbursement rates to providers without harming members. 22 MRS §42(8).

For similar reasons, the Department has increased the annual cap on Respite Services from $1,000 to $1,100 to accommodate the rate increase for this service for SFY2018 directed by the Act and for which the Department is engaged in concurrent Ch. III rulemaking. Absent this cap increase on an emergency basis, members will be immediately be harmed if providers are able to retroactively submit claims at higher rates and no adjustment is made to the Respite Services cap (i.e., members' access to these services will be decreased). 5 MRS §8054. For this reason, the Department is adopting this change retroactive to July 1, 2017, as permitted under 22 MRS §42(8).

The final change in this emergency rule is the removal of the weekly cap from Home Support-Remote Support services under Section 29.05-7. Home Support services (both Remote and ¼ Hour) are currently included and will continue to be included under the combined services cap in Section 29.07-2. Removing the weekly hourly cap will accommodate the increase in the annual cap to $52,425 so as to avoid immediate harmful effects on members. 5 MRS §8054.

Overall, the Legislature's authorization of an increased combined service cap and the related and necessary changes described above will enable Section 29 members to have increased flexibility in receiving services with fewer restrictions. The Department is seeking and anticipates approval from the Centers for Medicare and Medicaid Services for these changes.

Pursuant to 5 MRS §8054(3), this emergency rule will be effective for 90 days. The Department will be pursuing routine technical rulemaking for Ch. II Section 29 to avoid any lapse.

Fiscal impact of rule:
The Department anticipates that this emergency rule will cost approximately $19,770,210 in SFY18, which includes $5,861,867 in state dollars and $12,722,130 in federal dollars, and $26,360,280 in SFY19, which includes $7,818,459 in state dollars and $16,960,204 in federal dollars.

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1) & (8), §3173; 5 MRS §8054, 8073; PL 2017 ch. 284, §§ MMMMMMM-2, TTTT-1
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 29**, Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
Filing number:	**2017-158**
Effective date:	10/1/2017
Type of rule:	Major Substantive
Emergency rule:	Yes

Principal reason or purpose for rule:

The emergency adopted rule implements rate increases enacted by the Legislature in PL 2017 ch. 284 §MMMMMMM-2 retroactive to July 1, 2017.

Basis Statement:

The Department is adopting this emergency major substantive rule in accordance with PL 2017 ch. 284, *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, 2018 and June 30, 2019* ("Act"). This Act provides funding to increase reimbursement rates for 16 procedure codes in Ch. III Section 29. See part ZZZZZZ, ZZZZZZ-9. The legislation directs the Department to increase the rates for the specific procedure codes in equal proportion to the funding provided for that purpose, and to do so via major substantive rulemaking. See part MMMMMMM, §MMMMMMM-2(2) through -2(4). The Act further authorizes the Department's adoption of rules on an emergency basis without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety or general welfare. See part TTTT §TTTT-1.

In addition to the rate increases required by the Act, the Department has also increased the rate for a 17th procedure code: T2017QC (Home Support-Remote Support-Monitor Only). Pursuant to 5 MRS §8054, the Department has determined that this rate increase is necessary to avoid an immediate threat to public health, safety, or general welfare. The Department's findings of an emergency are as follows: the Act increased the other procedure codes related to Home Support services. Increasing the rate for the procedure code that was "left out" creates consistency with the other codes, in line with the Section 29 service and reimbursement scheme. If the rate for this code is not increased, it is likely to create pressure to move members to services with higher rates for financial reimbursement reasons, rather than member need.

These increased rates will be effective retroactive to July 1, 2017. The Department has determined that a retroactive increase to the beginning of the state fiscal year is appropriate, since the appropriation is intended for the entire fiscal year. The retroactive application comports with 22 MRS §42(8).

The Legislature did not appropriate additional funding for these rate increases beyond June 30, 2018, therefore rates will revert to their current levels (pre July 1, 2017) on July 1, 2018.

In addition, the Department is adding two procedure codes for Shared Living services (S5140 and S5140 UN). The Department is concurrently adopting an emergency rule for Ch. II Section 29 to add this benefit to available covered services for members. This change in Ch. II

will ensure the Department's expeditious provision of this service to vulnerable members who are in need of residential stability. The Department is seeking and anticipates approval from the Centers for Medicare and Medicaid Services for this change. The Department has determined that the corresponding rates must be added on an emergency basis in Ch. III so as to allow the immediate implementation of this service. The Shared Living rates added to Section 29 are consistent with rates for these same services under Section 21 to ensure parity. Because the Legislature has appropriated funds to increase the rates for Shared Living services under Section 21 for SFY ending July 1, 2018, the Department is implementing these higher rates of reimbursement for Shared Living services under Section 29 for the same period. See PL 2017 ch. 284 part MMMMMMM §MMMMMMM-2(1).

The Department moved to emergency rulemaking once the rates were calculated and finalized. In creating the rates for the codes shown below, the Department examined utilization of these services, and then calculated rates to ensure parity between Section 29 and Section 21, to lessen administrative complications for providers.

This emergency major substantive rule makes the following changes:

- In Section 1400: Shared Living is added to the list of services being reimbursed at a standard rate.
- In Section 1810, the group rates for Work Support have been increased
- In Appendix I:
    - S5140 Shared Living (Foster Care, adult)-Shared Living Model-One member served has been added
    - S5140 UN Shared Living (Foster Care, adult)-Shared Living Model-Two members served has been added
    - T2017 Home Support-Quarter Hour has been increased
    - T2017 GT Home Support-Remote Support-Interactive Support has been increased
    - T2017 QC Home Support-Remote Support-Monitor only has been increased
    - T2021 Community Support (Day Habilitation) has been increased
    - T2021 SC Community Support (Day Habilitation) with Medical Add-On has been increased
    - T2019 Employment Specialist Services (Habilitation, Supported Employment waiver) has been increased
    - T2019 SC Employment Specialist Services (Habilitation, Supported Employment waiver) with Medical Add-On has been increased
    - H2023Work Support (Supported Employment)-Individual has been increased
    - H2023 SC Work Support (Supported Employment)-Individual with Medical Add-On has been increased
    - H2023 UN Work Support (Supported Employment)-Group 2 members served has been increased
    - H2023 UP Work Support (Supported Employment)-Group 3 members served has been increased
    - H2023 UQ Work Support (Supported Employment)-Group 4 members served has been increased
    - H2023 UR Work Support (Supported Employment)-Group 5 members served has been increased
    - H2023 US Work Support (Supported Employment)-Group 6 members served has been increased
    - T2015 Career Planning (Habilitation, prevocational) has been increased
    - S5150 Respite Services-1/4 hour has been increased
    - S5151 Respite Services-Per Diem has been increased

Pursuant to 5 MRS §8073, this emergency major substantive rule may be effective for up to 12 months, or until the Legislature has completed its review. The Department intends to proceed with major substantive rulemaking, which will be provisionally adopted, and then submitted to the Legislature for its review.

Fiscal impact of rule:
This emergency rule is estimated to cost approximately $4,520,357 in SFY18 for rate increases, which includes $1,340,286 in state dollars and $2,908,850 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 42(8), 3173; 5 MRS §8054; PL 2017 ch. 284 §§ MMMMMMM-1, TTTT-1
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 19**, Home and Community Benefits for the Elderly and Adults with Disabilities
Filing number:	**2017-169**
Effective date:	11/1/2017
Type of rule:	Routine Technical
Emergency rule:	Yes

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

Basis Statement:
This emergency rule increases reimbursement rates to comply with PL 2017 ch. 284, (Ch. 284) part MMMMMMM-1, *An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Funds 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, 2018 and June 30, 2019.*

PL 2017 ch. 284 part MMMMMMM-1 requires the Department to amend its rules for reimbursement rates for home-based and community-based personal care and related services provided under the provisions of 10-144 CMR Ch. 101, *MaineCare Benefits Manual*, Ch. III Section 19, "Home and Community Benefits for the Elderly and Adults with Disabilities" and referenced in the February 1, 2016 report "*Rate Review for Personal Care and Related Services: Final Rate Models*" prepared for the Department by Burns & Associates, Inc. Further, part MMMMMMM-1 directs the Department that the increase in rates of reimbursement must be applied in equal proportion to all home-based and community-based personal care and related services referenced in the Burns & Associates, Inc. report using the funding provided for that purpose in Ch. 284. Ch. 284 provides funding to increase these rates. See part ZZZZZZ §ZZZZZZ-2.

PL 2017 ch. 284 part TTTT §TTTT-1 authorizes the Department to adopt rules increasing these rates on an emergency basis without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety or general welfare.

The Legislature did not appropriate additional funding for these rate increases beyond June 30, 2018; therefore, rates will revert to their current levels (pre-July 1, 2017) on July 1, 2018.

Fiscal impact of rule:
The Department anticipates that this rulemaking will cost approximately $3,146,974.00 in SFY 18, which includes $1,121,896 in state dollars and $2,025,078 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 42, 3173; PL 2017 ch. 284 §ZZZZZZ-9
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 45**, Hospital Services
Filing number: **2017-173**
Effective date: 11/14/2017
Type of rule: Routine Technical
Emergency rule: No

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

Basis Statement:
The Department is adopting changes in these rules, as set forth below. The Department is seeking and anticipates receiving approval from CMS for the rule changes. Pending CMS approval, the rule changes are effective November 14, 2017. The changes include the following:

Chapter II

a) An amendment to Section 45.05-4, "Restricted Services", clarifying that dental services which are medically necessary and done in a hospital setting are allowed.
b) A clarification in Section 45.05-6, "Restricted Physician Services Associated with Hospital Services", stating that all hospital-based providers are subject to the limitations in Ch. II Section 90, "Physician Services".
c) An update to language in Section 45.13, "Reporting Requirements for Acute Care Critical Access Hospitals and Private Psychiatric Hospitals", to reflect current reporting requirements; to provide additional guidance for updating 340B status changes when applicable; and include the requirement to have mechanisms in place to prevent duplicate discounts on drugs.
d) The addition in Section 45.04-4, "Supplies, Appliances and Equipment", of separate reimbursement for Long Acting Reversible Contraceptives (LARC) when the device is inserted during the postpartum inpatient hospital stay. The LARC will be covered in addition to the hospital Diagnosis-Related Group (DRG) payment to provide adequate reimbursement to providers for the device.
e) An update to Section 45.04-8, "Diabetes Self-Management Training Services", amending the language to accurately reflect the program's current title and model.
f) Correction and/or deletion of outdated references and minor language editing for clarification purposes.

