Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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(7)(H), 3173; 42 CFR §§ 431.108, 455.434, 447.56, 431.224, 431.12; 42 CFR Parts 1001 and 1003; *Bipartisan Budget Act of 2018*, Sec. 53102, PL No. 115-123
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. I Section 1**, General Administrative Policies and Procedures
Filing number:	**2022-101**
Effective date:	5/29/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This final rule makes various complex changes, including changes to comply with federal regulations, make updates to reflect current practices, clarify ambiguous and vague sections of policy, and increase the MaineCare Program Integrity Unit's ability to safeguard against fraud, waste, and abuse. The changes in this final rule are listed below.

The previous rule did not address retroactive enrollment for providers other than federally qualified health centers, rural health centers, and Indian health centers. This final rule broadens Sec. 1.03-1(F) to allow for retroactive enrollment for other eligible providers, subject to review and approval by the Department of Health and Human Services (the Department) in accordance with 42 CFR §431.108. A request for retroactive enrollment is subject to the Department's review and discretion and is not a guarantee of claim payment or prior authorization. The Department may grant retroactive enrollment back to providers' Medicare enrollment effective dates but will not grant a retroactive enrollment date that is more than 365 days prior to the date of providers' MaineCare application submissions.

To comply with 42 CFR §455.434, the final rule adds a section on fingerprint-based criminal background checks (FCBC), mandating that providers or applicants whose categorical risk level meets the federal definition of high risk must consent to a FCBC. The new Section 1.03-1(J) includes relevant criteria for provider termination or denial of enrollment and outlines which providers and suppliers have high categorical risk.

The current "rounding rule" in Sec. 1.03-8(J)) allows providers to round up a unit of service if the unit of service delivered is equal to or greater than fifty percent. The current version of this rule will remain in effect until December 31, 2022. To encourage better alignment between the amount of covered, medically necessary services delivered and billed, the final rule makes changes so when a partial unit of service is delivered, the provider may either bill for the partial unit of service provided or round up if eighty percent of the unit of service was delivered. The rule retains the ability to round up if fifty percent of the unit of service was delivered, but only when unforeseen circumstances prevent a provider from delivering a whole unit of service. As a result of comments, these changes will be effective January 1, 2023 to allow providers time to change their billing systems in order to comply with the changes.

The final rule also adds misuse of the "rounding rule" to examples of conduct that could constitute fraud.

This final rule expands the definition of non-covered services to include administrative tasks (Sec. 1.06-4(B)(8)), including verification of MaineCare eligibility, updating member contact information, scheduling of appointments, tasks performed for the provider's own administrative purposes, and similar activities. The final rule includes an exception explaining that certain administrative tasks may be covered if addressed in an appropriate section of the *MaineCare Benefits Manual*. This provision strengthens the Office of MaineCare Services (OMS) Program Integrity Unit's enforcement of the prohibition on billing for administrative tasks, which already exists per current MaineCare rules.

To comply with section 53102 of the *Bipartisan Budget Act of 2018*, .L No. 115-123, the final rule removes Section 1.07-3(F)(1) to reflect that the Department will no longer pay and then seek reimbursement, commonly known as pay and chase, from liable third parties for prenatal services.

In Section 1.19-1(C)(2), the final rule clarifies that the Department may reimburse providers for covered services rendered during the period following a notice of termination up to the effective date of termination, instead of for a period not to exceed thirty days after the date of receipt of the notice of termination. This change was made because providers may not be reimbursed after termination of a provider agreement. The final rule also adds that providers must follow the provisions of their provider agreements and the MaineCare Benefits Manual to continue to receive reimbursement for services.

To enable the OMS Program Integrity Unit to implement appropriate sanctions, the final rule allows the Department, in its discretion, to consider a request from a provider to impose a lower percentage than 20% recoupment. The rulemaking adds a list of factors in Sec. 1.20-2 the Department may consider when assessing this type of provider request.

In order to correct provider deficiencies, the final rule adds a sanction permitting the Department to require providers to submit a detailed plan of correction for review and approval. This will allow the OMS Program Integrity Unit to ensure providers comply with MaineCare rules and monitor providers who experience rapid growth or changes. Providers that grow rapidly may not have adequate infrastructure to maintain quality of service provision. The final rule allows providers to satisfy the plan of correction requirement by submitting a plan that was approved by another Division within the Department if it addresses identical violations. The additional sanctions added to Section 1.20-2 provide that the Department may:

- Impose a suspension of referrals to a provider;
- Deny or pend any enrollment applications submitted by a provider;
- Limit the number of service locations a provider may enroll; and
- Limit the number of MaineCare members the provider may serve.

The final rule clarifies the provisions in Sec. 1.21 regarding reinstatement following termination or exclusion to make the provisions easier to understand and apply.

The final rule adds Section 1.24-4 on expedited member appeals that includes: (1) the procedure to request an expedited appeal, (2) criteria for the Division of Administrative Hearings (DAH) to consider when deciding whether to grant requests, (3) deadlines for when the Department must take final agency action, and (4) other requirements, per 42 CFR § 431.224. The final rule amends Section 1.24-3 to provide that MaineCare Member Services shall send all expedited hearing requests to a hearings representative and the DAH within 24 hours of identifying the request.

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The MaineCare Advisory Committee (MAC) developed structural and process changes to improve its function and efficiency. The final rule implements these changes in Section 1.25. The MAC changes include, among others, increasing MAC membership and including at least two Medicaid beneficiaries as members.
The final rule also makes the following changes:

- Defines the ownership and control relationships that are subject to an offset and/or recoupment;
- Establishes a 10-day timeframe for when providers need to update OMS of changes to their National Provider Identifier or other enrollment information;
- Requires providers who change their name or "doing business as" name to change their MaineCare Provider Agreement;
- Clarifies that providers must take all reasonable and appropriate steps requested by the Department to transition members before changes of ownership, closures, and disenrollment, except in the case of reasonably unforeseen circumstances, and, upon request, submit a transition plan to the Department for review and approval;
- Update the rule in accordance with 10-144 *Code of Maine Rules*, Chapter 128, Certified Nursing Assistant and Direct Care Worker Registry Rule, to require agencies hiring direct care workers (DCWs) to check the Maine Certified Nursing Assistant and Direct Care Worker Registry to ensure DCWs are eligible for employment in Maine and comply with all requirements stipulated in the rule;
- Adds that providers may not bill MaineCare for an interpreter service supplied by an entity in which the providers, any owner of the providers, or an immediate family member of the providers or any of their owners has any direct or indirect ownership or financial interest, unless the provider also reimburses other entities for the provision of interpreter services and the entity providing the interpreting service makes those services commercially available to MaineCare providers or other businesses that do not share a direct or indirect familial ownership interest with the interpreting entity;
- Changes the billable amount for interpreter services to be the lesser of the interpreter's usual and customary charge and the rate authorized by the Department;
- To comply with section 53102 of the Bipartisan Budget Act of 2018, increases the number of days, from 30 to 100, that providers must wait for a response from an absent parent's third party insurance before billing MaineCare;
- Adds that the Department may impose sanctions on providers who fail to provide information to the Department or to otherwise respond to Departmental requests for information within a reasonable timeframe established by the Department;
- Adds a penalty of 25% of MaineCare payments for covered goods and services where the providers' records lack a required signature by a member or the member's guardian;
- Changes penalties to equal 20%, as opposed to not exceeding 20%, when mandated records are missing but providers are able to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary;
- Clarifies the Department's authority to exclude individuals, entities, and providers from participation in MaineCare for any reason identified in 42 CFR Part 1001 or 1003;

- Adds considerations for reinstatement from termination or exclusion to include the conduct of the individual or entity prior to and after the date of the notice of exclusion;
- Clarifies that providers may request an informal review within 60 calendar days from the date of written notification of the Department's alleged grievance and extends the deadline to the next business day if it falls on a weekend or holiday; and
- Makes minor grammatical and technical changes.

As described in detail in the Summary of Comments and Responses document, the Department made a few changes to the final adopted rule, including: delaying the implementation of the Sec. 1.03-8(J) rounding rule changes until January 1, 2023; clarifying in Section 1.03-8(J) that providers may bill partial units of service to the first or second decimal place and adding an example of how providers may bill for partial units; removing the proposed "shall" and retaining the original "in its discretion may" language in Section 1.20-2(H); adding that "certain administrative tasks may be covered when described in the appropriate Section of policy" in Section 1.06-4(B)(8); adding a provision to Section 1.20-2(I) that states "providers may satisfy the plan of correction requirement by sharing a copy of a plan of correction approved by another Office or Department for the identical violation(s) for which OMS sought the plan of correction."; clarifying the language referencing the CNA and DCW Registry in Section 1.03-12; removing the proposed 340B Drug Pricing Program in Section 1.03-14; and clarifying Section 1.12-C(2) to address when a provider is related to another provider by ownership and control.

Fiscal impact of rule:

The Department anticipates that this rulemaking will save approximately $46,203 in SFY 2022, which includes $16,685 in state dollars and $29,518 in federal dollars, and $46,203 in SFY 2023, which includes $16,648 in state dollars and $29,555 in federal dollars. This savings is primarily due to the implementation and expected use of the new 25 percent penalty on providers' whose records lack required signatures, which is an increase over the current 20 percent penalty applied for these types of violations.

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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; 42 CFR §441.301(c)
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. I Section 6**, Global HCBS Waiver Person-Centered Planning and Settings Rule
Filing number:	**2022-010**
Effective date:	1/19/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This new rule implements the federal requirements for Maine's Section 1915(c) home and community-based waiver programs as set forth in 42 CFR §441.301(c), and includes requirements for person-centered service planning and for settings in which home and community-based waiver services ("HCBS") are provided, including requirements for provider-owned or controlled residential settings. Adoption of this rulemaking means that the rule is judicially enforceable. *See* 5 MRS §8002(9). The Department adopted this rule implementing these requirements in order to be in compliance with federal Medicaid law and regulations, so that the Department can continue to receive federal funding for HCBS waiver programs.

The adopted rule implements additional requirements or changes to HCBS waiver programs under the following sections of the *MaineCare Benefits Manual*:

Section 18: Home and Community-Based Services for Adults with Brain Injury;

Section 19: Home and Community Benefits for the Elderly and Adults with Disabilities;

Section 20: Home and Community-Based Services for Adults with Other Related Conditions;

Section 21: Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder; and

Section 29: Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder.

In the event of conflict between the requirements of this adopted rule and any rule listed above, the terms of the adopted rule will supersede and shall apply.

The rule tracks closely the federal requirements set forth in 42 CFR §441.301(c). It clarifies that the Member leads the person-centered planning process and that the process should reflect the Member's cultural considerations and provide necessary information to allow the Member to make informed choices and decisions. The rule outlines what must be contained in the person-centered service plan, requires that it must be understood and agreed to by the Member, and provides when and how a modification may be made to the person-centered service plan. The rule establishes general requirements for HCBS settings so that the setting ensures the Member's rights of privacy, dignity and respect, freedom from coercion and restraint, and facilitates individual choice regarding HCBS waiver services and settings.

There are additional requirements for provider-owned or controlled residential settings. These include Members having privacy in their sleeping or living unit, Members having freedom to access food at any time, and Members having the ability to have visitors at any time. The adopted rule also contains a provision related to certain disability-specific settings (such as sec. 18 Work Ordered Club House Services). The rule leaves open the Department's

ability to amend sec. 18, sec. 20, sec. 21 and/or sec. 29 regulations through rulemaking to impose additional requirements.

The adopted rule outlines requirements for provider qualifications as well as Department oversight and enforcement to ensure full compliance with HCBS waiver services and related sections of the *MaineCare Benefits Manual*, including ch. I sec. 1, "General Administrative Policies and Procedures".

The Department shall submit to CMS and anticipates CMS approval of Waiver amendments related to this rule.

The rule will become effective 5 days after the finally adopted rule is filed with the Secretary of State's office, per 5 MRS §8052(6). The rule provides for a prospective application date for HCBS settings that were approved as settings prior to March 17, 2014, for sections 6.04(A) (Home and Community-Based Settings - General Requirements) and 6.04(B) (Additional Requirements for Provider-Owned or Controlled Residential Settings) which will have a prospective application date of September 30, 2022.

Finally, as a result of public comments and further review by the Department and the Office of the Attorney General, there were additional minor grammatical and formatting changes to the adopted rule language.

Fiscal impact of rule:

The Department does not anticipate this rulemaking will have a fiscal impact on the state budget.

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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, 42 CFR Sec. 441.301(c), 42 USC §1396b(l)
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:	**2022-087**
Effective date:	5/22/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
The Department is adopting comprehensive amendments of 10-144 CMR Chapter 101, *MaineCare Benefits Manual* ("MBM"), Chapter II Section 21, "Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder".

This Section 21 rule implements and regulates a Section 1915(c) home and community-based services (HCBS) Medicaid waiver approved by the Centers for Medicare and Medicaid ("CMS") in the U.S. Dept. of Health and Human Services. Under this Section 21 waiver program, the Department provides comprehensive services to support eligible adult MaineCare Members with an intellectual disability or autism living in the community. MBM Chapter II Section 21 is a routine technical rule pursuant to 34-B MRS §5432(3).

On September 25, 2020,CMS approved the request of the Maine Department of Health and Human Services (DHHS or the Department) to renew the Section 21 HCBS waiver for a five-year period, with an effective date of July 1, 2020. The Section 21 waiver was further amended effective January 1, 2021, April 1, 2021, and July 1, 2021, and the Department will prepare and request CMS approval of additional amendments of the waiver authorizing additional changes made as part of this rulemaking.

On or about December 29, 2021, the Office of the Secretary of State gave notice of proposed amendments of MBM Chapter II, Section to the Executive Director of the Legislative Council, and published notice of the rulemaking. The Department gave notice of the rulemaking to known interested parties, and held a remote public hearing pursuant to 34-B MRS § 5465(4) on January 19, 2022 and accepted other public comment regarding the proposed rulemaking pursuant to 5 MRS §8057-A(3) until the close of business on January 31, 2022. A summary of public comments, the Department's responses, and changes made to the rule after it was published for public comment will be filed with the Secretary of State in conjunction with this rulemaking.

In conformance with the CMS-approved Section 21 waiver, the Department now:

- Adds a definition of "Competitive Integrated Employment" in § 21.02;
- Updates the definitions of "Autism Spectrum Disorder", "Intellectual Disability", "Activities of Daily Living", "Instrumental Activities of Daily Living", "Person-Centered Service Plan", and "Shared Living";
- Eliminates Counseling as a Section 21 Covered Service. Counseling services are available to Section 21 Members under Section 65 of the MaineCare Benefits Manual (MBM). All Section 21 Members who were receiving Counseling services under Section 21 received written notice of this change in October 2020;

- Updates, expands, and/or clarifies the description of the following Covered Services in §21.05:
  - Career Planning
  - Community Support
  - Crisis Intervention Services (Requires additional documentation by the Planning Team.)
  - Home Support – Agency Per Diem (Requires that at least one staff person be present and awake at all time one or more Members are at home, 24/7, in order to respond immediately to Member requests for assistance.)
  - Home Support – Family Centered Support
  - Home Support – Quarter Hour
  - Non-Medical Transportation Service
  - Shared Living (Foster Care Adult)
  - Specialized Medical Equipment
  - Speech Therapy (Maintenance) (Clarifies the intent is to prevent regression, loss of movement, injury and medical complications that would result in a higher level of skilled care.)
  - Work Support – Individual (Clarifies the primary focus of the service is job related and encompasses adherence to workplace policies and safety.).
- **U.S. Department of Justice (DOJ) Settlement Agreement**: On June 4, 2021, the Department entered into a Settlement Agreement with the DOJ (DJ No. 204-34-72). The Department agreed to adopt a rule which establishes an exceptions process that provides Section 21 Members, and Members applying to receive Section 21 benefits, may request services in excess of otherwise-applicable Section 21 monetary and/or unit caps, where necessary to ensure that Section 21 Members receive adequate and appropriate services and supports in the most integrated setting appropriate to their needs, consistent with Title II of the Americans with Disabilities Act (ADA). This rulemaking adopts this exceptions process as *Requests for Exceptions* in §21.14.
- On January 19, 2022 the Department adopted a new rule which implements the federal requirements for Maine's Section 1915(c) home and community-based waiver programs set forth in 42 CFR §441.301(c). This adopted rule is codified as 10-144 CMR ch. 101, *MaineCare Benefits Manual*, Chapter I Section 6, "Global HCBS Waiver Person-Centered Planning and Settings Rule", referred to as the Global HCBS Rule. The Global HCBS Rule includes requirements for person-centered service planning and for settings in which home and community-based waiver services are provided, including requirements for provider-owned or controlled residential settings. Consistent with the Global HCBS Rule, MBM Chapter II Section 21 rule incorporates applicable HCBS planning and settings requirements (*See, e.g.*, §21.04-2 [Person Centered Service Planning Process] and § 21.05-1 [Home and Community Based Settings]).
- This adopted rule notifies providers and the public that all Section 21 providers must comply with all applicable federal and state laws, which includes applicable Maine licensing laws and regulations as well as Ch I Section 1 of the MBM including maintaining current licenses, as applicable.
- **Plan of Corrective Action ("POCA")**: The Department adopts a new provision which expands upon the quality assurance activities authorized under Appendix V of the rule. This new §21.14 authorizes the Department to issue written Notices of Deficiency, and to require providers to submit and implement Plans of Corrective Action as approved by the Department. Providers have the right to appeal written Notices of Deficiency. This POCA process provides increased protections for Members

and ensures that providers are in compliance with service requirements, have sufficient clinical and administrative capability to carry out the intent of the service, and have taken steps to assure the safety, quality, and accessibility of the service for Members.

- **§21.08-3 (Termination from Participation as a MaineCare Provider)**: The Department clarifies this provision by expressly notifying providers of the MBM Ch. I, Sec. 1 requirement that providers must give written notice of their intent to terminate all participation in the MaineCare Program. In addition, this provision requires Section 21 providers to notify all Section 21 Members they serve of any intent to terminate participation in the MaineCare program.
- **§21.10-1 (Direct Support Professional Qualifications):** The Department requires all DSPs, regardless of capacity and prior to provision of services to a Member, to receive training regarding the "Global HCBS Waiver Person Centered Planning and Settings Rule", *MaineCare Benefits Manual*, Chapter I Section 6; eliminates the requirement for grievance process training prior to working with Members; and adds a requirement for DSPs who provide Crisis Intervention to receive behavioral intervention training. Within six (6) months of hire and annually thereafter, the adopted rule requires DSPs to comply with the Department's regulations: Reportable Events System (14-197 CMR ch. 12) and the Adult Protective Services System (10-149 CMR ch. 1). The Department changes Provider Qualifications and Requirements for Direct Support Professionals (DSPs) for Career Planning and Employment Specialist Services.
- **§21.10-9 (Electronic Visit Verification)**: The Department requires providers of Home Support-Quarter Hour services to comply with Maine DHHS Electronic Visit Verification (EVV) system standards and requirements. This complies with the *21st Century Cures Act* (PL 114-255), Section 12006, as codified in 42 USC §1396b(l).
- **§21.11 (Member Appeals)**: The Department is adding a sentence to provide that Members have the right to appeal decisions made regarding priority level and waitlist determinations.
- **Appendix IV (Performance Measures)**: The Department eliminates Appendix IV because the Department utilizes data available through the Department of Labor, Person Centered Service Plans, and authorization data as part of the Department's commitment to quality assurance and quality improvement system. Additionally, specific performance measures are either no longer relevant or necessary to measure the performance of specifically listed employment services, or have been met.

With this rulemaking, the Department adopts and will seek CMS approval of the following additional changes:

- Community Support services are separated into three tiers of service delivery: Community Only-Individual, Community Only-Group, and Center-Based, to support individualized needs of the participant population more broadly.
- **§21.07-2 (Limits):** The Department changes the limit from $26,640 to $39,875 for the combined annual cost of Work Support-Group, Work Support-Individual, and Community Support Services, retroactive to January 1, 2021. This retroactive application is authorized under 22 MRS §42(8), as the change is a benefit to both Members and Providers.

As a result of public comments and further review by the Department and the Office of the Attorney General, the adopted rule includes clarifying language for various Covered Services, including: §21.05-1, Home and Community-Based Settings, §21.05-11, Community Support Services, §21.05-13, Home Support-Quarter Hour Services, §21.05-14, Home Support-Remote Support Services, and §21.05-20 (Shared Living / Foster Care, Adult).

Additionally, as a result of public comment the adopted rule includes a definition for Competitive Integrated Employment (§21.02-9) consistent with the Department's CMS-approved waiver, a revised definition for §21.02-5, Autism Spectrum Disorder, to align with the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, (American Psychiatric Association), and a clarified definition for §21.02-4, Agency Home Support.

Finally, as a result of public comment, the Department has revised the Plan of Corrective Action (POCA) process, specifically §21.10-14 (D), to align with Chapter I Section 1 of the MBM in allowing providers 60 days to appeal a Notice of Deficiency and including the mailing address of the Clinical Review Team at §21.14-2(C).

Fiscal impact of rule:

This rulemaking updates Member services, incorporates the Department's Global HCBS (MCBM ch 1 Sec. 6) by reference, and adopts a Plan of Correction procedure for providers.

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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 §8073; PL 2019 ch. 616 part A §A-7; PL 2021 ch. 398
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:	**2022-044** *(Repeal)*
Effective date:	3/23/2022
Type of rule:	Major Substantive
Emergency rule:	Yes

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

Basis statement:
The Department is repealing an emergency major substantive rule that was effective on April 7, 2021, that included reimbursement rate increases for certain services under *MaineCare Benefits Manual*, ch. III section 21, "Allowances for Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder", pursuant to PL 2019 ch. 616. Under 5 MRS §8072, emergency major substantive rules are effective for up to 12 months or until Legislative review. The Department has not yet initiated the proposed major substantive rulemaking associated with the April 7, 2021 emergency major substantive rule, and thus there is no provisional major substantive rule pending for review before the Legislature.

There is no decrease in reimbursement for any service affected by this repeal of the April 2021 emergency major substantive rule changes. The Department is repealing this emergency major substantive rule because of additional Section 21 reimbursement rate changes that were required by PL 2021 ch. 398 (the "Act").

Simultaneous with the repeal of the emergency major substantive rule, pursuant to the Act, the Department will implement separate emergency routine technical rule changes that increase rates for section 21 providers. As set forth in the MAPA documents for the separate rulemaking, the Act authorized the Department to make those specific section 21 reimbursement rate changes on an emergency basis via routine technical rulemaking, even though ch. III section 21 rulemaking is typically major substantive. All of the section 21 reimbursement rates that were increased via the April 7, 2021 emergency major substantive rule (that is now being repealed) are included in the rate increases for the separate emergency routine technical rule. Because of the separate routine technical emergency rule, the repeal of the emergency major substantive rule will not have the effect of causing the reimbursement rates to revert to the lower rates that were in the current permanent major substantive ch. III sec. 21 (eff. 7/28/2019).

The separate routine technical emergency rule changes shall be effective for up to 90 days. The Department intends to proceed with proposed routine technical rulemaking to make permanent the increases to reimbursement rates enacted through the emergency rule changes. These increased rates in the separate routine technical rulemaking will be effective retroactive to January 1, 2022, as directed by the Act, per 22 MRS §42(8).

Fiscal impact of rule:
(No response)

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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 2021 ch. 398
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:	**2022-045**
Effective date:	3/23/2022
Type of rule:	Routine Technical
Emergency rule:	Yes

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

Basis statement:
In response to the statewide staffing crisis and to comply with PL 2021 ch. 398 (the "Act"), the Department is implementing emergency routine technical rule changes to increase rates for providers of services under ch. III section 21, "Allowances for Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder".

Section AAAA-1 of the Act enacts 22 MRS ch. 1627, "Essential Support Worker Reimbursement". The new law requires that, effective January 1, 2022, the labor components of MaineCare reimbursement rates for specified services delivered by "essential support workers" must equal at least 125% of the minimum wage established in Title 26 section 664, subsection 1. Essential support workers are individuals who by virtue of employment generally provide to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or have direct access to provide care and services to clients, patients or residents regardless of the setting. 22 MRS §7401. In addition, part AAAA states that the reimbursement rate must include an amount necessary to reimburse the provider for taxes and benefits related to the wages. 22 MRS §7402(2). Section AAAA-2 of the Act specifies that the 125% of minimum wage requirement for essential support workers applies to ch. III section 21 services.

Additionally, part OOO of the Act authorizes the Department to implement cost of living increases (COLAs). In calculating the rate increases necessary to comply with part AAAA of the Act, the Legislature and the Department took into consideration the impact of planned COLAs on ensuring the labor components of the reimbursement rates for section 21 and other services specified under part AAAA are equal to at least 125 percent of minimum wage.

Rulemaking required for these particular rule changes are routine technical per 22 MRS §7404 (for the essential support worker increases), and part OOO of the Act (for the COLA-related increases) even though ch. III section 21 is generally a major substantive rule. *See, e.g.,* 22 MRS §3195.

Section GGGG-1 of the Act provides the Department with authority to enact these routine technical changes on an emergency basis, without the need to make findings in support of an emergency per 5 MRS §8054. These routine technical emergency rule changes shall be effective for up to 90 days. The Department intends to proceed with proposed routine technical rulemaking to make permanent the increases to reimbursement rates enacted through this emergency adoption.

These increased rates will be effective retroactive to January 1, 2022, as directed by the Act. The retroactive application of this rule comports with 22 MRS §42(8), which provides state authority for the Department to adopt rules with a retroactive application for a period not to

exceed eight (8) calendar quarters where there is no adverse financial impact on any MaineCare member or provider. Here, the rule change is a beneficial change for the providers.

Separately, effective December 31, 2021, and coinciding with the adoption of this emergency routine technical rule, the Department shall repeal an emergency major substantive rule that was adopted on April 7, 2021, and that included reimbursement rate increases for certain services under ch. III section 21 pursuant to PL 2019 ch. 616; emergency major substantive rules are effective for up to twelve months, or until Legislative review. The Department has not yet initiated the proposed major substantive rulemaking associated with the April 7, 2021, emergency major substantive rule, and thus there is no provisional major substantive rule pending for review before the Legislature. There is no decrease in reimbursement for any service affected by the repeal of the April 2021 emergency major substantive rule.

The Department shall seek approval from the Centers for Medicare & Medicaid Services (CMS) for the increased reimbursement rates. In addition, the Governor's proposed budget will ask the legislature for additional funds to support these increases and to meet the intent of part AAAA of the Act ensuring labor components of all rates are at least equal to 125% of minimum wage.

Fiscal impact of rule:

(No response)

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Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42 and 42(8), 3173; PL 2021 ch. 398
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:	**2022-119**
Effective date:	6/15/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
In response to the statewide staffing crisis and to comply with PL 2021 ch. 398 (the "Act"), the Department is adopting routine technical rule changes to increase rates for providers of services under Ch. III Section 21, "Allowances for Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder".

Section AAAA-1 of the Act enacts 22 MRS Chapter 1627, "Essential Support Worker Reimbursement". The new law requires that, effective January 1, 2022, the labor components of MaineCare reimbursement rates for specified services delivered by "essential support workers" must equal at least 125% of the minimum wage established in Title 26 section 664 subsection 1. Essential support workers are individuals who by virtue of employment generally provide to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or have direct access to provide care and services to clients, patients or residents regardless of the setting. 22 MRS §7401. In addition, Part AAAA states that the reimbursement rate must include an amount necessary to reimburse the provider for taxes and benefits related to the wages. 22 MRS §7402(2). Section AAAA-2 of the Act specifies that the 125% of minimum wage requirement for essential support workers applies to Ch. III, Section 21 services.

Additionally, Part OOO of the Act authorizes the Department to implement cost of living increases (COLAs). In calculating the rate increases necessary to comply with Part AAAA of the Act, the Legislature and the Department took into consideration the impact of the planned COLAs on ensuring the labor components of the reimbursement rates for Section 21 and other services specified under Part AAAA are equal to at least 125 percent of minimum wage.

Rulemaking required for these particular rule changes are routine technical per 22 MRS §7404 (for the essential support worker increases), and Part OOO of the Act (for the COLA-related increases) even though Ch. III Section 21 is generally a major substantive rule. *See, e.g.,* 22 MRS §3195.

On March 22, 2022, the Department implemented these increased rates via an emergency routine technical rule, which shall be effective for up to 90 days. The rates are effective retroactive to January 1, 2022, as directed by the Act. The retroactive application of this rule comports with 22 MRS §42(8), which provides state authority for the Department to adopt rules with a retroactive application for a period not to exceed eight (8) calendar quarters where there is no adverse financial impact on any MaineCare member or provider. Here, the rule changes are beneficial for the providers. This adopted routine technical rulemaking seeks to make permanent the increases to the reimbursement rates enacted via emergency rule.

As noted in detail in the Summary of Comments and Responses, certain commenters incorrectly asserted that (1) the final rule, Sec. 1300(3), implements a reduction in per diem rates, and (2) the changes in reimbursement do not fully include rates equal to at least 125% of the minimum wage.

With regard to (1), this rule continues the previous policy of lower reimbursement for hours in excess of 168; the actual rate for hours in excess of 168 has increased by $3.95. Hence there is no reduction and no violation of the Maintenance of Effort required under Section 9817 of the *American Rescue Plan*.

With regard to (2), per PL 2021 ch. 635, *An Act To Make Supplemental 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, 2022 and June 30, 2023*, the Legislature has approved additional funds to support these increases and to meet the intent of Part AAAA of the Act ensuring labor components of all rates are at least equal to 125% of minimum wage.