Chapter III

a) Updates throughout the rule of the term "radiology" to "imaging" to reflect prevalent terminology usage.
b) Expansion of the definition of "Discharge" (§45.01-6) to include inpatient maintenance chemotherapy as an exception to the fourteen-day (14) readmission protocol due to the required planning for standards of care.
c) The addition to Section 45.02-5, "Reporting and Payment Requirements", of requirements for providers to submit mapping documents as part of the required documentation when filing the As-Filed Medicare Cost Report with the Department to aid the Department in payment methodology calculations.

d) Amend 45.02-5(E), "Payment Requirements in the Event of an Overpayment to the Hospital", to require payment of 100% (instead of 50%) of the hospital-discovered overpayment as determined by the As-filed Medicare Cost Report. This change is required by federal law. (42 USC §1320a-7k)

e) The addition of the Payment Window Rule (Sections 45.03-1(D)(1)(b) and 45.06-1(B)(2)) instructing hospitals, or entities wholly-owned or wholly-operated by a hospital, to bill the technical component of outpatient services provided within a 3-day (or 1-day) window preceding inpatient admission on the inpatient claim. The 1-day payment window applies to distinct rehabilitation, psychiatric, and substance abuse units. This provision is consistent with 42 CFR §412.2(c)(5) and 42 CFR §413.40(c)(2), and is currently in place by Medicare to treat certain technical components as operating costs of the inpatient hospital services.

f) Added a new provision, Section 45.03-1(D)(3), "Hospital Outpatient Provider-Based Departments" (PBDs). This provision adopts the Medicare Outpatient Prospective Payment System/Ambulatory Surgical Center (OPPS/ASC) rule, which essentially requires that, with the exception of dedicated emergency department services, services furnished in off-campus provider-based hospital outpatient departments that began billing under the OPPS on or after November 2, 2015, no longer be paid under the OPPS. With the exception of these "excepted locations," services provided in PBDs must use modifiers to identify non-excepted items and services. These non-excepted services are paid at a reduced MaineCare rate.

g) In Section 45.07, an increase in the amount of the supplemental pool is being made to comply with PL 2017 ch. 284 §ZZZZZZ-9. The Department is also adopting a restructuring of the supplemental pool methodology. The new methodology creates two supplemental pools; an inpatient supplemental pool and an outpatient supplemental pool. This change is to ensure that the annual supplemental payments can be issued to providers without exceeding the allowable upper payment limits as described in 42 CFR §447.272 (upper payment limits for inpatient services) and §447.321 (upper payment limits for outpatient services). The new methodology is based on a calculation of a hospital's relative share of inpatient or outpatient MaineCare payments (rather than a hospital's relative share of inpatient MaineCare discharges) since the new methodology is utilizing both an inpatient and an outpatient supplemental pool. The data used to calculate the relative share of a hospital's MaineCare payment is data from the state fiscal year 2014, which provides a consistent and more accurate basis with minimal risk of additional claim activity.

h) Updating the prospective interim payment (Section 45.04-2) methodology used to identify the estimated departmental annual obligation relating to both inpatient and outpatient services. This change provides for more accuracy in estimating prospective interim payments.

i) Addition of language in the Out-of-State Hospitals' reimbursement, Section 45.10, clarifying that reimbursement for laboratory and imaging outpatient service shall not exceed the 100% of Medicare reimbursement rate for the Maine area '99 locality, and that the hospitals are required to report and are subject to all applicable pricing modifiers. This change is to ensure payments do not exceed Medicare amounts.

j) Clarification of language in the "Clinical Laboratory and Imaging Services", Section 45.11, to more succinctly explain how services are covered and reimbursed in accordance with applicable sections of the *MaineCare Benefits Manual.*

k) Revision of language in Section 45.13-2 to reflect that the Final, rather than Interim, Cost Report will be used by the Department when calculating a Disproportionate Share Hospital (DSH) settlement to more accurately reflect inpatient utilization rates.

This is also consistent with the regulation which provides that hospitals within the category are assessed for DSH eligibility "after final settlement is complete for all hospitals in a category."

l) Addition of ICD-10 code H65.01, Acute serous otitis media, right ear, to Appendix B, which had been inadvertently left out during the last amendment to this rule.

m) Minor corrections and editing of language and formatting for clarification and organizational purposes.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $4,539,234 in SFY 2018, which includes $1,618,939 in state dollars and $2,920,295 in federal dollars, and $4,539,234 in SFY 2019, which includes $1,618,691 in state dollars and $2,920,543 in federal dollars. This is the net impact from the cost of the supplemental pool increase and the savings from the other reimbursement changes in this rulemaking.

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173; 5 MRS §8054; PL 2017 ch. 284 (128th Legis.) part MMMMMMM-1
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 12**, Allowances for Consumer-Directed Attendant Services
Filing number:	**2017-174**
Effective date:	11/14/2017
Type of rule:	Routine Technical
Emergency rule:	Yes

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

Basis Statement:
The Department of Health and Human Services ("the Department") adopts this emergency rule to increase the rates of reimbursement for home-based and community-based personal care services pursuant to PL 2017 ch. 284 part MMMMMMM-1, *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, 2018 and June 30, 2019.*

PL 2017 ch. 284 part MMMMMMM-1 requires the Department to amend its rules for reimbursement rates for home-based and community-based personal care and related services provided under the provisions of 10-144 CMR Ch. 101, *MaineCare Benefits Manual*, Ch. III Section 12, "Allowances for Consumer-Directed Attendant Services", and referenced in the February 1, 2016 report: "Rate Review for Personal Care and Related Services: Final Rate Models" prepared for the Department by Burns & Associates, Inc. Further, part MMMMMMM-1 directs the Department that the increase in rates of reimbursement must be applied in equal proportion to all home-based and community-based personal care and related services referenced in the Burns & Associates, Inc. report using funding provided for that purpose in Ch. 284. In addition to this Section 12 rule, the Department is also adopting increased rate changes, on an emergency basis, for Sections 19 & 96 rules. Ch. 284 provides funding to increase these rates. See part ZZZZZZ §ZZZZZZ-2.

PL 2017 ch. 284 part TTTT and §TTTT-1 authorize the Department to adopt rules increasing these rates on an emergency basis without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety, or general welfare.

This emergency rule increases the following rates:

* S5125, Attendant Care Services
* S5125 U2 UN, Attendant Care Services - 2 person
* S5125 U2 UP, Attendant Care Services - 3 person

Pursuant to 5 MRS §8054, this emergency rule may be effective for up to ninety (90) days. The Department intends to proceed with routine technical rulemaking to permanently adopt this rule.

The increased rates will be effective retroactive to July 1, 2017. The Department has determined that a retroactive increase to the beginning of the state fiscal year is appropriate, since the appropriation was intended for the entire fiscal year. The retroactive application comports with 22 MRS §42(8) which authorizes the Department to adopt rules with a retroactive application for a period not to exceed 8 calendar quarters and there is no adverse financial impact on any MaineCare member or provider.

The Legislature did not appropriate additional funding for these rate increases beyond June 30, 2108. Therefore, rates will revert to their current levels (Pre-July 1, 2017 rates) on July 1, 2018.

The Department is seeking, and anticipates receiving, approval from the Centers for Medicare and Medicaid Services (CMS) for these rate changes.

Fiscal impact of rule:

The Department expects this rulemaking will cost the Department approximately $407,024 in SFY 2018, which includes $145,104 in state dollars and $261,920 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 42(8), 3173; 5 MRS §8054; PL 2017 ch. 284 (128th Legis.) parts MMMMMMM-1, TTTT-1
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 96**, Private Duty Nursing and Personal Care Services
Filing number: **2017-176**
Effective date: 11/14/2017
Type of rule: Routine Technical
Emergency rule: Yes

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

Basis Statement:
The Department of Health and Human Services ("the Department") adopts these emergency rules to increase the rates of reimbursement and level of care limits for home-based and community-based personal care and other related services pursuant to PL 2017 ch. 284 part MMMMMMM-1, *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, 2018 and June 30, 2019.*

PL 2017 ch. 284 part MMMMMMM-1 requires the Department to amend its rules for reimbursement rates for home-based and community-based personal care and related services provided under the provisions of 10-144 CMR ch. 101, *MaineCare Benefits Manual*, ch. II & III section 96, "Private Duty Nursing and Personal Care Services", and referenced in the February 1, 2016 report: "Rate Review for Personal Care and Related Services: Final Rate Models" prepared for the Department by Burns & Associates, Inc. Further, part MMMMMMM-1 directs the Department that the increase in rates of reimbursement must be applied in equal proportion to all home-based and community-based personal care and related services referenced in the Burns & Associates, Inc. report using the funding provided for that purpose in Ch. 284. In addition to this Section 96 rule, the Department is also adopting increased rate changes on an emergency basis for Section 12, "Allowances for Consumer-Directed Attendant Services" and Section 19, "Home and Community Based Services for the Elderly and Adults with Disabilities" rules. Ch. 284 provides funding to increase these rates. See part ZZZZZZ §ZZZZZZ-2.

PL 2017 ch. 284 part TTTT §TTTT-1 authorizes the Department to adopt these rules increasing these rates and level of care caps on an emergency basis without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety, or general welfare.

This Ch. III emergency rule increases the following rates:
G0299 (0551)-RN Services
G0299 TD UN (0551)-RN Services–multiple patients (2)
G0299 TD UP (0551)-RN Services-multiple patients (3)
G0300 TE (0559)-LPN Services
G0300 TE UN (0559)-LPN Services–multiple patients (2)
G0300 TE UP (0559)-LPN Services–multiple patients (3)
T1000 TD-Independent RN
T1000 TD UN-Independent RN-multiple patients (2)
T1000 TD UP-Independent RN–multiple patients (3)

T1004 (0571)-Home Health Aide/Certified Nursing Assistant Services
T1004 UN (0571)-Home Health Aide/Certified Nursing Assistant Services-multiple patients (2)
T1004 UP (0571)-Home Health Aide/Certified Nursing Assistant Services–multiple patients (3)
T1019 (0589)-Personal Support Services
T1019-Personal Support Services (PCA Agencies only)
T1019 UN-Personal Support Services (PCA Agencies only) multiple patients (2)
T1019 UP-Personal Support Services (PCA Agencies only) multiple patients (3)
S5125 TF (0589)-PCA Supervisit
S5125 TF UN (0589)-PCA Supervisit-multiple patients (2)
S5125 TF UP (0589)-PCA Supervisit–multiple patients (3)
S5125 TF-PCA Supervisit (PCA Agencies only)
S5125 TF UN-PCA Supervist (PCA Agencies only) multiple patients (2)
S5125 TF UP-PCA Supervisit (PCA Agencies only) multiple patients (3)
This Chapter II emergency rule increases the following level of care limits:
Level I
Level II
Level III
Level IV
Level V
Level VIII
Level IX

Pursuant to 5 MRS §8054, these emergency rules may be effective for up to ninety (90) days. The Department intends to proceed with routine technical rulemaking to permanently adopt these rules.

The increased rates and level of care limits will be effective retroactive to July 1, 2017. The Department has determined that a retroactive increase to the beginning of the state fiscal year is appropriate, since the appropriation was intended for the entire fiscal year. The retroactive application comports with 22 MRS §42(8) which authorizes the Department to adopt rules with a retroactive application for a period not to exceed eight (8) calendar quarters and there is no adverse impact on any MaineCare member or provider.

The Legislature did not appropriate additional funding for these rate and level of care increases beyond June 30, 2018. Therefore, rates will revert back to their current levels (pre-July 1, 2017) on July 1, 2018.

Fiscal impact of rule:

The Department expects these rulemakings will cost approximately $2,826,925 in SFY 2018, which includes $1,007,574 in state dollars and $1,818,721 in federal dollars.