The Department had previously implemented rates to include these labor component amounts (that are all equal to at least 125% of the minimum wage) in the emergency rule and also proposed the same rates. This final adopted rule includes rates with labor components that are all at least equal to 125% of the minimum wage.

The Department received temporary approval on March 7, 2022 and intends to seek permanent approval from the Centers for Medicare & Medicaid Services (CMS) for the adopted increased reimbursement rates with a retroactive effective date of January 1, 2022.

The Department did not make any additional changes to the adopted rule as a result of public comments.

Fiscal impact of rule:

(No response)

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 2021 Ch. 398 Sec. A-17 Part CCC *and* Part GGGG
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II** and **III Section 25**, Dental Services and Reimbursement Methodology *(replaces Ch. II Section 25, "Dental Services", and Ch. III Section 25, "Allowances for Dental Services)*
Filing number:	**2022-125** *(Repeal and replace)*
Effective date:	7/1/2022
Type of rule:	Routine Technical
Emergency rule:	Yes

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

Basis statement:

The Department adopts this emergency rule, which repeals Ch. II and Ch. III, Section 25, and replaces them with a new Ch. II rule, "Dental Services and Reimbursement Methodology."

Emergency Rulemaking Authority for Dental Services: Pursuant to PL 2021 Ch. 398 (eff. July 1, 2021), Sec. A-17, *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, 2021, June 30, 2022 and June 30, 2023,* (the "Budget") Part CCC, Sec. CCC-1, of the Budget enacted changes to the MaineCare dental statute – 22 MRS 3174-F(1)(Coverage for Adult Dental Services), by adding subsection G, which provides: "Other comprehensive preventive, diagnostic and restorative dental services to maintain good oral health and overall health in accordance with rules adopted by the department." Section CCC-2 of the Budget required the Department to adopt emergency rules by July 1, 2022, to implement the new provisions of 22 MRS Section 3174-F(1), which expanded covered services for members 21 and older (adults), after consideration of recommendations by the dental subcommittee of the MaineCare Advisory Committee ("MAC").

Between August 2021 and May 2022, the Department met with the dental subcommittee of the MAC ten times and with the full MAC once. The Department also held two stakeholder forums to receive input on the benefit design and reimbursement methodology. Stakeholders included MaineCare dental providers and various oral health advocates, including representatives from Maine Equal Justice, Maine Primary Care Association, and Children's Oral Health Network of Maine. This rule incorporates recommendations from this stakeholder engagement, invests $45 million to increase rates and expand the adult dental benefit, as well as fully integrate the children and adult benefits and rates into a single rule. The emergency rule adds a comprehensive array of dental services for adult members, per 22 MRS 3174-F(1).

Emergency Rulemaking Authority for Dental Services Reimbursement Methodology: Part GGGG Section GGGG-1 of the Budget authorized the Department to amend the rule on an emergency basis "to implement recommendations of the MaineCare comprehensive rate system evaluation report for dental rates." The Department's Comprehensive Rate System Evaluation, conducted by the firm Myers and Stauffer, showed that MaineCare rates for preventive, diagnostic, and endodontic services are lower than rates

for state Medicaid agencies in Connecticut, New Hampshire, Vermont, North Carolina, and Montana. Through this emergency rulemaking, the Department repeals the current Ch. III, Section 25, and implements a new reimbursement methodology in the emergency Ch. II, Section 25. The new Section 25 dental reimbursement rates will be posted on a website, and those rates will be set based on either the "Commercial Median Benchmark" or the "All-States Medicaid Average Benchmark," as defined by the emergency rule. The dental codes shall undergo annual updates, per the methodology included in the emergency rule. On average, the reimbursement rates for dental services are increasing by 74%. Since April 11, 2022, the Department has conferred multiple times with providers and the MAC regarding this new reimbursement methodology.

Differences Between the Repealed Rules and the Emergency Rule:

The Department finds that the holistic approach of including coverage of both children's and adult services as well as the reimbursement methodology in a single rule is a more efficient and streamlined approach for the dental rule.

Accordingly, the emergency rulemaking repeals and replaces 10-144 CMR Ch. 101, *MaineCare Benefits Manual* (the "MBM") Chapters II and III Section 25, "Dental Services", and replaces those rules with one Ch. II Section 25 rule.

The differences between the emergency and the former Chapters II and III Section 25, rules include the following:

1. **Section 25.06 (Reimbursement Methodology). The rule replaces specified rates with a reimbursement methodology.** Whereas the former Chapter II Section 25, rule stated rates would be the amount listed in Chapter III Section 25, the emergency rule implements a reimbursement methodology that increases overall reimbursement consistent with recommendations from the comprehensive rate setting evaluation.

   The reimbursement methodology sets rates for diagnostic, endodontic, periodontic, and preventative services based on 67% of the Commercial Median Benchmark or 133% of the Medicaid State Average Benchmark, if the Commercial Median Benchmark rate is unavailable or unreliable.

   The reimbursement methodology sets rates for adjunctive, oral and maxillofacial surgery, orthodontics, prosthodontics, and restorative services based on 50% of the Commercial Median Benchmark or 100% of the Medicaid State Average Benchmark if the Commercial Median Benchmark rate is unavailable or unreliable.
2. **In addition, the rule eliminates inconsistent payment for services billed as medical versus dental services**. To ensure that there is not a rate disparity between CDT and CPT codes that represent the same service, the emergency rule removes coverage of some oral and maxillofacial surgery and maxillofacial prosthetic services so that they are solely covered under Section 90, Physician Services. The Department removes services from the proposed rule that have a CPT code equivalent, that are medical in nature, and are primarily delivered by oral surgeons who already bill the services under Section 90, "Physician Services".
3. **Replaces emergency-only adult dental coverage with comprehensive adult dental coverage**. To implement the new comprehensive adult dental benefit, the emergency rule adds coverage for adults for diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, and adjunctive services. To enable this comprehensive adult coverage, the emergency rule removes the Section 25.04 requirement that adult dental care be limited to acute surgical care directly related to an accident; oral medical procedures not involving the dentition and gingiva; extraction of teeth that are severely decayed and pose a serious threat of infection during cardiovascular surgery; or treatment necessary to relive pain, eliminate infection, or prevent imminent tooth loss.

4. **Replaces separate adult and child coverage provisions with a single covered services description generally applicable to all members**. As a result of removing the restrictions on adult dental coverage, the emergency rule contains one "Covered Services" provision, which includes the services, limits, and other requirements for all members, regardless of age, unless otherwise specified. Some services will continue to be age-limited, and they are noted as such in the rule.
5. **In addition to adding broad coverage for adult dental services, the emergency rule adds or increases coverage for many existing services, including the following**:
   a. Comprehensive periodontal evaluations
   b. Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
   c. Removable unilateral space maintainers
   d. Multiple types of crowns
   e. Prefabricated crowns
   f. Apicoectomies
   g. Immediate partial dentures
   h. Complete denture repairs
   i. Partial denture relines
   j. Multiple types of pontics and prosthodontic retainers
   k. Re-cement or re-bond and repairs of fixed partial dentures
   l. Dental case management
   m. Single bitewings
   n. Panoramic radiographs
   o. Topical fluoride
   p. Denture adjustments
6. **Aligns limits and prior authorization requirements with other state Medicaid agencies, commercial payers, and stakeholder recommendations**. Because of the limited scope of the adult dental benefit in the current rule, the emergency rule makes changes to align the covered services and limits with typical comprehensive dental coverage. Specifically:
   a. The emergency rule removes the requirement that adults have a qualifying medical condition to receive removable prosthodontics (dentures).
   b. The emergency rule establishes medically appropriate limitations where none previously existed, based on recommendations from clinical consultation and alignment with other comprehensive dental coverage (commercial payers and other Medicaid agencies).
   c. The emergency rule adds and removes prior authorizations to align with other payors and based on recommendations from clinical consultation and provider feedback.
   d. The emergency rule removes the "more than once every 150 days" requirement for detailed and extensive and periodic oral evaluations and prophylaxis treatments.
7. **Removes unnecessary and overly detailed provisions**. The emergency rule removes the following from the rule:
   a. Unnecessary and unused definitions.
   b. Reference to coverage for members residing in an "Intermediate Care Facility for Persons with Mental Retardation (ICF-IID)" because these members will now receive the services covered for members 21 and over (adults).
   c. Requirements that address the covered services certain provider types can provide under their scope of practices because providers' scope of practices are already defined in 32 MRS Ch. 147.

d. Prescriptive descriptions of services that are overly detailed for the rule.
e. Section 25.03-9, Temporomandibular Joint Services, because it is not clear what specific services this provision encompasses and because services that are related to the temporomandibular joint are listed in the new covered services Section.
f. Section 25.06-1, Member's Records, because Chapter I, Section 1.03-8(M) and Board rule 02-313 CMR Chapter 12 both contain member/patient record requirements.
g. Section 25.06-2, The Division of Program Integrity, because it only refers providers to Chapter I, which already applies to all providers.
h. Requirements and instructions in Section 25.06-3, Prior Authorization of Dental Services, because they either exist in Chapter I of the MBM or in MaineCare's Prior Authorization Manual on the HealthPAS Portal.
i. Section 25.06-5, Case Management, because it describes standard health care provider practices and because the emergency rule adds coverage for a dental case management service.
j. Sections 25.07-4, Denturist Services, and 25.07-5, Dental Hygienist Services, because it is unnecessary to include the services that these providers can deliver under their scopes of practice, which are defined in 32 MRS Ch. 147. Section 25.07-5 also includes outdated guidance.
k. Section 25.07-6, Independent Practice Dental Hygienist (IPDH) Services, because IPDHs must comply with their scope of practice, as defined in 32 MRS Ch. 143 § 18375, and it is redundant to list services that IPDHs can deliver in rule. In addition, the requirements for IPDHs delivering temporary fillings no longer have a basis in Board rules and have been a roadblock to delivering this service. The requirements for processing and exposing radiographs are also no longer in effect.
l. The appendix because the forms either exist on the HealthPAS Portal or will no longer be required.

The Department will propose a routine technical rule to permanently repeal Chapters II and III Section 25, and replace them with the single Ch. II Section 25 rule.

The Department shall seek approval from the Centers for Medicare and Medicaid Services (CMS) of state plan amendments (SPAs) for the changes in this rulemaking. Additionally, on or before July 1, 2022, the Department will publish a notice of change in reimbursement methodology pursuant to 42 CFR §447.205.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $45,080,337 in FY 2023 in state dollars and $29, 089, 011 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 2021 Ch. 398 Sec. A-17 Part CCC *and* Part GGGG
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 25**, Dental Services *(Repeal* **Ch. III Section 25**, Allowances for Dental Services *(Repeal)* **Ch. II Section 25**, Dental Services and Reimbursement Methodology *(Replaces repealed Ch. II and III)*
Filing number:	**2022-193, 194** *(Repeal and replace)*
Effective date:	9/28/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
The Department adopts this rule, which repeals Ch. II and Ch. III Section 25, and replaces them with a new Ch. II rule, "Dental Services and Reimbursement Methodology."

On July 1, 2022, the Department implemented the vast majority of changes in this adopted rule via emergency rulemaking, pursuant to PL 2021 Ch. 398 (eff. July 1, 2021), Sec. A-17 (the "Budget"), Part CCC Sec. CCC-1, Part GGGG, and Section GGGG-1.

Between August 2021 and May 2022, the Department met with the dental subcommittee of the MaineCare Advisory Committee ("MAC") ten times and with the full MAC once. The Department also held two stakeholder forums to receive input on the benefit design and reimbursement methodology. Stakeholders included MaineCare dental providers and various oral health advocates, including representatives from Maine Equal Justice, Maine Primary Care Association, and Children's Oral Health Network of Maine. This rule incorporates recommendations from this stakeholder engagement, invests $45 million to increase rates and expand the adult dental benefit, as well as fully integrates the children and adult benefits and rates into a single rule. The adopted rule adds a comprehensive array of dental services for adult members, per 22 MRS §3174-F(1).

Additionally, this adopted rule implements the recommendations from the Department's Comprehensive Rate System Evaluation, conducted by the firm Myers and Stauffer. The new Section 25 dental reimbursement rates will be posted on a website, and those rates will be set based on either the "Commercial Median Benchmark" or the "All-States Medicaid Average Benchmark," as defined by the adopted rule. The dental code benchmarks shall undergo updates every two years, per the methodology included in the adopted rule. Since April 11, 2022, the Department has conferred multiple times with providers and the MAC regarding this new reimbursement methodology.

The differences between the adopted rule and the former, now repealed Chapters II and III, Section 25, rules include the following:

1. **Section 25.06 (Reimbursement Methodology). The rule replaces specified rates with a reimbursement methodology.** Whereas the former Chapter II, Section 25, rule stated rates would be the amounts listed in Chapter III, Section 25, the adopted rule implements a reimbursement methodology that increases overall reimbursement consistent with recommendations from the comprehensive rate setting evaluation.

The reimbursement methodology sets rates for diagnostic, endodontic, periodontic, preventive, and limited orthodontic treatment services based on 67% of the Commercial Median Benchmark or 133% of the Medicaid State Average Benchmark, if the Commercial Median Benchmark rate is unavailable or unreliable.
The reimbursement methodology sets rates for adjunctive, oral and maxillofacial surgery, orthodontics (except for limited orthodontic treatment), prosthodontics, and restorative services based on 50% of the Commercial Median Benchmark or 100% of the Medicaid State Average Benchmark if the Commercial Median Benchmark rate is unavailable or unreliable.