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(8), 3173; PL 2015 ch. 481 part C
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 2**, Adult Family Care Services
Filing number:	**2017-201**
Effective date:	12/23/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule complies with PL 2015 ch. 481 part C, *An Act To Provide Funding to the Maine Budget Stabilization Fund and To Make Additional Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds To Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2016 and June 30, 2017.* PL 2015 ch. 481 part C directs the Department to set the inflation amount adjustment in accordance with the United States Department of Labor, Bureau of Labor Statistics' Consumer Price Index-Medical Care Services Index for the fiscal year ending June 30, 2018.

This rule seeks to implement a three and a half (3.5) percent cost-of-living rate increase for adult family care services for the fiscal year ending June 30, 2018. Ch. III Section 2, "Adult Family Care Services", increases the unadjusted price from $46.79 to $48.43 and the resource-adjusted prices increased accordingly. In addition, Ch. III Section 2, "Adult Family Care Services", increases the resource-adjusted prices accordingly to adult family care homes that satisfy the definition of remote island facilities from $48.43 to $55.69.

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services (CMS) for this change. Pending CMS approval, the three and a half (3.5) percent cost-of-living rate increase will be effective retroactive to July 1, 2017. A Change in Reimbursement Methodology Notice was posted June 28, 2017 on the Office of MaineCare Services' website.

Basis Statement:

The Department of Health and Human Services (Department) adopts this rule change to 10-144 CMR ch. 101, *MaineCare Benefits Manual (MBM)*, Ch. III Section 2, "Adult Family Care Services", to effectuate a three and a half (3.5) percent cost-of-living rate increase for the fiscal year ending June 30, 2018. The proposed changes were filed with the Secretary of State's Office on August 8, 2017, and the Department now adopts them permanently.

The cost-of-living rate increase is made pursuant to PL 2015 ch. 481 part C, *An Act To Provide Funding to the Maine Budget Stabilization Fund and To Make Additional Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and To Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2016 and June 30, 2017* (effective April 16, 2016). This legislation required the Department to make two cost-of-living rate increases for Section 2, "Adult Family Care Services", the first being a four percent (4%) increase for the fiscal year ending June 30, 2017 which the Department already accomplished through rulemaking, and the second being a cost-of-living increase set in accordance with the United States Department of Labor, Bureau of Labor Statistics Consumer Price Index (CPI) medical care services index, which the Department seeks to achieve through this current rulemaking. The Department has adjusted the Section 2, "Adult Family Care Services" rates by three and a half (3.5) percent by utilizing CPI data measuring annual inflation as of December 2016, and

by utilizing the more specified inflation factor for "nursing home and adult day services," a subcategory of "medical care services." This approach is consistent with other MBM rules that rely on changes in the CPI indices and also ensures parity in reimbursement to providers of both Section 2, "Adult Family Care Services", and Section 97, "Private Non-Medical Institution Services".

The Department is seeking and anticipates receiving approval from the federal Centers for Medicare and Medicaid Services (CMS) for this change. Pending CMS approval, the three and a half (3.5) percent cost-of-living rate increase will be effective retroactive to July 1, 2017. This retroactive rate increase is consistent with the underlying legislation requiring the rate increase for SFY 2018, and is permitted under 22 MRS §42(8) since the rate increase is a benefit to both providers and members. A Change in Reimbursement Methodology Notice was posted on June 28, 2017 on the Office of MaineCare Services' website pursuant to 42 CFR §447.205.

The Department estimates that the General Fund impact for this change is $378,144 in SFY 2018 and estimates federal expenditures of $243,449.

This rulemaking will not impose costs on municipal or county governments, or on small businesses employing twenty or fewer employees.

Fiscal impact of rule:

The Department does not anticipate that this rulemaking will result in any additional cost to the Department or other Offices.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 21**, Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder
Filing number:	**2017-203**
Effective date:	12/24/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The rule change will expand the number of members who are eligible as Priority 1 on the waitlist for Ch. II Section 21, "Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder". The language addresses waitlist eligibility for members whose primary caregiver has reached the age of 65 or has a terminal illness and is having difficulty providing the necessary supports to the member, where the member has no other responsible or willing caregiver. The rule specifies criteria whereby those members may qualify as Priority 1 based on the member's medical condition or behavioral need; high risk for institutionalization; history of hospitalizations; and imminent danger to the member or others. A provision is also included specifying that Priority 1 is granted only when the member's needs cannot be met absent provision of services under this comprehensive waiver program. Therefore, Priority 1 on the Section 21 waitlist would be available only for members who specifically need these services; members whose needs could be met with the less intense services provided under the State Plan or Section 29 would be referred to those services. This provision does not preclude the member waiting at another Priority level on the Section 21 waitlist. This rulemaking is required in order to establish clear criteria for prioritization of members, beyond what currently exists. While the Department may offer funded openings to Priority 2 members in the event Priority 1 is exhausted, the Department wishes to establish clear, codified criteria to guide access, now and in the future.

The rule also expands the number of members who are eligible as Priority 2. The language expands eligibility to members whose primary caregiver has reached the age of sixty and is having difficulty providing the necessary supports to the member in the family home. A definition of primary caregiver is also included. This will supersede language in the current rule that applies this criterion only to the member's parents. The provision expands the Priority 2 provision to members being cared for by extended family members, and whose parents are deceased, missing, or unable to care for the member.

The rule requires an annual review of the priority assignments of members, in order to remain on the Section 21 waitlist.

Basis Statement:

The Department is adopting changes to Ch. II Section 21, "Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder", that expand the number of members who qualify for Priority 1 status on the waitlist for funded openings. The expansion of the Priority 1 waitlist applies to members who do not yet meet the need for adult protective services (APS), but: (1) whose primary caregiver has reached the age of 65 or has a terminal illness, and is having difficulty providing the necessary supports to the member; (2) who have no other responsible or willing caregiver; and (3) who satisfy at least one and are at risk of another additional risk factors. In conjunction with these changes, the

Department is also adopting a definition of “Primary Caregiver” to address the reality that members may be receiving care from their parents or from extended family members when their parents are deceased, missing, or unable to care for the member.

The expanded criteria for Priority 1 status in the rule adoption reflects public input on the rule proposal and accords with the Department’s intent to make services available to vulnerable members for whom APS involvement may be avoided. For similar reasons, the Department is declining to adopt a provision in the rule proposal that Priority 1 status is granted only when the member’s needs cannot be met absent provision of services under the State Plan or the Section 29 waiver program. The Department’s goal is to expand the provision of services, not limit them.

In addition to establishing clear criteria for members with Priority 1 status, this rule adoption also clarifies that Priority 2 status is granted to members who do not yet satisfy Priority 1 status, but who nonetheless remain at risk for abuse, neglect, or exploitation absent the provision of services. Consistent with changes in Priority 1, the Department has modified the examples of members who may qualify for Priority 2 status by including members with a “Primary Caregiver” who has reached the age of sixty and is having difficulty providing the necessary supports. The Department believes this clarification will help expand members placed on the Priority 2 waitlist.

The Department is also adopting changes to this rule to ensure that the waitlist for Section 21 services accurately reflects members’ continued interest in services by requiring an annual confirmation. In response to comments, the adopted rule includes a more detailed process for this confirmation than articulated in the rule proposal. This process balances the Department’s efforts to maintain an updated waitlist while minimizing any burden to the member in completing the confirmation or risk to the member of unwanted removal from the waitlist. For similar reasons, the Department also modified language for the final rule adoption to remove the annual review of the priority assignments of members; this will be optional for the member and the member can request the Department’s evaluation of priority status at any time.

The Department is in the process of seeking and anticipates receiving approval from the Centers for Medicare & Medicaid Services for these changes.

Fiscal impact of rule:

The Department anticipates that this rulemaking will result in expenditure of up to $7.5 million from the State General Fund, with total impact of $25.3 million, including Federal Medicaid match.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services – Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; PL 2017 ch. 284
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 29**, Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder
Filing number:	**2017-209**
Effective date:	12/28/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The rule implements the direction of the Legislature in PL 2017 ch. 284.

Basis Statement:

The Department adopted amendments to this routine technical rule to make the following changes to Ch. II Section 29: (1) an increase in the combined services cap from $23,985 to $52,425; (2) the addition of Shared Living (Foster Care, Adult) as an available covered service to members; (3) the removal of Work Support services from and the addition of Shared Living services to the combined services cap; (4) an increase in the Respite Services cap from $1,000.00 to $1,100.00; and (5) the removal of the weekly cap for Home Support-Remote Support services. These final adopted amendments implement changes that were made to Section 29 on an emergency basis effective October 1, 2017, and which are effective for ninety (90) days.

These rule changes were triggered by PL 2017, ch. 284, *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, 2018 and June 30, 2019* (the "Act"). Part A, Sec. A-34 of the Act provides funding to increase the annual cap for combined services provided under the *MaineCare Benefits Manual*, Ch. II Section 29.07-2, from $23,985 to $47,500. The Department understands that the justification for increasing this cap to $47,500 under the Act was to enable Section 29 members to have the option to apply for residential services under this waiver program. Therefore, this rulemaking also added Shared Living (Foster Care, Adult) services to the covered benefits under Section 29. To implement these services, the Department has added definitions of Administrative Oversight Agency, Shared Living, and Shared Living Provider in Section 29.02 (Definitions), as well as provider requirements for Shared Living (Foster Care, Adult) in Section 29.10-4. These added definitions and provider requirements are consistent with Ch. II Section 21, "Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder", which also offers Shared Living services. The Department has also included Shared Living in Appendix IV, which describes additional requirements for providers related to organizational structure, personnel management, operational policies and procedures, financial management, and environment, consistent with other Section 29 providers. The Department adopted concurrent, emergency amendments effective October 1, 2017 for up to twelve months to add Shared Living services rates to Ch. III, Section 29, a major substantive rule, so that eligible members could begin receiving these services. All of these changes are integral to fully implementing the new Shared Living service under Section 29 of the *MaineCare Benefits Manual.*

The Department also understands that the $47,500 cap increase authorized under the Act not only accounted for the addition of Shared Living services, but also accounted for the removal of Work Support services. Removing Work Support services from the cap, and including Shared Living services within the cap, as described in Section 29.07-2 (Limits), will benefit members who may be eligible for residential services. Additionally, this change positively impacts members by allowing members who receive Work Support services to engage in these services with fewer restrictions.

The Department has also increased the annual cap from the $47,500 in the legislation to $52,425. The Act directed the Department to increase the Shared Living services rates under Ch. III Section 21 for SFY2018 (effective July 1, 2017 through June 30, 2018). See Part MMMMMMM, Sec. MMMMMMM-2(1). The Department has calculated the annual cost of the newly-added Section 29 Shared Living service, at the increased rate for this service in Section 21, and has determined that the cap should be set at $52,425 (instead of $47,500) to fully benefit Section 29 members who may now be eligible for this service.

The addition of Shared Living services to Ch. II and the reconfiguration of which services are included under the combined services cap at Section 29.07-2 was adopted through emergency rulemaking, effective October 1, 2017. However, the new cap of $52,425 for combined services under Section 29.07-2 is retroactive to July 1, 2017. The reason for having the cap retroactive is two-fold. First, the Legislature increased the cap in the Act (to $47,500) based on fiscal year calculations – i.e., starting on July 1, 2017. Second, the Act directed the Department to increase rates of reimbursement for procedure codes in Ch. III (effective July 1, 2017 to June 30, 2018), which the Department did through concurrent emergency major substantive rulemaking. See Part MMMMMMM, Sec. MMMMMMM-2(2). Increasing the cap retroactive to July 1, 2017, will allow for the increased reimbursement rates to providers without harming members. 22 MRS §42(8).

For similar reasons, the Department increased the annual cap on Respite Services from $1,000.00 to $1,100.00 to accommodate the rate increase for this service for SFY2018 funded by the Act that was another subject of the emergency amendments to Ch. III, effective October 1, 2017 and also retroactive to July 1, 2017, as permitted under 22 MRS §42(8).

The final change in this final adopted rule is the removal of the weekly cap on Home Support-Remote Support services under Section 29.05-7. Home Support services (both Remote and ¼ Hour) are currently included and will continue to be included under the combined services cap in Section 29.07-2. Removing the weekly hourly cap accommodates the increase in the annual cap to $52,425 so as to avoid harmful effects on members. 5 MRS §8054.

Overall, the Legislature's authorization of an increased combined service cap and the related and necessary changes described above will enable Section 29 members to have increased flexibility in receiving services with fewer restrictions. The Department is seeking and anticipates approval from the Centers for Medicare and Medicaid Services for these changes.

Fiscal impact of rule:

The Department anticipates that this rulemaking, to increase the cap in Section 29, will cost approximately $19,770,210 in SFY18, which includes $5,861,867 in state dollars and $12,722,130 in federal dollars, and $26,360,280 in SFY19, which includes $7,818,459 in state dollars and $16,960,204 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Maine Center for Disease Control and Prevention**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS ch. 558-C; 22 MRS §42; 22-A MRS §205
Chapter number/title: **Ch. 122**, Maine Medical Use of Marijuana Program Rule
Filing number: **2017-168**
Effective date: 2/1/2018
Type of rule: Routine Technical
Emergency rule: No

Principal reason or purpose for rule:

These rule changes implement revisions enacted by the 126th and 127th Legislature and streamline the rule by removing language that duplicates statute. Additionally, this rulemaking seeks to provide details to clarify processes employed by the Department to operationalize the statute (e.g., ensure compliance and written certification issuance), include new terms and definitions, remove outdated language, address inconsistencies, revise construction and wording to improve and clarify the rule.

Basis statement:

The adoption of this rule amends 10-144 CMR ch. 122 and implements changes enacted by the 126th and the 127th Legislature. These changes clarify processes employed by the Department to operationalize statutory requirements specific to regulating the cultivation, dispensing and administration of marijuana for medical use, including the issuance of registry identification cards, dispensary certificates of registration and written certifications. Changes also remove duplicative and outdated language, address inconsistencies, revise construction and wording for clarity. The effective date for this adopted rule is 90 days from the date the Department files the rule with the Secretary of State.

The adopted rule provides a more thorough explanation of the Department's administrative procedures, including compliance monitoring and enforcement, and establishes standards for compliance. Amendments include added terms and definitions, revised language around the acquisition and lawful disposal of prepared marijuana for medical use, and requirements for inventory interruption, reporting and record-keeping for caregivers and dispensaries, patient designations and cultivation by family and household members. Changes clarify that remote healthcare services are not prohibited, that a food establishment license is required prior to the preparation of consumable goods containing marijuana, and identifies more clearly what constitutes a collective. The adopted rule includes registry identification card application submission and approval criteria and adjusted fees to reflect current practice.

This adopted rule includes the following changes to implement legislative changes: (1) allow primary caregivers to possess and administer a non-smokable form of a minor qualifying patient's medical marijuana on school grounds and on school buses; (2) allow certified nurse practitioners to issue written certifications for the medical use of marijuana; (3) allow registered primary caregivers to have one employee; (4) allow qualifying patients to use allowable forms of medical marijuana as residents in an inpatient hospice or nursing facility; and (5) allow primary caregivers to dispose of excess prepared marijuana by transferring it to a registered dispensary, a qualifying patient or another primary caregiver. In Section 8, the adopted rule changes will provide for reduced applicant fees and subsequent reductions to fees outside of rulemaking.

Additionally, this rule adds clarification to program operations that implement statutory requirements. The adopted changes include the following: (1) in Section 10, the procedural details for the Department compliance assurance activities; (2) revisions to the Department's

processes for registration applications, patient designations, petitions to add a qualifying debilitating condition, the transfer of excess marijuana, and issuance of written certifications by a medical provider directly to qualifying patients and, for minor qualifying patients, without delay in the absence of a list of consulting physicians; (3) revised policy requirements for facilities that are subject to other regulating sources; and (4) additional reporting requirements for dispensary inventory and patient designation.

The Department has determined that the effective date for this rule is 90 days following adoption, which will allow regulated parties to make necessary adjustments, in order to comply with requirements. This additional time will allow for the Department to update forms, procedures and practices to effectively regulate the Maine Medical Marijuana Program based on adopted changes. The Department has determined that the additional regulatory requirements are necessary for compliance purposes and for future program planning. These additional requirements outweigh the minimal administrative burdens that caregivers and dispensaries may experience. The Department anticipates an increase in workload for staff, especially due to reporting requirements, which will be managed by the Department's current capacity.

Fiscal impact of rule:

No fiscal impact is anticipated on DHHS or municipalities. The Maine Medical Use of Marijuana Program, a self-funded program, provides funds to address costs associated with the Program, including the secure online portal that is part of the new written certification process. Indirectly, there may be potential impact on the MMMP fund as applicants realize reduced fees, and on the Department of Public Safety (legality of possession) and Maine Revenue Services (taxation of marijuana).

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Maine Center for Disease Control and Prevention**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 1541-1550; PL 2015 ch. 318
Chapter number/title:	**Ch. 249**, Smoking in Public Places Rule
Filing number:	**2017-204**
Effective date:	12/27/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

These rule changes are intended to ensure a safer and healthier environment for Maine residents and visitors, because it is clarifying prohibitions and exceptions for smoking in public places. Some of the changes occurred as a result of recent statutory updates to 22 MRS ch. 262, specifically §1541 Definitions section which added a definition for "electronic smoking device" and amended the "smoking" definition.

Basis statement / concise summary:

These changes to the Smoking in Public Places Rule delete unnecessary definitions ("club," "member" and "not open to the public" for this rule, add a new definition for "electronic smoking device," amend the definition of "smoking," reorganize Section 2 (smoking prohibitions and limitations), add a subsection to Section 3, and correct citations throughout the rule. The Department amended the final rule based on comments, by restoring the definition of "invited guest", changing the term "environmental smoke" to "secondhand smoke", and clarifying the definition of "ventilation" to state that ventilation technologies do not adequately protect people from secondhand smoke. Additional changes to the rule, based on public comment, include clarifying Section 2(A)(5) regarding smoking prohibitions in a beach or playground, 2(B)(1)(a) to correctly name private residence smoking prohibition, when family child care providers or baby sitters are caring for children, and Section 2(C)(5), regarding the allowance of smoking in lodging places.

Defining "electronic smoking device" and amending the definition of "smoking" align with statutory changes in 22 MRS §§ 1541(1-A) and 1541(6). Eliminating three definitions in Section 1 resolves any duplication in the Department's *Rules Relating to Smoking in the Workplace,* at 10-144 CMR Ch. 250. Section 2 mostly reorganizes specific prohibitions and limitations, in order to better clarify where smoking is prohibited and where it is *not* prohibited, so that the distinction is clearer, rather than the current line between smoking indoors or smoking outdoors, which did not clearly explain the prohibitions. Section 4 adds a section that was moved from Section 2(A)(5), in order to more clearly explain Section 4, now titled *Posting Signs, Notifications*, rather than just *Posting Signs*. All changes in response to comments further assure that the rule more clearly establishes protection of public health by protecting them from secondhand smoke when occupying public places in Maine.

These changes further restrict the use of electronic smoking devices in Maine and also reduce others' exposure to electronic smoking devices. In addition, the public will more clearly understand where smoking is allowed and where it is prohibited. This clarity will further protect Maine residents and visitors from secondhand smoke when they are in public.

Fiscal impact of rule:

None anticipated.

Agency name: Department of Health and Human Services, **Maine Center for Disease Control and Prevention**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 8944, 8943
Chapter number/title: **Ch. 280**, Maine Birth Defects Program Rule
Filing number: **2017-194**
Effective date: 12/13/2017
Type of rule: Routine Technical
Emergency rule: No

Principal reason or purpose for rule:

These changes update the reportable birth defects listing and clarify wording for referral to the Part C Agency (Child Development Services) in Maine.

Basis statement / concise summary:

This rule establishes the responsibilities of hospital administrators, physicians and other health care providers, including licensed midwives, for reporting birth defects in infants and fetuses; provides the confidentiality requirements of the Maine Birth Defects Program; describes the nature of contact between the Maine Birth Defects Program and families of children with birth defects; and describes parental objection to birth defect reporting or participation in the birth defect registry. This amendment updates the reportable birth defects listing and clarifies wording for referral to the Part C Agency (Child Development Services) in Maine. Changes include minor technical changes and reformatting.

Fiscal impact of rule:

No fiscal impact anticipated

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3104; 7 CFR §§ 272.1, 272.6, 272.8(a), 273.4, 273.7, 273.11, 273.18, 273.24
Chapter number/title:	**Ch. 301**, Food Supplement Program Certification Manual, **FS Rule #195A**: Disqualified Members, Work Registration, and Child Support Orders
Filing number:	**2017-100**
Effective date:	7/3/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The reasons for the rule changes are as indicated, by section, below. In addition, the rule includes formatting changes and removal of outdated references.

Section FS-1 – Changes update non-discrimination civil rights policy according to federal requirements and to add Employment and Training to the list of limitations of disclosure of participation in the program.

Section FS-111-5 – Work Registration. Requirement for members to register with the Department of Labor, Maine Job Bank to increase exposure to available employment and assist members in finding employment. Updates to the Work Requirements policy to clarify and correct the current manual to ensure a clear description of member expectations, consequences, and good cause.

Section FS-111-7 – Federally required "good cause" exemptions for times that ABAWDS are temporarily unable to meet work requirements based on circumstances outside of his/her control. The current manual does not have a good cause provision that covers ABAWD work requirements, even though federal rules require such an exemption.

Section 111-8 – Cooperation with Child Support Orders to require non-custodial parents who have an existing child support order to be in compliance with the terms of the order to qualify for FS benefits. This requirement is to compel compliance with support orders.

Section 444-4 – Disqualified Members. The changes associated with this rule are to bring the state into compliance with federal requirements for treatment of income, assets, and deductions for several disqualified household members; to change the benefit calculation for households that include ineligible aliens, to more accurately reflect those household's economic circumstances; and to account for policy changes this rule makes in other sections.

Section FS-555-7 - The Budget Worksheet changes correct typos.

Section FS-666-5 – This rule changes are in order to better align the Transitional Food Assistance (TFA) rule with the its purpose of providing transitional food assistance to former TANF recipients who have gone to work. To do so, it removes as triggers of TFA eligibility those TANF-disqualifying events that are not related to getting work.

Section FS-666-8 – Certified Household. Changes to this section are to remove the old policy referencing simplified reporting based on the new policy of change reporting.