2. **In addition, the rule eliminates inconsistent payment for services billed as medical versus dental services**. To ensure that there is not a rate disparity between CDT and CPT codes that represent the same service and to leverage the 'percent of Medicare methodology' in Section 90, the adopted rule removes coverage of some oral and maxillofacial surgery and maxillofacial prosthetic services so that they are solely covered under Section 90, Physician Services. The Department removed services from the adopted rule that have a CPT code equivalent, that are medical in nature, and are primarily delivered by oral surgeons who already bill the services under Section 90, Physician Services.
3. **Replaces emergency-only adult dental coverage with comprehensive adult dental coverage**. To implement the new comprehensive adult dental benefit, the adopted rule adds coverage for adults for diagnostic, preventive, restorative, endodontic, periodontic, prosthodontic, oral and maxillofacial surgery, and adjunctive services. To enable this comprehensive adult coverage, the adopted rule removes the Section 25.04 requirement that adult dental care be limited to acute surgical care directly related to an accident; oral medical procedures not involving the dentition and gingiva; extraction of teeth that are severely decayed and pose a serious threat of infection during cardiovascular surgery; or treatment necessary to relive pain, eliminate infection, or prevent imminent tooth loss.
4. **Replaces separate adult and child coverage provisions with a single covered services description generally applicable to all members**. As a result of removing the restrictions on adult dental coverage, the adopted rule contains one "Covered Services" provision, which includes the services, limits, and other requirements for all members, regardless of age, unless otherwise specified. Some services will continue to be age-limited, and they are noted as such in the rule.
5. **In addition to adding broad coverage for adult dental services, the adopted rule adds or increases coverage for many existing services for members under 21, including the following**:
    a. Comprehensive periodontal evaluations
    b. Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
    c. Removable unilateral space maintainers
    d. Multiple types of crowns
    e. Prefabricated crowns
    f. Apicoectomies
    g. Immediate partial dentures
    h. Complete denture repairs
    i. Partial denture relines
    j. Multiple types of pontics and prosthodontic retainers
    k. Re-cement or re-bond and repairs of fixed partial dentures
    l. Dental case management
    m. Single bitewings

n. Panoramic radiographs
o. Topical fluoride
p. Denture adjustments
q. Nutritional counseling
r. Preventive resin restorations

6. **Aligns limits and prior authorization (PA) requirements with other state Medicaid agencies, commercial payers, and stakeholder recommendations**. Because of the limited scope of the adult dental benefit in the previous rule, the adopted rule makes changes to align the new covered services and limits with typical comprehensive dental coverage. Specifically:
   a. The adopted rule removes the requirement that adults have a qualifying medical condition to receive removable prosthodontics (dentures).
   b. The adopted rule establishes medically appropriate limits where none previously existed, based on recommendations from clinical consultation and alignment with other comprehensive dental coverage (commercial payers and other Medicaid agencies).
   c. The adopted rule adds and removes PAs to align with other payers and based on recommendations from clinical consultation and rule commenters. The emergency rule did not contain PAs for scaling and root planing (SRP), crowns, and sedation, but the proposed rule included PAs for all three to allow for further public comment and Department deliberation. As a result of comments, the Department removed the PA for crowns for members under age 21, removed the PA for the first unit of SRP delivered to each quadrant, and removed the PA for sedation, which only applied to members 21 and over. Also as a result of comments, the Department removed the PAs in the proposed rule for replacement of a lost or broken retainer and for a third prophylaxis treatment.
   d. The adopted rule removes the "more than once every 150 days" requirement for detailed and extensive and periodic oral evaluations and prophylaxis treatments.
7. **Removes unnecessary and overly detailed provisions**. The adopted rule removes the following from the rule:
   a. Unnecessary and unused definitions.
   b. Reference to coverage for members residing in an "Intermediate Care Facility for Persons with Mental Retardation (ICF-IID)" because these members will now receive the services covered for members 21 and over (adults).
   c. Requirements that address the covered services certain provider types can provide under their scope of practices because providers' scope of practices are already defined in 32 MRS Ch. 147.
   d. Prescriptive descriptions of services that are overly detailed for the rule.
   e. Section 25.03-9, "Temporomandibular Joint Services", because these services are covered under Section 90, "Physician Services", and they are billed for using Common Procedural Terminology (CPT) codes.
   f. Section 25.06-1, "Member's Records", because Chapter I Section 1.03-8(M) and Board rule 02-313 CMR Chapter 12 both contain member/patient record requirements.
   g. Section 25.06-2, "The Division of Program Integrity", because it only refers providers to Chapter I, which already applies to all providers.
   h. Requirements and instructions in Section 25.06-3, "Prior Authorization of Dental Services", because they either exist in Chapter I of the MBM or in MaineCare's *Prior Authorization Manual* on the HealthPAS Portal.
   i. Section 25.06-5, "Case Management", because it describes standard health care provider practices and because the adopted rule adds coverage for a dental case management service.

j. Sections 25.07-4, "Denturist Services", and 25.07-5, Dental Hygienist Services, because it is unnecessary to include the services that these providers can deliver under their scopes of practice, which are defined in 32 MRS Ch. 147. Section 25.07-5 also includes outdated guidance.
k. Section 25.07-6, "Independent Practice Dental Hygienist (IPDH) Services", because IPDHs must comply with their scope of practice, as defined in 32 MRS Ch. 143 § 18375, and practice requirements outlined in Board rule 02-313 CMR Ch. 12, and it would be redundant to list either in this rule. In addition, the requirement for IPDHs delivering temporary fillings to have a dentist who can treat the member within 60 calendar days is not required in statute or Board rules.
l. The appendix because the forms either exist on the HealthPAS Portal, will no longer be required, or the documents are required by the Board, not the Department.

The Department shall seek approval from the Centers for Medicare and Medicaid Services (CMS) of state plan amendments (SPAs) for the changes in this rulemaking. In addition, on June 29, 2022, the Department published a notice of change in reimbursement methodology pursuant to 42 CFR §447.205.

As described in detail in the List of Changes to the Final Rule at the end of the Summary of Comments and Responses document, the Department made the following changes in the adopted rule (compared to the changes that were included in the proposed rule):

1. The Department added coverage for sealants on premolars (bicuspids) for members under age 21 in Section 25.03-2(C).
2. In Section 25.03-2(H), the Department added coverage for preventive resin restorations (PRRs) once per eligible tooth per three years for members with a moderate to high caries risk when an active cavitated lesion in a pit or fissure does not extend into the dentin.
3. The Department clarified in Section 25.03-2(C) that sealants are covered for permanent and primary first and second molars.
4. The Department added coverage for CDT code D1310, nutritional counseling for control of dental disease, in Section 25.03-2(I) with a limit of once per member per year when delivered in addition to another covered service. The Department also added a description of the service.
5. The Department changed the reimbursement methodology used to set rates for limited orthodontic treatment from the 50% of commercial median benchmark methodology described in Section 25.06(B)(2) to the 67% of commercial median benchmark methodology described in Section 25.06(B)(1), to reflect evidence indicating that limited orthodontic treatment is an effective preventive approach to avoid severe malocclusion.
6. The Department updated Section 25.03-5(E) to not require a PA for the first unit of SRP delivered to each quadrant but will require PA for the second unit and any additional units of SRP delivered to each quadrant. For example, SRP delivered for the first time to the first quadrant will not require PA, but a PA is required to deliver SRP again to the first quadrant.
7. The Department will no longer require risk assessment results and a PA that includes those results to authorize a third prophylaxis treatment. Instead, a third prophylaxis treatment per year will be permissible without PA if the member meets the criteria added to Section 25.03-2(A).
8. The Department clarified in Section 25.03-9(F) that behavior management is covered when behavior delays, as well as prevents, a covered service from being delivered, meaning providers may bill behavior management whether a covered service is delivered or not. The Department also increased the limit from three times per member per lifetime per service location to three times per member per year per service location.

9. The Department clarified the limit for bitewings in Section 25.03-1(B).
10. The Department re-added coverage for diagnostic casts (CDT code D0470) in Section 25.03-1(F) because they enable orthodontic treatment planning.
11. The Department removed the PA requirement for replacement of lost or broken retainers in Section 25.03-8(G).
12. As a result of comments, in Section 25.05-3, the Department clarified that "year" in the context of service limits defined on a "per year" basis means calendar year. For any limit that is defined on a multi-year basis, each "year" means a rolling 365-day period or the 365 days following the date of the delivery of the first covered service subject to the limit. For example, a "two per three years" limit means a member cannot receive more than two of the specified services in any given 1,095-day period.
13. The Department removed the PA requirement for sedation in Section 25.03-9(A).
14. The Department removed the PA requirement for crowns for members under the age of 21 in Section 25.03-3(B).
15. The Department revised the definition for dental extern because the Board no longer issues permits to dental externs.
16. The Department redefined "dental resident" to mean "any person with a resident dental license, as defined in 32 MRS §18302."
17. The Department clarified in Section 25.03-6(A) that replacement dentures are covered when they are no longer sufficiently functional and there is not a cost-efficient way to repair them, not when they are "medically necessary," because dentures are not technically medically necessary.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $45,080,337 in FY 2023, which includes $15,991,326 in state dollars and $29,089,011 in federal dollars in state dollars and $29,089, 011 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 §8072; PL 2019 ch. 616 part A §A-7; PL 2021 ch. 398
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:	**2022-046** *(Repeal)*
Effective date:	3/23/2022
Type of rule:	Major Substantive
Emergency rule:	Yes

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

Basis statement:
The Department is repealing an emergency major substantive rule that was effective on April 7, 2021, and that included reimbursement rate increases for certain services under *MaineCare Benefits Manual*, ch. III section 29, "Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder", pursuant to PL 2019 ch. 616. Per 5 MRS §8072, emergency major substantive rules are effective for up to 12 months or until Legislative review. The Department has not yet initiated the proposed major substantive rulemaking associated with the April 7, 2021, emergency major substantive rule, and thus there is no provisional major substantive rule pending for review before the Legislature.

There is no decrease in reimbursement for any service affected by this repeal of the April 2021 emergency major substantive rule changes. The Department is repealing this emergency major substantive rule because of additional section 29 reimbursement rate changes that were required by PL 2021 ch. 398 (the "Act").

Simultaneous with the repeal of the emergency major substantive rule, pursuant to the Act, the Department will implement separate emergency routine technical rule changes that increase rates for section 29 providers. As set forth in the MAPA documents for the separate rulemaking, the Act authorized the Department to make those specific section 29 reimbursement rate changes on an emergency basis via routine technical rulemaking, even though ch. III section 29 rulemaking is typically major substantive. All of the section 29 reimbursement rates that were increased via the April 7, 2021, emergency major substantive rule (that is now being repealed) are included in the rate increases for the separate emergency routine technical rule. Because of the separate routine technical emergency rule, the repeal of the emergency major substantive rule will not have the effect of causing the reimbursement rates to revert to the lower rates that were in the current permanent major substantive ch. III section 29 (eff. 7/28/2019).

The separate routine technical emergency rule changes shall be effective for up to 90 days. The Department intends to proceed with proposed routine technical rulemaking to make permanent the increases to reimbursement rates enacted through the emergency rule changes. These increased rates in the separate routine technical rulemaking will be effective retroactive to January 1, 2022, as directed by the Act, per 22 MRS §42(8).

Fiscal impact of rule:
(No response)

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 2021 ch. 398
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:	**2022-047**
Effective date:	3/23/2022
Type of rule:	Routine Technical
Emergency rule:	Yes

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

Basis statement:
In response to the statewide staffing crisis and to comply with PL 2021 ch. 398 (the "Act"), the Department is implementing emergency routine technical rule changes to increase rates for providers of services under ch. III section 29, "Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder".

Section AAAA-1 of the Act enacts 22 MRS ch. 1627, Essential Support Worker Reimbursement. The new law requires that, effective January 1, 2022, the labor components of MaineCare reimbursement rates for specified services delivered by "essential support workers" must equal at least 125% of the minimum wage established in Title 26 section 664 subsection 1. Essential support workers are individuals who by virtue of employment generally provide to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or have direct access to provide care and services to clients, patients or residents regardless of the setting. 22 MRS §7401. In addition, part AAAA states that the reimbursement rate must include an amount necessary to reimburse the provider for taxes and benefits related to the wages. 22 MRS §7402(2). Section AAAA-2 of the Act specifies that the 125% of minimum wage requirement for essential support workers applies to ch. III section 29 services.

Additionally, part OOO of the Act authorizes the Department to implement cost of living increases (COLAs). In calculating the rate increases necessary to comply with part AAAA of the Act, the Legislature and the Department took into consideration the impact of planned COLAs on ensuring the labor components of the reimbursement rates for section 29 and other services specified under art AAAA are equal to at least 125 percent of minimum wage.

Rulemaking required for these particular rule changes are routine technical per 22 MRS §7404 (for the essential support worker increases), and part OOO of the Act (for the COLA-related increases) even though ch. III section 29 is generally a major substantive rule. *See, e.g.,* 22 MRS §3195.

Section GGGG-1 of the Act provides the Department with authority to enact these routine technical changes on an emergency basis, without the need to make findings in support of an emergency per 5 MRS §8054. These routine technical emergency rule changes shall be effective for up to 90 days. The Department intends to proceed with proposed routine technical rulemaking to make permanent the increases to reimbursement rates enacted through this emergency adoption.

These increased rates will be effective retroactive to January 1, 2022, as directed by the Act. The retroactive application of this rule comports with 22 MRS §42(8), which provides state authority for the Department to adopt rules with a retroactive application for a period not to

exceed eight (8) calendar quarters where there is no adverse financial impact on any MaineCare member or provider. Here, the rule change is a beneficial change for the providers.

Separately, effective December 31, 2021, and coinciding with the adoption of this emergency routine technical rule, the Department shall repeal an emergency major substantive rule that was adopted on April 7, 2021, and that included reimbursement rate increases for certain services under ch. III section 29 pursuant to PL 2019 ch. 616; emergency major substantive rules are effective for up to twelve months, or until Legislative review. The Department has not yet initiated the proposed major substantive rulemaking associated with the April 7, 2021, emergency major substantive rule, and thus there is no provisional major substantive rule pending for review before the Legislature. There is no decrease in reimbursement for any service affected by the repeal of the April 2021 emergency major substantive rule.

The Department shall seek approval from the Centers for Medicare & Medicaid Services (CMS) for the increased reimbursement rates. In addition, the Governor's proposed budget will ask the legislature for additional funds to support these increases and to meet the intent of Part AAAA of the Act ensuring labor components of all rates are at least equal to 125% of minimum wage.

Fiscal impact of rule:

(No response)

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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; PL 2021 ch 398; PL 2021 ch. 635
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:	**2022-118**
Effective date:	6/15/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
In response to the statewide staffing crisis and to comply with PL 2021 ch. 398 (the "Act"), the Department is adopting routine technical rule changes to increase rates for providers of services under Ch. III Section 29, "Allowances for Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder".

Section AAAA-1 of the Act enacts 22 MRS Chapter 1627, "Essential Support Worker Reimbursement". The new law requires that, effective January 1, 2022, the labor components of MaineCare reimbursement rates for specified services delivered by "essential support workers" must equal at least 125% of the minimum wage established in Title 26 section 664 subsection 1. Essential support workers are individuals who by virtue of employment generally provide to individuals direct contact assistance with activities of daily living or instrumental activities of daily living or have direct access to provide care and services to clients, patients or residents regardless of the setting. 22 MRS §7401. In addition, Part AAAA states that the reimbursement rate must include an amount necessary to reimburse the provider for taxes and benefits related to the wages. 22 MRS §7402(2). Section AAAA-2 of the Act specifies that the 125% of minimum wage requirement for essential support workers applies to Ch. III Section 29 services.

Additionally, Part OOO of the Act authorizes the Department to implement cost of living increases (COLAs). In calculating the rate increases necessary to comply with Part AAAA of the Act, the Legislature and the Department took into consideration the impact of the planned COLAs on ensuring the labor components of the reimbursement rates for Section 29 and other services specified under Part AAAA are equal to at least 125 percent of minimum wage. In addition, per PL 2021 ch. 635, *An Act To Make Supplemental 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, 2022 and June 30, 2023*, the Legislature has approved additional funds to support these increases and to meet the intent of Part AAAA of the Act ensuring labor components of all rates are at least equal to 125% of minimum wage.