Section FS-999 – Definitions. The definition for "fleeing felon" is added to comply with federal requirements from the 2014 Farm Bill.

Basis statement:

This rule adopts numerous changes to the *Food Supplement Manual*. There are changes to the treatment of income, resources, and deductions of disqualified household members and new policies that require mandatory work registrants to register with the Department of Labor,

require compliance with child support orders, establish good cause for ABAWD noncompliance, and limit eligibility for the transitional food assistance program. Other changes include adding the federally required non-discrimination statement, administrative updates, and removal of outdated references. The Department added the federal definition of "fleeing felon" to the definitions section. The adopted rule pages include changes that are unrelated to policy, such as page formatting and updating references to other programs and citations of law.

Fiscal impact of rule:
The benefit impact on members is unknown. The impact to the state will be changes to ACES and staff training, but the cost should be minimal because both have already been included in the yearly budget.

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3104; 5 MRS §8054
Chapter number/title:	**Ch. 301**, Food Supplement Program Certification Manual, Food Supplement Program Manual, **FS Rule 292E** (COLA SUA FFY 2018): **FS-000-1**, Basis of Issuance: **FS 333-1**, Asset Eligibility Standards; **FS-444-8**, Households with Special Circumstances: **FS-555-5** and **FS-555-6**, Income and Deductions
Filing number:	**2017-145**
Effective date:	10/1/2017
Type of rule:	Routine Technical
Emergency rule:	Yes

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

Basis statement:
Federal rules 7 CFR §273.9 and 7 CFR §273.8(b)(1) require that income allowances, standard and excess shelter standards, minimum and maximum benefit limits, and standard heating/cooling, non-heat, phone allowances, as well as resource standards be updated each year, effective October 1, 2017. USDA Food and Nutrition Services (FNS) provides updated income allowances, standard and excess shelter, minimum and maximum benefit standards, and resource standards to states and territories, annually. FNS also annually approves SUA allowances determined by states that are based on changes in the Consumer Price Index for fuel and utilities, for June 2016 and June 2017.

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

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Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3104; PL ch. 284 sec, NNNNNNN-8; 7 CFR §§ 273.9(d), 273.8(B)(1), 273.10; "Supplemental Nutrition Assistance Program: Eligibility, Certification, and Employment and Training Provisions of the Food, Conservation and Energy Act of 2008"
Chapter number/title:	**Ch. 301**, Food Supplement Program (Maine Food Supplement Program Certification Manual), **FS Rule #202A** (COLA SUA FFY 2018 and Food Act 2008) – multiple sections
Filing number:	**2017-197**
Effective date:	12/19/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
A rule change is necessary to remain in compliance with 7 CFR §§ 273.9(d), 273.8(b)(1), and 273.10, which require annual review and adjustment to federal income, standard deduction, resource standards, minimum and maximum benefit levels, as well as annual adjustment to standard utility allowances (SUA). Additionally, it is necessary to comply with recent changes in state and federal law, as identified in the "statutory authority" section, above.

Basis statement:
Sections: FS-000-1 Basis of Issuance; FS-222-4 Interview Process; FS-333-1 and FS-333-2 Asset Eligibility Standards; FS-444-4 and FS-444-8 Households with Special Circumstances; FS-555-5 and FS-555-6 Income and Deductions; FS-666-6 Certified Households; FS-888-1 and FS-888-5 Income and Eligibility Verification System
This rule adopts the following:

- The annual update for standard heating/cooling and non-heat/cooling utility allowances, and phone allowance
- An increase in the Asset Limit for Households that include elderly/disabled individuals
- Updates the annual Cost of Living Allowances, which will cause Food Supplement benefits to decrease for some households.

Emergency Rule #202E implemented these values, effective as of October 1, 2017.
Additionally, this rule adopts the following:

- Federal provisions from the *Food, Conservation and Energy Act of 2008* which includes the provision that dependent care deductions may apply to children under 18 and individuals of any age who are incapacitated, adds retirement accounts as asset exclusions, specifies that reporting requirements for income changes are related to receipt of the first payments associated with income changes, adds clarification on receipt of unclear information, and adds the provision of telephone interviews to be used in lieu of face-to-face interviews in most situations.
- Achieving a Better Life Experience (ABLE) education savings accounts as excluded assets (as determined by USDA guidance, dated April 4, 2016) – this provision is from the *Tax Increase Prevention Act of 2014* and is consistent with Section 5(d)(10) of the *Food and Nutrition Act of 2008*.

- Provision from PL ch. 284 sec. NNNNNNN-8, 22 MRS §3104 sub-§§ 15 and 16, which determines certain felons convicted of violent crimes and sexual assault to be ineligible for Food Supplement benefits.
- Removes outdated text associated with rounding up $1, $3, and $5 allotments to $2, $4, and $6 respectively; the need to round up is associated with FS coupons, which have been discontinued and replaced by EBT cards. A small number of households that are receiving benefits in these increments may see a $1 decrease in benefits.
- Removes references to related TANF and MaineCare rules from all affected rule pages.
- Removes duplicate statements and rule pages.
- Formatting of pages to the correct font size, margins and adjusted affected page numbers.

Change from the proposed rule: FS-444-4 page 1, Disqualified Members, item F, the 6th bullet: the phrase, "is ineligible to receive food assistance through the food supplement program" was removed as it was redundant and confusing in context.

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

Fiscal impact of rule:

None. Because they are federally funded benefits, changes to benefit levels, which will be minor, will not impact the Department.

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 3762(3)A, 3763(11)-(12), 3769-A
Chapter number/title:	**Ch. 331**, Maine Public Assistance Manual (TANF), **TANF Rule #106A (EBT)**: **Ch. VI**, Administrative Procedures, Electronic Benefit Transfer System
Filing number:	**2017-006**
Effective date:	2/1/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule implements the statutory changes restricting the purchase of certain items using TANF benefits through the electronic benefit (EBT) system, and creates penalties for violations of the rule. The policy change will enhance and ensure program integrity that TANF funds are used for living necessities and not for non-essential and discretionary purchases such as tobacco/liquor, gambling and firearms. The penalties for knowingly violating the rule include issuing an overpayment in the amount used for the prohibited purchase, and the possibility of an increased period of disqualification from the TANF benefits, depending on the number of offenses. The statutory changes enacted in April 2016 were made via PL 484 and codified as 22 MRS §3763(11)-(12).

Basis statement:

This rule implements the statutory changes restricting the purchase of certain items using TANF benefits through the electronic benefit (EBT) system and creating penalties for violation of the rule. The penalties for knowingly violating the rule include establishing an overpayment in the amount used for the prohibited purchase, and the possibility of an increased period of disqualification from TANF benefits depending on the number of offenses. The statutory changes enacted in April 2016 via PL 484 are codified at 22 MRS §3763(11)-(12).

The rule serves to clarify potentially ambiguous terms in the statute, including ammunition and vacation and travel services. After notice and comment, the Department modified its definition of vacation and travel services to make clear that routine transportation and emergency travel are not restricted. The proposed version allowed for that type of interpretation, which was not the intent of the statute.

This rule also includes formatting changes throughout the chapter to improve overall appearance, readability, and consistency of terminology. For example, the term “individual” is changed to “recipient,” and “assistance unit” is changed to “assistance group.” Cross references to the *Food Supplement Manual* have been removed to ensure that obsolete policy is not referenced by mistake.

Fiscal impact of rule:

None known.

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3762(3)(A); 45 CFR 400.301
Chapter number/title:	**Ch. 331**, Maine Public Assistance Manual (TANF), **TANF Rule #108A** (Repeal of RCA): Table of Contents, Introduction; **Ch. VI**, Types and Methods of Payments; Overpayments; Electronic Benefits Transfer (EBT) System; **Ch. VII**, Refugee Cash Assistance Program (RCA)
Filing number:	**2017-146**
Effective date:	9/20/2017
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This rule is promulgated to effectuate the termination of administration of the Refugee Cash Assistance program (RCA). The State of Maine, through the Department, will no longer administer the federally funded Refugee Resettlement Program, which includes RCA. Federal regulations allow a state to repeal the choice to administer the program, and notice of revocation was given to the Federal Government in November 2016. A third party agency has taken over administration of the RCA program.

Fiscal impact of rule:
The impact will be a reduction of revenue in the amount of $168,000 and a reduction of expenditures by the same amount. There will be minor technology changes associated with removing eligibility rules from the Department's integrated eligibility system, the costs for which are already factored into the yearly budget.
No known impact to small businesses or municipalities.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	5 MRS §8054; 22 MRS §§ 42(1), 3762, sub-§3, B, 3769-C, sub-§1, 3782-A(6), 3785 sub-§8, g 3790(7); PL 2017 ch. 256 (22 MRS §§ 3762 sub-§3, 3785); PL 2017 ch. 290 (22 MRS §§ 3762 sub-§3); PL 2017 ch. 284 pt. NNNNNNN §§ 9, 11, 14; pt. TTTT §1
Chapter number/title:	**Ch. 331**, Maine Public Assistance Manual (TANF), **TANF Rule #109E** (128th Legislative Changes): **Introduction**; **Ch. I**, Eligibility Process; **Ch. II**, Eligibility Requirements (Non-Financial); **Ch. IV**, Budgeting Process; **Ch. V**, Post TANF Benefits; **Ch. VI**, Administrative Procedures; **Ch. VIII**, Emergency Assistance; **Ch. XI**, TANF Economic Support for Working Families; **Appendices**, **Charts**, **Budget Sheets**
Filing number:	**2017-151**
Effective date:	9/19/2017
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

To conform to policy changes made in statute in the 128th legislative session, this rule makes several changes to the *Maine Public Assistance Manual* (TANF). The changes include increases in the maximum payment amounts for the TANF basic benefit and the Special Need Housing Allowance payment. Eligibility changes include the removal of the deprivation requirement for TANF and changes to the ratio of housing costs to income for the Special Need Housing Allowance payment. The description of good cause reasons for failure to cooperate with the TANF employment and training program, ASPIRE, has been revised and specific examples have been deleted and replaced with a reference to the good cause section of the TANF-ASPIRE program. A TANF Work Incentive Payment has been created to pay a once in a lifetime $400 payment to recipients who go to work and keep their job for four consecutive months.

Basis statement:

This rule makes several changes to the *Maine Public Assistance Manual* (TANF). The changes include increases in the maximum payment amounts for the TANF basic benefit and the Special Need Housing Allowance payment. Eligibility changes include the removal of the deprivation requirement for TANF and changes to the ratio of housing costs to income for the Special Need Housing Allowance payment. The description of good cause reasons for failure to cooperate with the TANF employment and training program, ASPIRE, has been revised and specific examples have been deleted and replaced with a reference to the good cause section of the TANF-ASP[RE program. A TANF Work Incentive Payment has been created to pay a once in a lifetime $400 payment to recipients who go to work and keep their job for four consecutive months.