The Department had previously implemented rates to include these labor component amounts (that are all equal to at least 125% of the minimum wage) in the emergency rule and also proposed the same rates. This final adopted rule includes rates with labor components that are all at least equal to 125% of the minimum wage.

Rulemaking required for these particular rule changes are routine technical per 22 MRS §7404 (for the essential support worker increases), and Part OOO of the Act (for the

COLA-related increases) even though Ch. III Section 29 is generally a major substantive rule. *See, e.g.,* 22 MRS §3195.

On March 22, 2022, the Department implemented these increased rates via an emergency routine technical rule, which shall be effective for up to 90 days. The rates are effective retroactive to January 1, 2022, as directed by the Act. The retroactive application of this rule comports with 22 MRS §42(8), which provides state authority for the Department to adopt rules with a retroactive application for a period not to exceed eight (8) calendar quarters where there is no adverse financial impact on any MaineCare member or provider. Here, the rule changes are beneficial for the providers. This adopted routine technical rulemaking seeks to make permanent the increases to the reimbursement rates enacted via emergency rule.

The Department received temporary approval on March 7, 2022 and intends to seek permanent approval from the Centers for Medicare & Medicaid Services (CMS) for the adopted increased reimbursement rates with a retroactive effective date of January 1, 2022.

The Department did not make any additional changes to the adopted rule as a result of public comments.

Fiscal impact of rule:

(No response)

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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 MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 42(8), 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 45**, Hospital Services, *and* **Ch. III Section 45**, Principles of Reimbursement for Hospital Services
Filing number:	**2022-212**
Effective date:	10/24/2022
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 (the "Department") finally adopts these rule changes in 10-144 CMR Chapter 101, Chapter II Section 45, "Hospital Services"; and Chapter III Section 45, "Principles of Reimbursement for Hospital Services".

The adopted rules consist of the following changes in Chapter II Section 45, "Hospital Services", and Chapter III Section 45, "Principles of Reimbursement for Hospital Services".

A. CHAPTER II, SECTION 45, HOSPITAL SERVICES

The adopted rule adds Outpatient Partial Hospitalization Services as a covered service for MaineCare members. These services may be offered by Acute Care Non-Critical Access Hospitals, Acute Care Non-Critical Access hospital-based clinics, or in a distinct part of the Acute Care Non-Critical Access Hospital, if allowed by the Hospital's license. These programs provide intensive psychiatric care that is more intensive than outpatient day treatment but less intensive than an inpatient program. Upon admission, a physician must certify that the member would need inpatient hospitalization services if the partial hospitalization services were not provided. The certification must include the diagnosis and psychiatric need for partial hospitalization. The adopted rule also allows for Certified Intentional Peer Support Specialist (someone who has undergone the training for this specialty and who maintains their certification) to be part of the multi-disciplinary team that provides Outpatient Partial Hospitalization Services.

After public comment, the Department declined to adopt the proposed rule change that required Hospital Emergency Departments to make referrals to designated Health Home providers. Instead, the adopted rule requires that Hospital Emergency Departments include discharge instructions for eligible individuals with chronic conditions to contact designated Health Home providers as required under the *Social Security Act* (SSA), Title 19, 42 USC Section 1945(d).

After public comment, the Department received CMS approval for several changes to the rule and updated the language in the adopted rule to reflect these approvals. The Department finds that these changes are necessary to improve clarity in the rules and to accurately reflect CMS' approval.

B. CHAPTER III, SECTION 45, PRINCIPLES OF REIMBURSEMENT FOR HOSPITAL SERVICES

The adopted rule adds Ch. III Sec. 45.07, "Value-Based Purchasing (VBP) Supplemental Sub-Pool", pursuant to PL 2021 ch. 398. The VBP Supplemental Sub-Pool distributes $600,000 annually, to eligible hospitals (acute care non-critical access, critical access, and hospitals reclassified to a wage area outside of Maine) that participate in the MaineCare

Accountable Communities initiative (defined by Ch. III Sec. 45.01-1). The funds are distributed based on performance of one or more quality measures. The Department ranks each eligible hospital based on the quality measures and allocates the funds according to performance, weighted by its Hospital Service Area.

Pursuant to Resolves 2021 Ch. 119, the adopted rule also provides reimbursement for members discharged from Southern Maine Health Care's psychiatric inpatient unit in the amount of $10,166 per distinct discharge effective retroactively to October 1, 2021.

The adopted rule also eliminates the need for annual rulemaking to update the supplemental pool amounts. The specific dollar amounts for the supplemental pools have been removed from the rule and replaced with a link to the MaineCare website and a phone number, which the public can call for detailed information on annual supplemental pool amounts. Ch. III Sec. 45.04-1(C); 45.08.

The proposed rule included a change to Ch. III, Sec. 45.03(3), which would have removed payments for graduate medical education costs in non-rural hospitals. After reviewing the public comments, the Department declines to adopt this provision of the proposed rule. The original language of this section remains unaltered in the adopted rule.

Fiscal impact of rule:

The Department anticipates that these changes will cost $12,393,864 in State Fiscal Year 2022 and $12,562,523 in State Fiscal Year 2023.

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Rules Adopted January 1, 2022 to December 31, 2022
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 §8053; 42 CFR Part 8; PL 2019 ch. 407; PL 2021,Ch. 398
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 65**, Behavioral Health Services
Filing number: **2022-219**
Effective date: 11/9/2022
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 ("the Department") adopted this rule to finalize the following changes to 10-144 CMR Ch. 101, *MaineCare Benefits Manual*, Chapter II Section 65, "Behavioral Health Services".

The Department adopts this rule to incorporate various new Intensive Outpatient Program (IOP) Services to be covered in Chapter II, including Mental Health, Developmental Disabilities/Behavioral Health, Geriatric, Dialectical Behavior Therapy, and Eating Disorder (Level I and Level II) IOPs. The adopted rule updates Substance Use IOP requirements and establishes requirements for new IOP services to include: IOP service and staff requirements, general and specific member eligibility criteria, as well as program requirements.

To align with federal regulations under 42 CFR Part 8, the Department adopts language in Chapter II replacing the term "Medication Assisted Treatment with Methadone (MAT)", with the term, "Opioid Treatment Program (OTP) with Methadone." The adopted Chapter II rule also updates requirements for OTPs, under Section 65.05-11, to align with the federal regulation including Counseling, Substance Use Disorder Testing, Medication Administration, and Facility Operation requirements in 42 CFR §8.12.

To reduce barriers to services and administrative burden to providers, the Department adopts a change in the definition of the Crisis Resolution Services "treatment episode" under 65.05-1, from limiting the service to "six (6) face-to-face visits and related follow up phone calls over a thirty (30) day period after the first face-to-face visit," to "face-to face visits and related follow up phone calls, as clinically indicated, for up to a sixty-day period after the first face-to-face visit." Additionally, the Department adopts the removal of language from Section 65.07-5(B) that limited substance use individual and family outpatient therapy to three (3) hours per week, for thirty (30) weeks in a forty (40) week period. Each of these changes provide broader access to these Section 65 services.

The rule also adopts clarifications on qualified staff allowed to provide Crisis Resolution Services (65.05-1) and Crisis Residential Services (65.05-2) to include Clinicians (as defined in 65.01-11), "Mental Health Rehabilitation Technicians (MHRTs)", "Behavioral Health Professionals (BHPs)", or with Certification at the level appropriate for the services being delivered and for the population being served.

As a result of comments, the Department determined not to adopt a rule change that would have removed the requirement that licensed Mental Health Agencies and Substance Use Agencies must separately contract with the Office of Child and Family Services and/or the Office of Behavioral Health.

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The adopted rule reorganizes requirements related to Individualized Treatment Plans in 65.08-4(B) and updates requirements for treatment plans for members receiving OTP services.

In addition and separately, the Department is adopting rulemaking to repeal and replace the former Ch. III of Section 65. The changes in Chapter III Section 65 make it consistent with the Chapter II-related updates, and related budget initiatives that require reimbursement increases for Section 65 providers, per PL 2021 ch. 398. The Chapter III Section 65 rulemaking shall be filed simultaneously, so that the upcoming changes will be effective at the same time these changes in Chapter II Section 65 are finally adopted.

Throughout the rule, the Department adopted edits to language to make updates to formatting, citations, and references where necessary, including changes to address potentially stigmatizing language based on recommendations from the Maine opioid task force and legislation passed in 2018 to minimize stigma (PL 2017, ch. 407).

The Department shall seek CMS approval for the new covered services and provider requirements, as specifically noted in various adopted rule changes.

Considering public comment, in addition to the changes to the adopted rule described above, the Department made the following changes to the adopted rule:

1. Pursuant to Comment #4, The Department updated its definition of Serious Emotional Disturbance in 65.01-41 to align with national standards through SAMHSA.
2. Pursuant to Comment #11, 65.05-5.A.2.a has been updated from "Intake and Comprehensive Assessment" to "Intake and service assessment" to reflect the purpose of the assessment under the IOP program.
3. Pursuant to Comment #1, 65.07-6 has been updated to remove the prohibition of billing the Comprehensive Assessment separately from final rule.
4. Pursuant to Comment #12, 65.07-6 has been updated to add "Members may receive additional outpatient services as medically necessary when the treating condition(s) is distinct from the condition(s) addressed by the IOP."
5. Pursuant to Comment #16, 65.05-1 been amended to change "specific to the population being served" to read "…at the level appropriate for the services being delivered and appropriate for the population being served" to allow for staff types to serve members when appropriate to do so.
6. Pursuant to Comment #21, 65.05-5.B.2.a has been updated to note the physician evaluation must be clinically indicated. The change is as follows:

"Assessment by a Clinician; and evaluation by a physician (MD/DO) as clinically indicated, as part of the service assessment; and…"

7. Pursuant to Comment #24, 65.05-6.C.2 has been updated to add "or" after each of the at risk criterion to clearly state a member meet one of a-d.
8. Pursuant to Comment #25, to 65.05-5.D.5 was updated to add "Otherwise Specified Feeding or Eating Disorder" and "Unspecified Feeding or Eating Disorder" in the final rule
9. Pursuant to Comment #31, 65.05-9.A.1.e was updated to add "or caregiver involvement, when appropriate."
10. Pursuant to Comment #38, 65.08-4.A.1-3 was updated to fix the numbering error.
11. Pursuant to Comment #39, the final rule updated references to amend the title of the "Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood" and to update to the current version 5 ("DC: 0-5").
12. As a result of legal review, the Department finds that it must update the definition of "Affected Other" has been updated to more clearly state the "Affected Other" have a familial relationship to the member.

13. As a result of legal review, the Department finds that it must make technical edits to 65.05-9.A for clarity and readability.

Fiscal impact of rule:

The Department intends to address the fiscal impact of all Ch. II-related updates and related budget initiatives identified in PL 2021 ch. 398 with corresponding changes in the *MaineCare Benefits Manual*, Ch. III Section 65.

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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; 42 CFR Part 8; PL 2019 ch. 407; PL 2021 ch. 398; PL 2021 ch. 635
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 65**, Behavioral Health Services
Filing number:	**2022-220**
Effective date:	11/9/2022
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 (the "Department") adopts this rule to repeal and replace the prior 10-144 CMR Ch. 101, *MaineCare Benefits Manual*, Chapter III Section 65, "Behavioral Health Services".

The Department adopts this rule to comply with PL 2021 Ch. 398 (the "Budget") and PL 2021 Ch. 635 (the "Supplemental Budget"). Per the Budget, the rule adopts increased medication management rates. This provision will be effective retroactive to October 1, 2021, as directed by the Supplemental Budget, and in alignment with 22 MRS §42(8), which authorizes the Department to adopt retroactive rules that do not have any adverse financial impact on any MaineCare provider or member. The Department received CMS approval for these rate changes in January 2022.

Additionally, pursuant to Legislative directive and funding, the rule will incorporate updates to Chapter III from an independent rate study recommending increases to rates for Substance Use Disorder Intensive Outpatient Program (IOP) services. This provision will be effective retroactive to January 1, 2022, pursuant to 22 MRS §42(8). On March 31, 2022, the Department submitted a request for changes to its SPA to implement these changes.
Also, pursuant to Legislative directive and funding, from the Budget as well as the Supplemental Budget, the rule adopts cost-of-living adjustments (COLAs) for services that have not received a rate adjustment in the prior 12 months, according to appropriate criteria for calculating COLAs. This provision will be effective retroactive to July 1, 2022, pursuant to 22 MRS §42(8). On September 30, 2022, the Department submitted a request for changes to its SPA to implement these changes.

The Department is adopting a separate rule for Chapter II Section 65, simultaneous with this adopted rule. The adopted changes in Chapter II include the addition of various new IOP Services including Mental Health, Developmental Disabilities/Behavioral Health, Geriatric, Dialectical Behavior Therapy, and Eating Disorder (Level I and Level II). The Department also adopted a new modifier (ST) for use with the H2021 code, for reimbursement tracking purposes of the Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) treatment modality, which is already allowable under Children's Comprehensive Community Support Services – HCT-Master's Level. This Chapter III rulemaking will adopt rates from an independent rate study for the new IOP Services pursuant to Legislative directive and funding from the Budget. These reimbursement rates shall be effective prospectively, upon the legal effective date of the adopted rule.

Throughout the rule, the Department adopts language consistent with the adopted Chapter II rule to address potentially stigmatizing language based on

recommendations from the Maine opioid task force and legislation passed in 2018 to minimize stigma (PL 2017 ch. 407).

The Department made the following change to the final rule:

- As a result of the Department's review, the Department finds that it must delete the term LADC because it was erroneously included in the proposed rule under the designated Substance Use Agency codes of H0004 (Outpatient Services – Individual/Family Therapy) and H0004 HQ (Outpatient Services – Group Therapy).

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $5,390,529 in SFY2022, which includes $1,170,242 in state dollars and $4,220,287 in federal dollars and $26,146,406 in SFY 2023, which includes $7,147,672 in state dollars and $18,998,734 in federal dollars.

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Rules Adopted January 1, 2022 to December 31, 2022
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 2021 Ch. 398 Sec. A-17; PL 2021, Ch. 348
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 90**, Physician Services
Filing number:	**2022-079**
Effective date:	5/14/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This final rule makes the following changes:

Pursuant to PL 2021 Ch. 398 Sec. A-17, *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, 2021, June 30, 2022 and June 30, 2023* (the "Budget"), and in alignment with the recommendations from the comprehensive rate setting evaluation conducted by Myers and Stauffer at the request of the Department, this final rule increases the reimbursement rate from 70% of the lowest level in the 2009 Medicare fee schedule to 72.4% of the current year's Medicare rate per code. In addition, the final rule sets the reimbursement rates for select primary care services at 100% of current Medicare rates, from 100% of 2014 Medicare rates, for eligible primary care providers, which is an additional reimbursement increase. These reimbursement changes shall be effective July 1, 2022, as authorized and required by the Budget.

Also per the Budget, the final rule adds a new provision, Section 90.04-7(B), "Physician-Administered Drugs that have Biosimilar Equivalents and/or Prior Authorization (PA) Criteria". This provision implements a Biosimilar Preferred Drug List which establishes preferred and non-preferred drug statuses based on cost and biosimilar equivalency for physician-administered drugs. Physician-administered drugs are those that satisfy the criteria in 90.04-7(A), but they also may be drugs administered orally. For drugs that are not administered orally, the adopted changes require providers not only to go through the steps set forth in 90.04-7(A), but also to use physician-administered biosimilar drugs when a physician-administered drug has a Food and Drug Administration- (FDA) approved, biosimilar equivalent that the Department identifies as more affordable. Annually, the Department shall identify drugs that have a more affordable FDA-approved biosimilar equivalent on the Biosimilar Preferred Drug List on the MaineCare Health PAS Online Portal. Physicians shall submit a PA request to administer the original drug. For physician-administered drugs that are administered orally, providers must satisfy the requirements in 90.04-7(B).

Section 90.04-7 also requires that some physician-administered drugs may require PA to ensure members meet age, clinical, or other requirements for MaineCare to provide payment and that the MaineCare Health PAS Online Portal contains a complete list of physician-administered drugs that require PA and corresponding PA criteria sheets. Providers must make requests for PA on the Department's approved form and get approval prior to the date of service. This new PA process is in addition to the requirements for PA in 90.04-7(A).

The final rule (Sec. 90.04-30) allows members under the age of 21 to receive the application of topical fluoride varnish up to four times per calendar year from eligible

providers, rather than two times per calendar year or three times for members with a high caries rate or new restorations placed in the last 18 months. This change aligns with other states' Medicaid program limitations on fluoride treatment and the current American Academy of Pediatrics recommendation on fluoride treatment. The final rule also removes the list of allowable providers who may provide topical fluoride varnish and has replaced "eligible providers" and "providers" with "qualified providers." The adopted rule (Sec. 90.04-31) also allows all members to receive an oral health risk assessment if they do not have a dental home and/or have not seen a dentist in the past year, rather than restricting the service to members under three years of age. In addition, the final rule adds dental hygienists to the list of providers in association with physician services in Section 90.04-15.

The final rule (Sec. 90.05-2(A)) clarifies that medication abortions are covered and shall be performed in compliance with applicable Food and Drug Administration law and guidelines.

The 130th Maine Legislature enacted PL 2021 Ch. 348, *An Act to Discontinue the Use of the Terms "Handicap," "Handicapped" and "Hearing Impaired" in State Laws, Rules and Official Documents*. The final rule replaces the term 'handicapped' with 'person with disabilities' pursuant to PL 2021 Ch. 348.

Effective June 21, 2022, this Section 90 rulemaking also eliminates Sec. 90.09-4, "Primary Care Provider Incentive Payment (PCPIP)", as part of the new Primary Care Plus (PCPlus) initiative. PCPIP authorizes an incentive payment to primary care practices (PCP) based on their performance on several access, utilization, and quality measures. Retaining this payment after PCPlus takes effect would be duplicative of the reimbursement PCPs will receive under the new PCPlus rule. PCPs who currently receive the Incentive Payment may instead apply to participate in PCPlus and, if approved as part of the program, will receive reimbursement based on their performance for members attributed to their practice.

To complete the transition to PCPlus, the Department also significantly revises MBM, Ch. II Sec. 91 (to be titled "Health Home Services – Community Care Teams"), which includes repealing "Health Home Practices". All of these rulemakings make up the PCPlus initiative, will be adopted simultaneously, and will have the same effective date.

The PCPlus program is intended to give primary care providers (PCPs) greater flexibility and incentives to effectively meet MaineCare members' health care needs by transitioning away from a volume-based (fee-for-service) payment system with little connection to value, toward an approach that provides risk-adjusted Population-Based Payments tied to cost- and quality-related outcomes. To receive reimbursement under PCPlus, providers are required to locate, coordinate, and monitor health care services for members who are attributed to them. The Department will continue to reimburse other MaineCare covered services under the fee-for-service system. Interested parties should refer to the new PCPlus rule (MBM, Ch. VI Sec. 3) for more details.

On April 21, 2022, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for the state plan amendment (SPA) to implement the PCPlus program. The Department shall seek approval from CMS for SPAs to repeal and revise any other programs necessary to implement the PCPlus program. The Department will publish notice of changes in reimbursement methodology pursuant to 42 CFR 447.205.

As described in detail in the Summary of Comments and List of Changes Made to Final Rule, the Department made a few changes to the final adopted rule, including: replacing the term "physician's assistant" with "physician assistant" in Sec. 90.04-15 and 90.04-24(B)(5); removing the list of allowable providers who may provide topical fluoride varnish and adding the term, "qualified providers;" adding dental hygienist to the list of providers in Sec. 90.04-15; and to align with the implementation of "Primary Care Plus", the Department established an effective date of June 21, 2022, for the removal of Sec. 90.09-4, "Primary Care Provider

Incentive Payment". The final adopted rule remains consistent with what was proposed and is not substantially different, per 5 MRS §8052(5).

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $8,276,041 in SFY 2022, which includes $2,661,873 in state dollars and $5,614,169 in federal dollars, and $16,552,083 in SFY 2023, which includes $5,355,592 in state dollars and $11,196,491 in federal dollars.

The initial phase (anticipated to be 18-24 months) of the PCPlus initiative is projected to be cost neutral. The cost of the new PCPlus rule is estimated to equal the savings from repealing Chapter VI Section 1, "Primary Care Case Management"; Section 91, "Health Homes Services" (excluding Community Care Teams); and the Primary Care Provider Incentive Payment within Section 90, "Physician Services". The Department will monitor program enrollment to assess ongoing fiscal impact. PCPlus and the Section 90 Primary Care Provider Incentive Payment program have different provider requirements, so there may be primary care providers who are currently eligible for the Sec. 90 Primary Care Provider Incentive Payment who will not be eligible for the PCPlus reimbursement.

Providers will receive increased reimbursement due to the changes in rates to 72.4% of the current year's Medicare rate per code and to 100% of current Medicare rates of select primary care services for eligible primary care providers.

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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 2021 Ch. 398 Sec. A-17; PL 2021, Ch. 348
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II and III Section 91**, Health Home Services – Community Care Teams
Filing number:	**2022-084**
Effective date:	6/21/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This adopted rule will have a future effective date of June 21, 2022, and will not be effective five days after filing the adopted rule with the Secretary of State's Office, as is typical.

This adopted rule makes the following changes:

This adopted rule eliminates Health Home Practices (HHP) from the Section 91 rule, makes various changes to Community Care Teams (CCTs), establishes the Housing Outreach and Member Engagement Provider (HOME Provider) as a provider of specialized CCT services and adds affiliated reimbursement rates to Chapter III Section 91, and changes the names of the Chapters II and III Section 91, rules to "Health Home Services – Community Care Team".

Health Home Practices and the PCPlus Initiative

HHPs are primary care practices that have been approved by MaineCare to provide Health Home Services. In this adopted rule, the Department eliminates HHPs as providers because it would be duplicative of the covered services and reimbursement which the members and primary care providers (PCPs), respectively, will receive via the new Primary Care Plus (PCPlus) program. To complete the transition to PCPlus, the Department repealed "Primary Care Case Management" (Ch. VI Sec. 1) and the Primary Care Provider Incentive Payment within Ch. II Sec. 90 ("Physician Services").

The PCPlus program is intended to give PCPs greater flexibility and incentives to effectively meet MaineCare members' health care needs by transitioning away from a volume-based (fee-for-service) payment system with little connection to value, toward an approach that provides risk-adjusted Population-Based Payments tied to cost- and quality-related outcomes. To receive reimbursement under PCPlus, providers are required to locate, coordinate, and monitor health care services for members who are attributed to them, as set forth in the PCPlus rule, Section 3.04. The Department will continue to reimburse other MaineCare-covered services under the fee-for-service system. PCPs who were HHPs may apply to participate in the soon-to-be-implemented PCPlus program and, if approved, will receive reimbursement based on their practice level characteristics and performance for members attributed to their practice. Interested parties should refer to the new PCPlus rule (MBM, Ch. VI, Sec. 3) for more details.

On April 21, 2022, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for the state plan amendment (SPA) to implement the PCPlus program. The Department shall seek approval from CMS for SPAs to repeal and revise any other programs necessary to implement the PCPlus program. The Department will publish notice of changes in reimbursement methodology pursuant to 42 CFR 447.205.

Members who were attributed to an HHP panel will not experience any direct impacts. Members will keep their PCPs, but those PCPs that were HHPs are no longer held to the HPP

provider and covered service requirements. Members will be notified of the HHP repeal if their PCP was an HHP and if their PCP becomes a PCPlus provider.

Community Care Teams

Under the adopted rule, CCTs support PCPs, rather than HHPs, by providing services to members who are high-risk and/or high-cost and whose health care needs are more intense than can be managed by a PCP. The rule expands, simplifies, clarifies, and removes redundancies from the covered service requirements.

Under the adopted rule, CCTs are subject to new provider requirements. CCTs must implement an electronic health record, participate in Department-required technical assistance and educational opportunities, maintain a Participant Agreement for data sharing with Maine's Health Information Exchange, follow ten core standards originally designed for and applied to HHPs, have a documented relationship with one or more PCPs, and have a multidisciplinary team of at least three health care professionals whose roles have been clarified.

The adopted rule also changes member eligibility requirements for CCT services to be more inclusive by decreasing the number of chronic medications, hospital admissions, and emergency department visits that are needed to qualify a member. Members are also now eligible if they are transitioning from an institutional setting and if members are identified by risk-stratification as at risk for deteriorating health; high-risk or high-cost due to severity of illness or high social needs; or higher health care needs than is expected for their clinical risk group. To receive CCT services Members must still have two or more chronic conditions or have one chronic condition and be at risk for another. The adopted rule also adds new risk factors that make a member at risk for a chronic condition.

Housing Outreach and Member Engagement Providers

Via *Resolve, To Increase Access to Housing-related Support Services*, LD 1318 (129th Legislature 2019), the Legislature directed the Department to examine federal opportunities to provide housing-related services to persons experiencing chronic homelessness who have mental health conditions or substance use disorder and other vulnerable populations. In addition, the Office of MaineCare Services, Maine State Housing Authority (MSHA), and various housing and homeless services providers applied for and were accepted into a Medicaid Innovation Accelerator Program (IAP) for State Medicaid-Housing Agency Partnerships with technical assistance from the Corporation for Supportive Housing (CSH) and the Center for Health Care Strategies (CHCS). The collaborative group focused on improving outcomes for MaineCare members with disabilities and chronic health conditions, including Substance Use Disorder (SUD), who are experiencing homelessness and developing a Medicaid benefit to support housing sustainability, improved health outcomes, and reduced overall costs of care. The group proposed to use Section 2703 of the *Affordable Care Act* to develop a new type of CCT, a "HOME Provider," that would provide comprehensive care management and medical and behavioral health care coordination with intensive levels of transitional care and individual supports to meet the needs of MaineCare members with long-term homelessness.

HOME Providers shall conduct outreach to underserved populations in need of intensive HOME services due to high emergency services utilization, chronic conditions, complex care coordination needs, and long-term homelessness. The HOME Provider shall be comprised of a manager, clinical leader, case manager, peer support staff, and housing navigator. HOME Providers shall receive and review referrals for HOME service eligibility and enrollment from any point of care, including but not limited to hospitals, medical and behavioral health providers, and community service organizations. HOME Providers shall provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services, and referral to community and social support services. There are three HOME service tiers in which members can be enrolled. Members must first meet the Intensive Tier criteria before entering the Stabilization and Maintenance Tiers. Each tier

represents an intensity level of covered services and has a different per member per billing month reimbursement amount. Eligible members who are children may receive covered HOME services, as long as the HOME Provider obtains written consent from a parent or legal guardian.

Lastly, the adopted rule requires both CCTs and HOME Providers to submit data necessary to compile and report on performance measures, as identified by the Department. This will aid in the development of value-based metrics to include in future iterations of rulemaking and to ensure that the services provided are high-quality. The rulemaking also defines "billing month" as the period from the 21st of a month to the 20th of the following month and, when appropriate, replaces "month" and "calendar month" with "billing month" to clarify the reimbursement period for providers.

As described in detail in the Summary of Comments and List of Changes to Final Rule, the Department made a few changes to the final adopted rule, including: the addition of physician assistants to the list of allowable CCT Medical Director provider types; reinserting "practice-integrated" into the CCT definition and making changes to allow HOME Providers to be practice-integrated providers; clarifying that only diagnoses relating to eligibility must be documented in the member's electronic health record (not the plan of care); requiring a member's choice between duplicative services be retained in the member's electronic health record instead of retaining a record of written documentation; and clarifying in Sec. 91.01-4 that CHW core competencies are those competencies as defined by *The Community Health Worker Core Consensus Project* (see https://www.c3project.org/roles-competencies). The final adopted rule remains consistent with what was proposed and is not substantially different, per 5 MRS §8052(5).

Fiscal impact of rule:

22 MRS §§ 42, 3173; Section 2703 of the *Affordable Care Act*; LD 1318 (129th Legislature 2019), *Resolve, To Increase Access to Housing-related Support Services*; PL 2021, ch. 398 Sec. A-17, *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, 2021, June 30, 2022 and June 30, 2023.*

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 2021 ch. 635 Part A
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 93**, Opioid Health Home Services, *and* **Ch. III Section 93**, Reimbursement for Opioid Health Home Services
Filing number:	**2022-147**
Effective date:	8/21/2022
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 (the "Department") finally adopts these rule changes in 10-144 CMR Ch. 101, *MaineCare Benefits Manual*, Chapter II Section 93, "Opioid Health Home Services", and Chapter III Section 93, "Reimbursement for Opioid Health Home Services", to improve access to treatment, reduce administrative barriers to providing treatment for Opioid Use Disorder (OUD), promote evidence-based treatment standards, and reinforce the importance of Opioid Health Home (OHH) integration with primary care. The Department received approval of a state plan amendment (SPA) from the Centers for Medicare & Medicaid Services (CMS) for some of these changes. The Department will publish notice of changes in reimbursement methodology pursuant to 42 CFR 447.205.
These rules will be legally effective on August 21, 2022.
The adopted rules consist of the following changes in Chapter II, Section 93, Opioid Health Home Services, and Chapter III, Section 93, Reimbursement for Opioid Health Home Services:

A. CHAPTER II SECTION 93, *OPIOID HEALTH HOME SERVICES*

The adopted rule makes various changes to the Medication for Opioid Use Disorder (MOUD) prescriber position. It allows practitioners licensed under state and federal law to order, administer, or dispense opioid agonist treatment medications to be MOUD prescribers for members in the Methadone Level of Care who receive OHH services from an Opioid Treatment Program (OTP). It requires the MOUD prescriber to coordinate with the OTP OHH when members in the Methadone Level of Care receive OHH services from a non-OTP OHH. It also requires MOUD prescribers to be involved in providing the services described under Chapter II Section 93.05-1, "Health Home Services".