With the removal of the deprivation requirement, TANF eligibility will no longer require that a child be deprived of the care and support of a parent. Families, where both parents are parenting, will now be eligible for TANF provided all other eligibility requirements are met. This rule will increase the maximum payment by 20% and will create a potential annual increase based on the COLA. In addition, the maximum payment for Special Needs Housing Allowance will increase from $200 to $300. Also, eligibility will expand to include those families whose shelter costs are 50% or more of their income for the Special Needs Housing allowance group. This rule will provide a work incentive payment of $400 to TANF recipients employed for at

least 30 hours per week and maintain their employment for 4 consecutive months. This payment is available to a recipient once in their lifetime. The purpose is to incentivize employment with a goal of encouraging recipients to remain employed. Finally, the rule shortens and modifies the list of good cause reasons for noncompliance with ASPIRE work participation requirements.

Fiscal impact of rule:

The provisions removing the deprivation requirement and changing the special needs housing allowance are expected to increase TANF block grant expenditures by $4,324,002 in fiscal year 2017-2018 and $5,765,337 in fiscal year 2018-2019, according to the chapter fiscal note for LD 336.

There is insufficient data to estimate the cost of providing a one-time $400 incentive payment to certain TANF recipients, but the TANF block grant will cover the expense.

Increasing the TANF basic benefit amount is expected to increase TANF block grant expenditures by $5,191,636 in fiscal year 2017-2018 and by $5,198,645 in fiscal year 2018-2019, according to allocations in the budget.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2017 to December 31, 2017
Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	5 MRS §8054; 22 MRS §§ 42(1), 3762, sub-§3, B, 3769-C, sub-§1, 3782-A(6), 3785 sub-§8, g 3790(7); PL 2017 ch. 256 (22 MRS §§ 3762 sub-§3, 3785); PL 2017 ch. 290 (22 MRS §§ 3762 sub-§3); PL 2017 ch. 284 pt. NNNNNNN §§ 9, 11, 14
Chapter number/title:	**Ch. 331**, Maine Public Assistance Manual (TANF), **TANF Rule #109A** (128th Legislative Changes): **Introduction**; **Ch. I**, Eligibility Process; **Ch. II**, Eligibility Requirements (Non-Financial); **Ch. III**, Eligibility Requirements (Financial); **Ch. IV**, Budgeting Process; **Ch. V**, Post TANF Benefits; **Ch. VI**, Administrative Procedures; **Ch. VIII**, Emergency Assistance; **Ch. XI**, TANF Economic Support for Working Families; **Appendices**, **Charts**, **Budget Sheets**
Filing number:	**2017-198**
Effective date:	12/19/2017
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
To conform to policy changes made in statute in the 128th legislative session, this rule makes several changes to the *Maine Public Assistance Manual* (TANF). The changes include increases in the maximum payment amounts for the TANF basic benefit and the Special Need Housing Allowance payment. Eligibility changes include the removal of the deprivation requirement for TANF and changes to the ratio of housing costs to income for the Special Need Housing Allowance payment. The description of good cause reasons for failure to cooperate with the TANF employment and training program, ASPIRE, has been revised and specific examples have been deleted and replaced with a reference to the good cause section of the TANF-ASPIRE program. A TANF Work Incentive Payment has been created to pay a once in a lifetime $400 payment to recipients who go to work and keep their job for four consecutive months. To comply with statutory requirements, these rule changes were adopted on an emergency basis in a separate filing in September.

In addition to the changes noted above, the rules makes several other changes. These changes could not be included in the emergency rule and thus were added to the proposed rule only. These additional changes to the Introduction and Ch. I, II, III, IV, VI, VII, and the Appendices were done to reformat and re-organize chapters, and to reword and make some ambiguously drafted provisions more clear. Whereas the proposed rule would amend several chapters, it would also completely repeal and replace Ch. II and XI. The removal of the deprivation requirement from Ch. II by emergency rule required several sections to be reformatted, and so the Department addressed the entire chapter to make it more intuitively organized and more precisely drafted. Ch. XI is replaced for better organization of its provisions. Except where expressly stated below, the repeal and replacement of those chapters does not include any policy change that is not already part of the emergency rulemaking. Ch. VII is being repealed altogether and not replaced, with its provisions being redistributed to more appropriate chapters in the manual. This also does not represent a change in policy. A detailed description of the non-emergency rule changes follows, by chapter:

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Introduction. References to the Refugee Cash Assistance Program, which is no longer administered by DHHS were removed, as well as a reference to Ch. VII Non-Citizens, which is being repealed.

Ch. I Application Process. Removed reference to internal processes that are not rule, reworded for clarity, changed "Bureau" to "Office," removed guidance on eligibility for Medicaid and inserted reference to MaineCare Program Manual. Removed Exception for attending TANF Orientation for applicants who had attended an Orientation in the previous 90 days. This assures participants become engaged with ASPIRE as early as possible.

Ch. II Eligibility Requirements (non-financial). Changes include a general clean-up of Ch. II. Revised format, deleted "GENERAL RULE" as a heading. Deleted "NOTES" and incorporated information into the relevant subsection, removed Food Supplement Program cross-references, removed references to internal process, reworded for clarity/consistency, corrected spelling, grammar errors and removed rules that belong in a different chapter. The deprivation section of this chapter was removed by emergency rule. Maintenance of a home has been clearly defined and rules have been revised to better identify which parent in shared custody situations is eligible to apply for TANF for that child. The rule defines when a minor parent/pregnant minor is considered to be maintaining a home for the child. Removed the requirement that if a minor parent is parenting her child, she must apply as a caretaker relative. Removed the rule that allowed a TANF family whose child(ren) had been taken into custody by OCFS to retain their TANF grant in limited circumstances. This rule was not used and did not meet the needs of the parent as continued TANF benefits did not include MaineCare for the adult. An exemption from ASPIRE participation for an SSDI recipient was added. This was previously excluded in error. Relocated eligibility requirements for the state-funded non-citizen cash assistance program from Ch. VII to Ch. II to consolidate the eligibility requirements for the state funded program into the chapter that address the non-financial rules for other applicants/recipients.

Additional changes to Ch. II following proposal - Age. An ASPIRE requirement related to school attendance was placed in this section in error. It has been removed. Several formatting errors were corrected and words substituted to clarify intent. Several references to deprivation were missed in the proposed rule and were removed in the adopted rule. The entire section on Assignment of Rights to Medical Payments was removed as it no longer applies to TANF.

Ch. III Eligibility Requirements (financial). Moved the rules regarding treatment of sponsor income and assets for certain non-citizens to this chapter to consolidate all financial eligible requirements into one chapter.

Additional changes to Ch. III following proposal - A reference to deprivation was removed. This was missed in the proposed rule. Formatting changes were made to p. 26, Sponsor Deeming.

Ch. IV Budgeting Process. The section explaining the Special Need Housing Allowance was rewritten for clarity. There were no substantial changes other than those made in the emergency rule.

Changes to Ch. V – Post TANF Benefits. Removal of Deprivation requirement – References to the deprivation requirement for TANF eligibility have been removed from this chapter on pages 1 and 6.

Additional changes to Ch. V following proposal - Several additional references to deprivation were identified and have been removed. Reference to the Transitional MaineCare Program was removed. This program is not relevant to TANF and is included in the MaineCare manual.

Ch. VI Administrative Procedures. Moved the rule for the collection of overpayments by sponsors of aliens to this chapter from Ch. VII-Non-Citizens to consolidate all rules relating

to overpayments in one chapter. Removed a chart showing the maximum allowed recoupment of overpayments. This is explained in the chapter and the chart was duplicative.

Ch. VII Non-Citizens. This chapter is repealed. Non-financial eligibility requirements for the state-funded cash assistance program for certain non-citizens has been relocated to Ch. II-Eligibility Requirements (non-financial) and the financial eligibility requirements for sponsors of aliens to Ch. III- Eligibility Requirements (financial). Rules regarding the recoupment of overpayments from sponsors of aliens has been moved to Ch. VI-Administrative Procedures.

Ch. VIII Emergency Assistance. The reverence to the deprivation requirement on page 4 has been removed.

Ch. XI TANF Economic Support for Working Families. This chapter is repealed and replaced for improved organization and readability.

Appendix. A statement to the chart on page 2 has been added that states the TANF benefit may increase annually. The benefit level charts were updated to reflect the increase to the maximum benefit and Standard of Need.

Additional changes to the Appendix - Change to the wording explaining the annual benefit increase as a result of public comments. Errors were found in the benefit level charts when calculating the benefit increase. These changes have been corrected.

This rule may have an indirect impact on municipalities or small businesses, to the extent that TANF families have more spending power.

Fiscal impact of rule:

The provisions removing the deprivation requirement and changing the special needs housing allowance are expected to increase TANF block grant expenditures by $4,324,002 in fiscal year 2017-2018 and $5,765,337 in fiscal year 2018-2019, according to the chapter fiscal note for LD 336.

There is insufficient data to estimate the cost of providing a one-time $400 incentive payment to certain TANF recipients, but the TANF block grant will cover the expense.

Increasing the TANF basic benefit amount is expected to increase TANF block grant expenditures by $5,191,636 in fiscal year 2017-2018 and by $5,198,645 in fiscal year 2018-2019, according to allocations in the budget.

The additional changes will have no associated costs.

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Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3173, 3274, 3763(11); 42 USCS §1382g
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manual, **Rule #285A**: **Part 11**, State Supplement; **Section 10**, EBT Method of Payment; Permissible Use
Filing number:	**2017-097**
Effective date:	7/1/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

To ensure the consistency of allowable purchases for cash benefits expended using an Electronic Benefit Transfer, (EBT) card, regardless of the source of the cash benefits (i.e., State Supplement benefits, Temporary Assistance for Needy Families (TANF) benefits).

Basis statement:

This rule change aligns the purchases allowed to be made with State Supplement benefits placed on an Electronic Benefits Transfer (EBT) card with the purchases allowed to be made with Temporary Assistance for Needy Families (TANF) benefits that are placed on EBT cards. Restrictions on the use of State Supplement benefits on an EBT card will be the same as the restrictions described in 22 MRS §3763(11) for TANF benefits on EBT cards.

The Department made changes to the rule after the comment period. A commenter raised the issue that the Department does not have authority to restrict State Supplement benefits without specific legislation restricting the use of those benefits. Under 22 MRS §42(1), the Department has broad authority to promulgate rules for the administration of the programs it provides. The purpose of this rule is to provide consistency in the use of the EBT card with MRS §3763(11), which restricts the use of TANF benefits for certain purchases. Although 22 MRS §3763(11) did not address State Supplement benefits, such benefits are often issued on the same EBT card as TANF. The Department relies on retailers to refuse sale of restricted items and services when an EBT card is the payment method, and this rule change is necessary to allow retailers to do so.

However, to resolve the commenter’s concerns and with the advice of the Office of the Attorney General, the Department made clear in the final rule that the restriction only applies to State Supplement benefits that have been issued on an EBT card, and not to such benefits that a recipient has elected to receive via direct deposit or check. Additionally, on advice of the AG, the Department will make a bona fide effort to notify State Supplement recipients and new applicants of this change and of their option to receive State Supplement benefits by direct deposit, for which the restrictions described in 22 MRS §3763(11) will not apply.

In response to another comment, the final rule also makes clear that these restrictions do not apply to federal SSI benefits.

Fiscal impact of rule:

No fiscal impact is anticipated.