The adopted rule makes various changes to the nurse care manager position on the OHH team. In response to requests from providers, the adopted rule allows licensed practical nurses to be nurse care managers. It requires any person serving as the nurse care manager to complete the eight-hour training for buprenorphine prescribing by physicians within six months of initiating service delivery for OHH members, unless the individual is an Advanced Practice Registered Nurse with a X-Drug Enforcement Administration (DEA) license. It no longer requires the nurse care manager to oversee and/or participate in all aspects of OHH services because the nurse care manager would not oversee OUD counseling. The final rule specifies that the nurse care manager position may be filled by another appropriately licensed medical professional on the OHH team, as long as the individual completes training for an X-DEA license within six months of initiating service delivery for OHH members.

The adopted rule adds methadone to the medications included in the OHH model and enables an OTP to provide methadone to OHH members. The adopted rule also adds a statement encouraging the co-prescribing of naloxone for OHH members, as appropriate, in alignment with best practice guidelines.

The adopted rule makes a number of changes to the counseling requirement. It clarifies that counseling is not required for the Medication Plus Level of Care and is not part of the OHH bundle for the Methadone Level of Care. It changes the counseling requirement to be assessed on a monthly instead of weekly basis, which is in response to feedback that weekly requirements are too stringent for this service and are challenged by normal life events. It clarifies that counseling requirements for each clinical phase are based on a "billable" month (in alignment with standard billing practice), which does not always equate to a full 60 minutes of counseling. The final rule requires OHH members in Intensive Outpatient (IOP) and Induction Levels of Care to engage in individual or group counseling for four billable hours per month; members in the Stabilization Level of Care for two hours; and members in the Maintenance Level of Care for one hour.

The adopted rule makes various changes to the reimbursement section. The adopted rule allows providers to bill the new Medication Plus and Methadone Levels of Care if the member is enrolled for at least one day during the billing month. It adds that OHH providers will not be reimbursed for an OHH member if that member also receives Section 97, "Private Non-Medical Institution Services"; Section 13, "Targeted Case Management Services"; Section 17, "Community Support Services"; or Section 92, "Behavioral Health Homes", unless the Section 13, 17, or 92 provider has a contract with the OHH to provide Health Home Services. The final rule also adds an Additional Provider Support provision for OHH members with additional community support needs related to mental health, HIV, medical concerns and/or utilization, and/or homelessness. The Department or its authorized entity must approve additional supports provided to eligible members and reimbursed through the pass-through payment described in Chapter III Section 93, "Reimbursement for Opioid Health Home Services", including an active release of information and a contractual agreement between the OHH and additional support provider.

The adopted rule also adds a pay-for-performance provision which withholds four percent of total OHH per member per month (PMPM) payments. This amount shall be paid to providers every six months if they satisfy the minimum performance threshold, and providers who meet the excellent performance threshold are eligible to receive any additional available amount. The Department shall set the performance thresholds so that no less than 70% of eligible OHHs are expected to be above the minimum performance threshold and no less than 20% of OHHs are expected to be above the excellent performance threshold. This means the Department anticipates that no more than 30% of eligible OHHs would not meet the minimum performance threshold and thus would not receive the four percent payment. Those four percent withhold amounts will be combined and distributed to OHH providers that meet the excellent performance threshold. If all OHH providers do satisfy the minimum performance threshold, then no amounts would be distributed to OHH providers who satisfy the excellent performance threshold. Performance calculations shall be based on the composite score of three performance measures, as set forth in the adopted rule. Providers shall receive reports quarterly to inform them about whether they satisfied the minimum or excellent performance threshold standards, what their reimbursement shall be, as well as instructions for appeal if they disagree with the Department's determinations.

This adopted rule also makes the following changes:

- Clarifies that the clinical counselor provides behavioral health expertise and contributes to care planning, assessment of individual care needs, and identification of and

connection to behavioral health services, as part of the services described in Chapter II Section 93.05-1.

- Allows community health workers to be patient navigators, in response to requests from providers. A definition and certification/training requirements for community health workers is also added.
- Requires Connecticut Community for Addiction Recovery (CCAR) or other Department approved recovery coach training for recovery coaches. OHHs will have six months from rule adoption to train existing staff, and each new recovery coach will have six months to complete the applicable training upon starting to deliver OHH services.
- Encourages people with lived experience to serve as recovery coaches but also allows recovery allies to serve as recovery coaches.
- Requires the OHH to adopt processes to identify and classify patients across their population served who are missing critical preventive services and/or other health screenings.
- Adds that members must be assessed for appropriateness of OHH services in alignment with American Society of Addiction Medicine guidelines.
- Requires OHHs to retain a signed consent form for all OHH members in the member record. The documentation must indicate that the individual has received information in writing, and verbally as appropriate, that explains the OHH purpose and the services provided and indicates that the individual has consented to receive the OHH services and understands their right to choose, change, or disenroll from their OHH provider at any time.
- Requires OHH providers to provide and document efforts to connect each OHH member to a primary care provider.
- Adds that health promotion activities may include health education and referral support for health-related risk factors (e.g. oral health, contraceptive counseling, preventive screenings).
- Removes language that referred to "coordinated case management" to align with language for the approved MaineCare SPA for these services, which instead utilizes an expanded team-based approach for the provision of additional supports, reimbursed through pass-through payments.
- Requires OHHs to conduct a comprehensive biopsychosocial assessment annually.

B. CHAPTER III SECTION 93, *REIMBURSEMENT FOR OPIOID HEALTH HOME SERVICES*

The adopted rule introduces the Medication Plus and Methadone Levels of Care. The Medication Plus Level of Care reimburses for all OHH covered services except for OUD counseling, which allows members to receive OUD medication without electing to participate in OUD counseling. The Methadone Level of Care allows members who receive methadone from Chapter II Section 65, Behavioral Health Services, providers to receive Health Home services from the team-based care delivery model of the OHH.

Under the current rule, when members receiving OHH services elect to receive comprehensive care management and comprehensive transitional care from an additional support provider, the Department reimburses both providers separately. CMS advised that the OHH must reimburse the additional support provider via a pass-through payment. Hence, this final rule increases the reimbursement amount to the OHH provider to include a pass-through payment of $394.40 for the IOP, Induction, Stabilization, and Maintenance Levels of Care when members elect to receive services from an additional support provider.

In alignment with the Department's goal to implement value-based payment models tied to quality, the final rule adds a pay-for-performance provision that will withhold four (4)

percent of OHH payments, pending the OHH's performance on three measures of OHH quality and effectiveness of service. The measures include assessing whether members in Maintenance and Stabilization Levels of Care have attended an annual primary care visit, had continuous pharmacotherapy as part of their MOUD, and are involved in regular employment or other forms of community engagement. While the methodology for this pay-for-performance provision is detailed in rule, MaineCare will evaluate the need for adjustments to ensure OHH providers are not inappropriately penalized for the costs or changes in quality/utilization that result from COVID-19. Performance measure thresholds and the performance of other providers will determine if OHHs receive the full four percent and if they are eligible for a pay-for-performance surplus payment.

C. SUMMARY OF CHANGES TO CHAPTER II SECTION 93, AND CHAPTER III SECTION 93, AS THE RESULT OF PUBLIC COMMENT

As described in detail in the Summary of Comments and Responses document, the Department made a few changes to the final adopted rule, including: replacing the term Medication Assisted Treatment (MAT), which implies that medication assists treatment, with the term Medication for Opioid Use Disorder (MOUD), a more current term that implies medication is its own form of treatment; changing the language of the Continuity of Pharmacotherapy for OUD numerator in Chapter III Section 93, to better align with the language used by the measure steward, USC; adding Chapter II Section 93.02-1(K), which requires OHHs to refer members to another OHH or appropriate provider when a member requires treatment or a level of care that the OHH does not offer; changing Chapter II Section 93.02-1(G), to require OHHs to establish and maintain a relationship with a primary care provider when an OHH member has a primary care provider, rather than require OHHs to establish and maintain a relationship with a primary care provider for each member served, which did not accurately reflect the requirement the Department intended to establish; implementing a cost-of-living-adjustment by increasing the proposed reimbursement rates in the final Chapter III Section 93, rule by 4.94%; and changing the term "dosage plan" to "medication plan;" and setting the effective date to August 21, 2022.

Fiscal impact of rule:

The Department anticipates that this rulemaking will cost approximately $20,082 in SFY 2022, which includes $4,828 in state dollars and $15,254 in federal dollars, and $240,983 in SFY 2023, which includes $58,622 in state dollars and $182,361 in federal dollars.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
Prepared by the Secretary of State pursuant to 5 MRS §8053-A sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173; *Social Security Act* §1905(t)(1) (42 USC §1396d(t)(1))
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. VI Section 3**, Primary Care Plus (*replaces* **Ch. VI Section 1**, Primary Care Case Management
Filing number:	**2022-083**
Effective date:	6/21/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This adopted rule will have a future effective date of June 21, 2022, and will not be effective five days after filing the adopted rule with the Secretary of State's Office, as is typical.

Ch. VI Sec. 1 (Primary Care Case Management)

This adopted rulemaking repeals Ch. VI Sec. 1, "Primary Care Case Management (PCCM)" from 10-144 CMR Ch. 101, **MaineCare Benefits Manual** (the "MBM").

Ch. VI Sec. 3 (Primary Care Plus)

This rulemaking replaces Ch. VI Sec. 1 (PCCM) with MBM Ch. VI Sec. 3, "Primary Care Plus (PCPlus)", a single integrated program for MaineCare's current primary care programs. To complete the transition to PCPlus, the Maine Department of Health and Human Services (the "Department") also repealed MBM Ch. II Sec. 90.09-4 ("Primary Care Provider Incentive Payment") and significantly revised MBM Ch. II Sec. 91 (titled "Health Home Services – Community Care Teams"), which includes repealing "Health Home Practices". All of these rulemakings relate to the PCPlus initiative and have the same effective date.

On April 21, 2022, the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for the state plan amendment (SPA) to implement the PCPlus program. The Department shall seek approval from CMS for SPAs to repeal and revise any other programs necessary to implement the PCPlus program. The Department will publish notice of changes in reimbursement methodology pursuant to 42 CFR 447.205.

As a result of comments, the Department determined that it would delay the effective date of the PCPlus rule until June 21, 2022. The removal of the Primary Care Provider Incentive Payment in Section 90 and the final adopted changes in Section 91 (described below and in separate MAPA documents) shall also be effective June 21, 2022.

Overview of the PCPlus Initiative

The Department and the Office of MaineCare Services (OMS) are committed to improving health care access and outcomes for MaineCare members, demonstrating cost-effective use of resources, and creating an environment where providers can innovate in delivering high-value care. PCPlus is part of OMS' commitment to have 40% of MaineCare expenditures paid through Alternative Payment Models (APMs) by the end of 2022. APMs are health care payment methods that use financial incentives to promote or leverage greater value, indicated by higher quality care and/or lower costs.

PCPlus is considered an "Integrated Care Model" by CMS under State Medicaid Director Letter #12-002, aligns with the Center for Medicare and Medicaid Innovation's (CMMI) Primary Care First Model (See also: https://innovation.cms.gov/innovation-models-options), and

operates under the authority of Section 1905(t)(1) of the **Social Security Act (SSA).** The PCPlus program is intended to give primary care providers (PCPs) greater flexibility and incentives to effectively meet MaineCare members' health care needs by transitioning away from a volume-based (fee-for-service) payment system with little connection to value, toward an approach that provides risk-adjusted Population-Based Payments tied to cost- and quality-related outcomes.

Participation in PCPlus is voluntary for PCPs. For PCPs that elect to participate, the Department will share quality and utilization data, offer a new value-based payment model, and provide technical assistance to assist practices to transform care delivery and achieve performance outcomes. The new payment model is risk-based, meaning reimbursement will increase or decrease depending on the PCPlus provider's performance, as set forth in Section 3.08 of the rule. Providers may appeal Departmental actions, pursuant to Chapter I, Section 1.

Member participation in this model is based on which PCP the member visited for health care services or by the members' identification of a PCP through calling MaineCare Member Services. Member participation is voluntary and does not interfere with MaineCare members' freedom of choice to access other MaineCare providers. If a member identified their PCP for attribution through MaineCare Member Services but does not receive at least one primary care service from their selected PCP within one year, then DHHS will notify and reattribute the member in accordance with the primary care services-based attribution methodology. Members may change their PCP or opt out of PCPlus at any time.

To receive reimbursement under PCPlus, providers are required to locate, coordinate, and monitor health care services for members who are attributed to them, as set forth in Section 3.04. All covered services rendered by PCPlus providers must be documented in the member's electronic health record. The Department will continue to reimburse other MaineCare covered services under the fee-for-service system.

Differences Between PCPlus and PCCM

CMS considers PCCM to be a form of managed care, which operates under Section 1905(a)(25) of the SSA and 42 CFR 438.6 with mandatory member participation for the majority of MaineCare members. PCPlus operates under 1905(t)(1) of the SSA and is not a managed care program. Since PCPlus is not a managed care program, it does not include many of the managed care requirements that PCCM follows. For example, except as set forth in the rule, member participation in PCPlus is based on members' selection of a PCP, members may opt out of this program, and this program has no bearing on MaineCare members' freedom of choice to access services from any qualified MaineCare provider. In addition, PCPlus, unlike PCCM, does not include the PCCM provisions on member participation or complaints, and PCP selection, change, and reassignment.

Under both PCCM and PCPlus, providers locate, coordinate, and monitor health care services. However, PCPlus expands service and practice requirements to support whole-person coordination and transitions of care; completing timely prior authorizations; providing, tracking, and following up on referrals; and closing care gaps, including a focus on preventive services.

PCCM providers who choose to participate in PCPlus will benefit from a new value-based payment model, which includes a risk-adjusted population-based payment tied to cost- and quality-related outcomes, rather than the flat per member per month management fee provided under PCCM. Given the additional requirements and support for providers, PCPlus should improve health outcomes for members.

Section 90 and 91 Rulemakings for PCPlus Initiative

Regarding the related adopted rulemaking for Section 90, the Department eliminated the Primary Care Provider Incentive Payment because it would duplicate the reimbursement model of the new PCPlus program. Physicians who received the Incentive Payment may apply

to be PCPs under the PCPlus program, and, if approved, will receive reimbursement based on the PCPlus service expectations and performance for members attributed to their practice.