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1); 45 CFR 400.301
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manual, **Rule #286A**: **Part 3**, Eligibility Groups Requirements; **Section 3.1**, Refugees / Asylees
Filing number:	**2017-136**
Effective date:	9/3/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

(See Basis Statement)

Basis statement:

This rule is promulgated to effectuate the termination of administration of the Refugee Medical Assistance (RMA) program, which is a repeal of part 3 §3.1, "Refugees/ Asylees". The State of Maine, through the Department, will no longer administer the federally funded Refugee Resettlement Program (RRP, of which RMA is part). Federal regulations allow a state to repeal the choice to administer the program and notice of revocation was given to federal government in November 2016.

Fiscal impact of rule:

There will be minor technology changes associated with removing eligibility rules from the Department's integrated eligibility system, the costs for which are already factored into the yearly budget.

Agency name: Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §42(1); 42 USC §§ 664, 666; 36 MRS §5276-A
Chapter number/title: **Ch. 351**, Maine Child Support Enforcement Manual:
Ch. 2, Definitions;
Ch. 16, Federal Income Tax Refund Offset;
Ch. 17, State Income Tax Refund Offset;
Ch. 19, Periodic Review and Modification of Support Orders
Filing number: **2017-048**
Effective date: 3/14/2017
Type of rule: Routine Technical
Emergency rule: No

Principal reason or purpose for rule:
These chapters in the current Manual contain errors or contain portions which are obsolete.

Basis statement:
This rulemaking corrects and updates chapters in the current *Maine Child Support Enforcement Manual* which contain errors, and portions of which are obsolete. The changes are minor, and are as follows:

Ch. 16 and **17** – repairs references to specific paragraphs in other Manual chapters which were edited in a previous rulemaking, resolves incorrect references to "welfare" vs. "non-welfare" cases, and simplifies each chapter for easier readability.
Ch. 19 is being abbreviated to contain only those provisions required by federal law, to prevent confusion with similar provisions in Ch. 12.
Ch. 2 – the definitions of "Arrears," "Overdue Support" and "Past-due Support" were added to differentiate the terms and lend clarity to edited provisions of Ch. 16 and 17.
The changes in this rulemaking are to improve the integrity of the Manual, and to avoid confusion over these passages in the future.

Fiscal impact of rule:
None.

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Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1)
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 2**, Definitions
Filing number:	**2017-119**
Effective date:	8/9/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The *Flexibility, Efficiency and Modernization in Child Support Enforcement Programs* final rule was published by the Federal government on December 20, 2016. Several provisions in the new regulation necessitate changes to the *Maine Child Support Enforcement Manual* ("Manual") in order to remain in compliance with the State Plan for Child Support Enforcement. This rulemaking brings the Manual up to date with these changes.

Ch. 2 - Definitions: This rulemaking will update the definition of "Medical Support" to include public assistance, and adds a definition for "Payee," which includes the designation of a conservator as required by the Federal Regulation.

Basis statement:

The *Flexibility, Efficiency and Modernization in Child Support Enforcement Programs* final rule was published by the Federal government on December 20, 2016. Several provisions in the new regulation necessitate changes to the *Maine Child Support Enforcement Manual* ("Manual") in order to remain in compliance with the State Plan for Child Support Enforcement. This rulemaking brings the Manual up to date with these changes.

Fiscal impact of rule:

None.

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Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1); 81 Fed. Ref. 93492
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 5**, Limitation of Debt; Bar Against Collection **Ch. 12**, Proceedings to Amend or Set Aside Administrative Decisions; Proceedings to Appeal Agency Action **Ch. 13**, Disposition of Proceedings by Settlement, Stipulation or Consent Decision; Waivers **Ch. 25**, Securing and Enforcing Medical Support
Filing number:	**2017-120**
Effective date:	8/9/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
The *Flexibility, Efficiency and Modernization in Child Support Enforcement Programs* final rule was published by the Federal government on December 20, 2016. Several provisions in the new regulation necessitate changes to the *Maine Child Support Enforcement Manual* ("Manual") in order to remain in compliance with the State Plan for Child Support Enforcement. This rulemaking brings the Manual up to date with these changes.

Basis statement:
The *Flexibility, Efficiency and Modernization in Child Support Enforcement Programs* final rule was published by the Federal government on December 20, 2016. Several provisions in the new regulation necessitate changes to the *Maine Child Support Enforcement Manual* ("Manual") in order to remain in compliance with the State Plan for Child Support Enforcement. This rulemaking brings the Manual up to date with these changes.

Ch. 5 - Limitation of Debt; Bar Against Collection (19-A MRS §2301); SSI: This change is to add a requirement that any funds incorrectly seized from an obligor's account must be returned within 5 days of discovery of the error.

Ch. 12 - Proceedings to Amend or Set Aside Administrative Decisions; Proceedings to Appeal Agency Action: This changes references to "written documents" to "in a record", reflecting a change in terminology at the Federal level, to account for the advent of electronic communications.

Ch. 13 - Disposition of Proceedings by Settlement, Stipulation or Consent Decision; Waivers: This change adds a Notice requirement for incarcerated obligors and the custodial parents to whom they owe a child support debt, to allow temporary suspension of the debt while the obligor is incarcerated, as required by the new Federal regulation.

Ch. 25 - Securing and Enforcing Medical Support: Changes terminology from "health insurance" to "health care coverage," and institutes the new requirement that health care coverage cost be considered reasonable when the total cost is (in the case of Maine) 6% of the obligor's gross income (rather than just considering the cost of adding a child or children to the plan).

Fiscal impact of rule:
None.

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Agency name: Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRS §§ 42(1), 3762 *et seq.*, 3781-A *et seq.*, 3782-A(6), 42 USC §§ 601, 602, 607, 609 *(as amended)*
Chapter number/title: **Ch. 607**, ASPIRE-TANF Program Rules, **ASPIRE Policy #23A** (Clarify and Correct)
Filing number: **2017-009**
Effective date: 2/6/2017
Type of rule: Routine Technical
Emergency rule: No

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

Basis statement:
This rule clarifies and corrects the ASPIRE-TANF Program Rules. Overall, changes encourage work and training participation by removing discretionary language that hinders success. For example, the rule strengthens job search requirements to include a more robust expectation of job search activities and follow up, which the Department or its designee will monitor. Participants in paid job training will now be required to accept employment offers of minimum wage and up, which will in turn open up paid job training opportunities for other unemployed participants. Additional changes include, but are not limited to, removing obsolete law and outdated procedures; adopting good cause exemptions in TANF manual; updating notification practices; removing references to postal mail; and clearly defining procedures for seeking payment of support services.

The revisions to the manual outline the Department's expectations for participants, Department staff, and case managers in administering the ASPIRE-TANF program. Participants can expect a less ambiguous procedure and will have a clearer understanding of expectations and responsibilities for themselves and of the Department. The Department removed references to ambiguous program requirements that do not effectively assist participants in the transition from reliance on public benefits to self-sufficiency. The rule also eliminates specific references to who must perform certain administration functions to allow the Department more flexibility.

There were several changes to the final rule made as a result of public comment and the advice of the Assistant Attorney General. In summary, the changes to the final rule are as follows;

- **Definitions (Section 1-1)** - Clarification of the definition of "appropriate childcare" to include that a participant chooses the provider for child care and background checks are required under 22 MRS §§ 8301-A and 8302-A.
- **ASPIRE participation exemptions (Section 3-1)** - Added ASPIRE-participation exemptions based on state and federal law. The additions include clarification of the only custodial parent or caretaker relative with a child under the age of 1 year, excluding those individuals under 20 years of age who have not completed high school; a recipient who is a child in the assistance unit, which includes minor parents; and an applicant or recipient parent caring for a disabled family member living in the household.
- **On the Job Training (OJT) (Section 13-2. A.5.)** – Added a phrase to state that the standards are based on those required by state law.

- **Promptness of Payment of Emergency Support Services (14-8, 9 IV)** – Clarification of procedure for request and receipt of emergency support services to include electronic method of payment (and not just via check).
- **Parents as Scholars (PaS) eligibility and participation requirements** – Two proposed changes to the eligibility criteria and participation requirements for the Parents as Scholars (PaS) program will not be adopted because 22 MRS §3790(3) requires that the current rule remain in place. A parent meeting certain assessment results must be accepted to the program even if space is limited (as opposed to the proposed "may be accepted") and a participant is required to have an average of twenty participation hours a week, instead of the proposed "minimum" average of twenty hours a week.

This rule may have an impact on municipalities and small businesses by adding new or returning workers to the workforce with updated skills, training, and education.

Fiscal impact of rule:

None anticipated.

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Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	5 MRS §8054; 22 MRS §§ 42(1), 3762 *et seq.*, 3782-A(6), 3785, 3790(7); PL 2017 ch. 284 part NNNNNNN §§ 13 *thru* 16, part TTTT §1
Chapter number/title:	**Ch. 607**, ASPIRE-TANF Program Rules, **ASPIRE Policy #24E**: Budget-related Changes for Good Cause and Parents as Scholars Program
Filing number:	**2017-152**
Effective date:	9/19/2017
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:
The state budget, PL 2017 ch. 284, which was enacted on July 4, 2017, included several TANF-ASPIRE measures that became effective July 1. This rulemaking incorporates those legislative changes into the policy manual.

Basis statement:
This rule is being processed as an emergency measure pursuant to PL 2017, ch. 284 part TTTT Sec 1, which explicitly grants the Department authority to do so.

The rule makes two changes to ASPIRE policy, based on state statutory changes from the 128th legislative session. First, mirroring such changes to state law, it shortens and modifies the list of good cause reasons for noncompliance with ASPIRE work participation requirements. Second, it adds a requirement to the Parents as Scholars Program (PaS) that the education path must be for the pursuit of a degree or certification with at least an average job outlook. The rule expands on the statutory directive by specifying that in deciding whether an educational path meets that criterion, the Department will rely on publicly available job-market data and analysis from Maine Department of Labor. It also specifies that the "Commissioner's designee," referred to in statute to approve education plans on a case by case basis that fail to meet that job-outlook criteria will be an ASPIRE Program Manager.

This rule may have an indirect impact on municipalities and small businesses by adding new or returning workers to the workforce with updated skills, training, and education.

Fiscal impact of rule:
No fiscal impact is anticipated.

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	5 MRS §8054; 22 MRS §§ 42(1), 3762 *et seq.*, 3782-A(6), 3785, 3790(7); PL 2017 ch. 284 part NNNNNNN §§ 13 *thru* 16, part TTTT §1
Chapter number/title:	**Ch. 607**, ASPIRE-TANF Program Rules, **ASPIRE Policy #24E**: Budget-related Changes for Good Cause and Parents as Scholars Program
Filing number:	**2017-199**
Effective date:	12/19/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The state budget, PL 2017 ch. 284, which was enacted on July 4, 2017, included several TANF-ASPIRE measures that became effective July 1. This rulemaking incorporates those legislative changes into the policy manual. It also includes a clarification that a single parent with a child under 6 can meet the work requirements with 20 hours a week of work activities.

Basis statement:

This rule makes changes to ASPIRE policy, based on state statutory changes from the 128th legislative session.

First, mirroring such changes to state law, it shortens and modifies the list of good cause reasons for noncompliance with ASPIRE work participation requirements.

Second, it adds a requirement to the Parents as Scholars Program (PaS) that the education path must be for the pursuit of a degree or certification with at least an average job outlook. The rule expands on the statutory directive by specifying that in deciding whether an educational path meets that criterion, the Department will rely on publicly available job-market data and analysis from Maine Department of Labor. In response to comments, the Department added objective criteria for petitioning the Commissioner or his or her designee when an occupation was not well-defined by established criteria.

Unrelated to legislative changes, the rulemaking adds detail to the manual to clarify – consistent with longstanding practice and applicable law – that a single parent with a child under 6 can meet the work requirements with 20 hours a week of work activities.

This rule may have an indirect impact on municipalities and small businesses by adding new or returning workers to the workforce with updated skills, training, and education.

Fiscal impact of rule:

No fiscal impact is anticipated.

Agency name: Department of Health and Human Services, **Maine Center for Disease Control and Prevention**
Umbrella-Unit: **10-146**
Statutory authority: 22 MRS §42; 19-A MRS §660
Chapter number/title: **Ch. 14**, Late-filed Certificate for Application of Marriage Rule
Filing number: **2017-196**
Effective date: 12/20/2017
Type of rule: Routine Technical
Emergency rule: No

Principal reason or purpose for rule:
The rule permits eligible applicants to apply for a late-filed certificate of marriage in the event that their marriage certificate was never filed in a municipal office and/or DHHS Office of Data, Research and Vital Statistics.

Basis statement:
The Department of Health and Human Services establishes the *Late-Filed Application for Certificate of Marriage Rule* to implement provisions within 19-A MRS §660 regarding the delayed issuance of a certificate of marriage to eligible applicants.

This rule describes the application process, the minimum marriage facts to be established, along with the requirements for documentary evidence necessary for the Department to determine eligibility of an applicant requesting a certificate of marriage that occurred more than one year previously and was never filed in a municipal office and/or with the Maine Center for Disease Control and Prevention, Data, Research and Vital Records.

Fiscal impact of rule:
None anticipated.

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Agency name:	Department of Health and Human Services, **Office of Child and Family Services**
Umbrella-Unit:	**10-148**
Statutory authority:	22 MRS §§ 42, 4008(7), 5601-5610; PL 2015 c. 501
Chapter number/title:	**Ch. 201**, Procedures for the Abuse or Neglect Substantiation Process, for Appeals for Persons Substantiated as Perpetrators of Abuse or Neglect of Children, and Appeals for Denial of Access to Confidential Records
Filing number:	**2017-072**
Effective date:	5/15/2017
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:
To be in compliance with changes in 22 MRS §4008(7) and PL 2015 c. 501.

Basis statement:
These rules are being adopted to ensure that individuals who are substantiated for child abuse or neglect and are facing collateral consequences have the opportunity to appeal that substantiation. In addition, these rules are adopted to ensure that individuals being denied access to their child's record have the ability to appeal the Department's denial of said records.

Fiscal impact of rule:
No fiscal impact anticipated.

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Prepared by the Secretary of State pursuant to 5 MRS §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of Substance Abuse and Mental Health Services**
Umbrella-Unit:	**14-118**
Statutory authority:	22 MRS §7252; PL 2015 ch. 488
Chapter number/title:	**Ch. 11**, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications
Filing number:	**2017-126**
Effective date:	9/16/2017
Type of rule:	Routine Technical *and* Major Substantive
Emergency rule:	No

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

Basis statement:
In an effort to combat the Maine opioid epidemic, the Maine Legislature enacted PL 2015 ch. 488 (*An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program* (PMP) (Title 22, Chapter 1603) to include prescriber limits on opioid medication prescribing, effective January 1, 2017. PL 2015 ch. 488 included veterinarians in the definition of prescribers, required electronic prescribing and required prescribers and dispensers to check the Prescription Monitoring Program (PMP) database. Ch. 488 required the Department to establish reasonable exceptions to prescriber limits, and ordered the Department to include prescribers in the process of drafting appropriate exceptions and in the drafting of draft rules. With the guidance of the State of Maine Health Officer, Dr. Christopher Pezzullo, the Department convened a PMP Stakeholder Group that included the Maine Medical Association, the Maine Hospital Association, the Maine Physician Assistant Association, the Maine Nurse Practitioners Association, the Maine Veterinary Medical Association, the Maine Pharmacy Association, and the Maine Osteopathic Association. This group met at least once monthly, starting in June, 2016. The Maine Legislature mandated a January 1, 2017 effective date for the limits on opiate prescribing, but also mandated that the Department confer with the PMP Stakeholder Group, which continued to meet and confer until early December, 2016.

In order to comply with the Legislature's mandates, including the January 1, 2017 effective date, the Department adopted an Emergency Major Substantive/Routine Technical rule, with an effective date of January 1, 2017.

Pursuant to 5 MRS §8073, emergency major substantive rule provisions may be effective for up to twelve months or until the Legislature has completed review of the rules. Pursuant to 5 MRS §8054, the emergency routine technical rule provisions are effective for up to 90 days.

The Department engaged in rulemaking to make permanent the emergency routine technical rule provisions of the January 1, 2017 emergency rule.

That rulemaking also provisionally adopted the emergency major substantive rule provisions of the January 1, 2017 emergency rule. This rulemaking was submitted to the Maine Legislature for its review.

The routine technical provisions of the rule, which were made finally effective by the emergency rulemaking, are **bolded** in the rule text, and also marked "routine technical" in the left hand margin.

The Department held a public hearing on February 16, 2017. Additionally, 89 written comments were submitted during the comment period.

This finally adopted rulemaking makes the following changes:

(1) Adds definitions (including definitions for “administer,” “acute pain,” “Benzodiazepine,” “chronic pain,” “hospital,” “opioid medication,” “serious illness,” and also includes veterinarians in the definition of “prescribers”;
(2) Adds general requirements for prescribing and dispensing, including the requirement that all prescribers must acquire DEA numbers and include the DEA number on each prescription, and includes exemption codes to match the exemptions from the opioid limitations set forth in the rule;
(3) Requires prescribers, dispensers, and veterinarians to register as PMP data requesters;
(4) Requires prescribers to include a designation on the prescription as to whether the prescription is for the treatment of acute or chronic pain.
(5) Indicates the statutory requirement regarding electronic prescriptions and waivers of such;
(6) Requires that dispensers report information to the PMP by electronic means and indicates the statutory waivers of such;
(7) Requires prescribers, dispensers and veterinarians to check the PMP system;
(8) Indicates the statutory limits on opioid medication prescribing;
(9) Defines exemptions to limits on opioid medication prescribing;
(10) Authorizes the Department to provide and receive PMP data from another state or Canadian province that has entered into an agreement with the Department for such sharing;
(11) Establishes civil violations for prescribers and dispensers;
(12) Establishes administrative sanctions for prescribers and dispensers;
(13) Establishes standards for immunity from liability for disclosure of information;
(14) Establishes standards for immunity from liability for a pharmacists which might result from dispensing medication in excess of the limit, if such dispensing was done in accordance with a prescription issued by a practitioner; and
(15) Authorizes the Department to verify and audit prescriber and dispenser compliance with the rules.

Additionally, as a result of public comments and further review by the Department and the Office of the Attorney General, there were additional technical changes, formatting updates, and changes to language for clarity. The Summary of Public Comments and Department Responses document identifies any changes that were made to the final rule.

The Maine State Legislature conducted a major substantive review of this rulemaking following the provisional adoption on March 31, 2017, and made additional changes to the rule, per Resolves 2017 Ch. 16. Those changes include:

(1) In Section 4, subsection A, paragraph 4, subparagraph b, division (i) in the portion of the rule that is a routine technical rule, Exemption Code A for active and aftercare cancer treatment, the 6-month limit for aftercare cancer treatment post remission has been removed;
(2) In Section 4, subsection A, paragraph 4, subparagraph b, division (i) in the portion of the rule that is a routine technical rule, Exemption Code H has been amended to provide that if an individual is prescribed a 2nd opioid after proving unable to tolerate a first opioid, the individual is not required to return the initial prescription to a pharmacy for collection prior to dispensation of the 2nd prescription. Language has also been added requiring dispensers to provide patients with guidance on proper disposal of the first opioid prescription;
(3) In Section 4, subsection B of the rule, a new paragraph 3 has been added to allow for dispensers to provide an early refill of a prescription to an individual before the

refill date if, in the judgment of the dispenser, the early refill does not represent a pattern of early refill requests by the individual;

(4) In Section 4, subsection B of the rule, a new paragraph 4 has been added to allow for dispensers to contact prescribers by telephone to verify and document information about prescriptions;

(5) In Section 4, subsection B of the rule, a new paragraph 5 has been added to establish a process for a dispenser who receives a prescription for an opioid medication from an out-of-state prescriber that does not comply with Department rules. The section allows the dispenser to fill the prescription if the dispenser records an oral confirmation with the validity of the prescription from the out-of-state prescriber and documents any missing information such as diagnosis code, exemption code, and acute or chronic pain notation and the dispenser makes a reasonable effort to determine that the oral confirmation came from the prescriber or prescriber's agent, which may include a telephone call to the prescriber's telephone number listed in a telephone directory or other directory; and

(6) In Section 5, subsection C, paragraph 1, subparagraph n of the rule, the requirement for dispensers to provide information to the Prescription Monitoring Program on the exemption code and ICD-10 code has been delayed until July 1, 2018 and a provision was added to authorize a waiver after that date from the Department for dispensers who are unable with good cause to comply with the requirement.

Finally, the Maine Legislature enacted PL 2017 ch. 213, on June 16, 2017. This legislation amended sections of Maine Statute that govern these Ch. 11 rules. Those changes include: (Please note that because there are section in the rule that reference statute, no changes to the rule text were made in those instances, however the underlying statutory language changes will impact operation of this rule.)

(1) Amending the statutory definitions of palliative care, serious illness, and dispenser.

(2) Removing the statutory requirement that dispensers must submit Prescription Monitoring Program (PMP) information to the Department regarding controlled substances that are dispensed by a hospital emergency department for use during a period of forty-eight (48) hours or less.

(3) Amending the statute to clarify that the requirement to check the PMP does not apply for surgical procedures.

(4) Adding language to the statute clarifying that directly ordering or administering an opioid or benzodiazepine in connection with surgical procedures is exempt from the one hundred (100) morphine milligram equivalents limitation.

(5) Adding to the list of statutorily allowed individuals who can access PMP information.

(6) Removing the statutory requirement that dispensers must notify the PMP program if the dispenser has reason to believe the prescription is fraudulent or duplicative, while maintaining the requirement that the dispenser contact the prescriber.

(7) Clarifying that an opioid medication that, according to federal Food and Drug Administration labeling, is to be dispensed only in a stock bottle with a supply exceeding 7 days, may be dispensed in accordance with the stock supply, so long as the amount dispensed does not exceed a 14 day supply.

As a result of final legal review by the Office of the Attorney General the necessary corrections and additions to the rule were made to be consistent with Maine law as explained above.

These finally adopted major substantive rule changes will be effective 30 days after the rule is filed with the Secretary of State, or at a later date as specified by the Department.

Fiscal impact of rule:
The fiscal impact of this rulemaking could not be determined.