For Section 91, as it relates to the PCPlus initiative, the Department removed Health Home Practices (HHPs) because payment for these Health Home services would be duplicative of the reimbursement the PCPs will receive and the covered services they provide via PCPlus. HHPs that received reimbursement through Section 91 may apply to participate in the PCPlus program, and, if approved, PCPs will receive reimbursement based on the PCPlus service expectations and performance for members attributed to their practice.

As more specifically set forth in the Summary of Public Comments and Department Responses document, the Department made several changes to the final adopted rule, including: clarifying in Sec. 3.02-6 that CHW core competencies are those competencies defined by The Community Health Worker Core Consensus Project (see https://www.c3project.org/roles-competencies); adjusting the attribution assessment period in Section 3.02-2 from twelve (12) months to twenty-four (24) months; changing the Section 3.03-2(J) CHW requirement to become effective April 1, 2024, rather than one year after the PCPlus effective date; adding to Section 3.08-1(B) that "providers may request a reassessment of their Population Group and Risk Category PMPM if there is a significant change within the practice, such as a relocation or inclusion of a new population;" and clarifying in Section 3.03-2(H) that "advisory activities may include, but are not limited to, having MaineCare members on an advisory board and/or holding focus groups with members. Solely collecting survey data, e.g., patient experience data, without inclusion of members/families in synchronous engagement activities to identify needs and solutions is insufficient." The final adopted rule remains consistent with what was proposed and is not substantially different, per 5 MRS §8052(5).

Fiscal impact of rule:

22 MRS §§ 42, 3173; *Social Security Act* §1905(t)(1) (42 USC §1396d(t)(1))

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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:	PL 2021 ch. 398; 22 MRS §§ 42, 42(8), 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. VII Section 5**, Estate Recovery
Filing number:	**2022-020**
Effective date:	2/20/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This adopted rule implements PL 2021 ch. 398 Part A §A-1, pg. 99 to modify MaineCare estate recovery rules to conform with the minimum mandatory federal requirements, which are set forth in 42 USC 1396p(b).

These rule changes were originally implemented via an emergency rule, effective November 24, 2021; routine technical emergency rules are effective for 90 days. This final adopted rule permanently changes the Department's estate recovery claim so that it is limited to the amount paid by MaineCare for all nursing facility services, home and community-based services, and hospital and prescription drug services related to these services paid on behalf of the Member. The effective date of this change is November 24, 2021, since that is when the emergency rule was implemented.

Additionally, this adopted rule clarifies the definition of life estate, including how life estates are valued.

As a result of public comments and further review by the Department and the Office of the Attorney General, there were additional minor changes to the adopted rule language for purposes of clarity. The Summary of Public Comments and Department Responses document identifies more specifically all changes that were made to the final rule.

Finally, this adopted rule removes language regarding CMS's pending approval because the Department has received CMS approval for those changes.

Fiscal impact of rule:
(No response)

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 §674(4)(D); 22 MRS Ch. 160; *Atomic Energy Act of 1954* (PL 83-703), *as codified* 42 USC 2011 et seq.
Chapter number/title:	**Ch. 220**, Radiation Protection Rule
Filing number:	**2022-210**
Effective date:	10/23/2022
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, Maine Center for Disease Control and Prevention (Department), advertised rulemaking changes for 10-144 CMR Ch. 220, the *Radiation Protection Rule*, on June 8, 2022, with a 30-day public comment period. The comment period ended on July 8, 2022. The Department received no comments related to the rulemaking.

The *Atomic Energy Act of 1954*, Section 274, provides the statutory basis under which the U.S. Nuclear Regulatory Commission (NRC) relinquishes portions of its regulatory authority to state agencies to license and regulate byproduct materials (radioisotopes), source materials (uranium and thorium), and certain quantities of special nuclear materials. The mechanism for the transfer of NRC's authority to a state is an agreement signed by the Governor of each state and the Chairman of the NRC Commission, in accordance with section 274b of the Act. As an "agreement state," Maine must remain compliant with the NRC's requirements to regulate sources of ionizing radiation and to maintain the public health and safety with respect to those materials covered in the agreement.

As an agreement state, Maine's regulations must be identical to the NRC's regulations for federal radioactive materials licensees, to achieve compatibility with health and safety categories established in the Office of Federal and State Materials and Environmental Management Programs (FSME) Procedures SA-200.

Therefore, the Department is adopting these changes to the rule, in part to implement corrections recommended by the NRC via communications dated: December 17, 2012, August 27, 2013, January 26, 2015, September 2, 2015, October 23, 2015, January 14, 2019, June 16, 2020, August 17, 2020, November 16, 2020, and September 8, 2021. In 2019, the Department amended the *Radiation Protection Rule*; however, the Department did not address all the NRC's recommendations from December 17, 2012, August 27, 2013, January 26, 2015, September 2, 2015, October 23, 2015, and January 14, 2019. This current rulemaking further implements all corrections not yet addressed by the NRC's recommendations, as well as all others recommended in the NRC's 2020 correspondence to the Department. These corrections align with federal radiation regulations, and clarify rule requirements. These rule changes make it easier for regulated entities to comply with these standards, due to the correction of errors and greater consistency with federal and state radiation rules outside of Maine. The Department made the following changes:

Part A General Provisions

- Add definitions for *initial transfer* and *ore*.
- Correct the internal reference in the definition of *radiation therapy physicist* from "Part G §961" to "Part G.690."

- Revise the definition of *unrefined* and *unprocessed ore* to include, "processing does not include sieving or encapsulation of ore or preparation of samples for laboratory analysis" to be consistent with 10 CFR §40.4.

Part C Licensing of Radioactive Material

- C.2.C: add additional information about exemption requirements for a license regarding source material to be consistent with 10 CFR §40.13(c).
- C.2.C(2)(a) and (b): clarify source products exempt from regulatory requirements to be consistent with 10 CFR §40.13c(2)(i) and (iii).
- C.2.C.(5)(a): remove reference to uranium counterweight distribution and licensing, due to 10 CFR §40.13(c)(5)(i) being removed.
- C.2.C.(5)(d): add statement to clarify the requirements in C(5)(a) and (b) for counterweights.
- C.2.C.(7), C(2)(C)(7)(a) & (b): clarify thorium and uranium when used as source material in optical lenses, optical instruments, and mirrors, to be consistent with 10 CFR §40.13(c)(7).
- C.2.C(8): remove "uranium contained in detector heads for use in fire detection units, provided that each detector head contains not more than 0.005 microcuries of uranium" due to 10 CFR §40.13(b) being removed.
- C.2.C(10), C(2)(C)(10)(a) & (b): add language to clarify licensing requirements for individuals to transfer, sell or distribute source materials to be consistent with 10 CFR §40.13(c)(10).
- C.2.C(10), C(2)(C)(9): for clarity reformat rule so that (9) becomes Subsection D and (10) becomes Subsection E.
- C.3.C(1)(g): add certain static elimination devices as an exempt item to be consistent with 10 CFR §30.15(a)(2).
- C.3.C.(1)(h): add certain ion generating tubes as an exempt item to be consistent with 10 CFR §30.15(a)(2).
- C.3.C(3)(C): update requirements for a license to process, produce or transfer for sale or distribution of certain self-luminous products.
- C.3.C.(4)(a): clarify this section regarding licensing and registration for persons to manufacture, process, produce or transfer certain gas and aerosol detectors containing radioactive material, to be consistent with 10 CFR §30.19(b).
- C.3.C(4)(a): replace "radioactive material" with "byproduct material," to be consistent with 10 CFR §30.20.
- C.3.C(4)(C): add "and for a certificate of registration in accordance with 10 CFR Part 32.210" for clarity.
- C.3.C(6) & (7): clarify is required to obtain a license and who is exempt from obtaining license to manufacture, transfer or sell products with byproduct radioactive material to be consistent with 10 CFR §30.22. Provide internal references to both the rule and to 10 CFR Part 32.210.
- C.5.A(1): clarify the purpose of obtaining a general license, to be consistent with 10 CFR §40.22(a).
- C.5.A(1)(a) through (d): add information about the amounts of uranium and thorium that a licensee may possess and under what conditions or circumstances, to be consistent with 10 CFR §40.22(a)(1) through (a)(4).
- C.5.A(2)(a) through (e): add information about the use and handling of source material, including use on humans, abandonment of source material, timely responses to written requests from the Department for information on the handling of source material, and restrictions on exporting source material to be consistent with 10 CFR §40.22(b).

- C.5.A(3): add language to minimize contamination to the facility and to the environment, to be consistent with 10 CFR §40.22(c).
- C.5.A(4): add language to provide additional information around exemptions that include internal references to the rule and to 10 CFR Part 21, to be consistent with 10 CFR §40.22(d).
- C.5.A(5): add language regarding the transfer and distribution of source material, including internal references to the rule, to be consistent with 10 CFR §40.22(e).
- C.6.(A), C.6.A(1) & (2): remove licensing requirements for a static elimination device and for an ion generating tube, because this requirement from 10 CFR §31.3 has been removed.
- C.6.C.(3)(h)(iii): update internal reference.
- C.7.G: add clarifying language and internal rule references for when a specific license must be obtained for byproduct material in a sealed source or a device that contains a sealed source, to be consistent with 10 CFR §30.32(g).
- C.7.H: update the manufacture date from “November 30, 2007” to “October 23, 2012”, to be consistent with 10 CFR §30.32(g).
- C.7.I. and J: add information regarding the registration of sealed sources and devices to be consistent with 10 CFR §32.53(f).
- C.8.F(4)(b): update internal rule references for accuracy.
- C.8.F(5): update requirements for decommissioning plan costs, to be consistent with 10 CFR §30.35(e).
- C.11.E(1)(b)(v): add “Quality assurance procedures to be followed that are sufficient to ensure compliance with C.11.E(3)”, to be consistent with 10 CFR §32.53(b)(5).
- C.11.E(1)(d)(iv) and (v): add requirements for the manufacture, assembly, or repair of luminous safety devices for use in aircraft, to be consistent with 10 CFR §32.53(d)(4) and (e).
- C.11.E(3): update quality assurance criteria for prohibitions on transfer of luminous safety devices, to be consistent with 10 CFR §32.55.
- C.11.E(4): remove quality assurance criteria for prohibitions on transfer of luminous safety devices, to be consistent with 10 CFR §32.56.
- C.11.E(5): update criteria for material transfer reports, to be consistent with 10 CFR §32.56.
- C.11.F(1)(e)(ii): update internal reference in this section, to be consistent with 10 CFR §32.72(d)(2).
- C.11.F(1)(f): add additional requirements for a license to manufacture calibration sources containing americium-241, plutonium or radium-226 for distribution, to be consistent with 10 CFR §32.57(e).
- C.11.F(2): remove this section from the requirements for a license to manufacture calibration sources containing americium-241, plutonium or radium-226 for distribution, due to the fact that 10 CFR §32.102 has been removed.
- C.11.F(4): add language to clarify the leak testing of each source, to be consistent with 10 CFR §32.59.
- C.11.I(1)(e)(iv): clarified language to be consistent with 10 CFR 32.61(e)(4).
- C.11.I(1)(f): add quality assurance tests of ice detection devices containing strontium-90, to be consistent with 10 CFR §32.61(f).
- C.11.I(1)(g): add a requirement that ice detection devices containing strontium-90 must be registered in the Sealed Source and Device Registry, to be consistent with 10 CFR §32.61(f).

- C.11.I(2)(c) through (e): update the quality assurance criteria for persons licensed to manufacture and distribute ice detection devices containing strontium-90, to be consistent with 10 CFR §32(c),(d) and (e).
- C.11.I(3): remove the schedule D prototype tests for ice detection devices containing strontium 90, because 10 CFR §32.103 has been removed.
- C.11.J(4): add, "a licensee shall satisfy the labelling requirements in C.J.1(c)", to be consistent with 10 CFR §32.72.
- C.11.L(4): add, "the source or device has been registered in the Sealed Source and Device Registry", to be consistent with 10 CFR §32.74(a)(3).
- C.12: update special requirements for issuance of license for initial transfer of small quantities of source material.
- C.14.B(1): clarify criteria for the application of a transfer license, to be consistent with 10 CFR §30.34(b)(1) and (2).
- C.14.D: update reporting requirements by stating, "The licensee shall report the results of any test that exceeds the permissible concentration listed in Part G.204.A of these rules at the time of generator elution, in accordance with Part G.3204 of these rules" to be consistent with 10 CFR §30.34.
- C.14.H: add to clarify the requirements for a license to initially transfer source material for use under the 'small quantities of source material' general license.
- C.21.E: add requirements for a license to initially transfer source material for use under the 'small quantities or source material' general licenses to be consistent with 10 CFR §40.54.
- C.21.F: add conditions of licenses to internally transfer source material for use under the 'small quantities or source material' general licenses to consistent with 10 CFR §40.55(a) through (d).
- C.24.A(1)(b): add, "Up to 180 days of accumulative works may be performed during the covered period." for clarity.
- C.25.A(2): Update record keeping requirement, to comply with 10 CFR §40.55.

Part D Standards for Protection Against Radiation

- 1403.C(1) and (2): clarify acceptable financial assurance mechanisms, to be consistent with 10 CFR §20.1403(c)(1).
- 1404.A(5): add language stating that through financial assurance, the Department (Agency) may terminate a license using alternate criteria greater than the dose criterion, to be consistent with 10 CFR §20.1404(a)(5).
- 1501.A: include language that surveys should also include the subsurface, to be consistent with 10 CFR §20.1406(b),(c) and (d).
- 1501.B: add, "records from surveys describing the location and amount of subsurface residual radioactivity identified at the site must be kept with records important for decommissioning, and such records must be retained in accordance with C.25, C.8.F(7)(f), as applicable", to be consistent with 10 CFR §20.1406(a)(b),(c) and (d).
- 1501.D(1) and (2): remove requirements for dosimetry accreditation from the national voluntary laboratory accreditation program (NVLAP), to be consistent with 10 CFR §34.47.
- 2201.B: update the requirement of written or telephone reports from the initial report, to be consistent with 10 CFR § 70.50(c)(2).
- 2207.H: Remove this section, due to the requirements being outdated.
- 2304.B: add, "Licensees shall, to the extent practical, conduct operations to minimize the introduction of residual radioactivity into the site, including the subsurface, in accordance with the existing radiation protection requirements in Subpart B and

radiological criteria for license termination in Subpart E of this part", to be consistent with 10 CFR §20.1406(c).
- Appendix B Table 1: add footnote notations to Nitrogen-13 and Oxygen-15, to be compatible with 10 CFR 20 Appendix B.
- Appendix B Table 1: corrected internal references to footnotes.

Part E Radiation Safety Requirements For Industrial Radiographic Operations
- E.18: remove, "an individual monitoring device that meets the requirements of Part D.1501", due to the reference to personnel dosimetry accreditation being removed from Part D.1501(1) and (2).
- E.18(A)(3): update this section to include, "Film badges must be replaced at least monthly and all other personnel dosimeters that require replacement must be replaced at least quarterly. All personnel dosimeters must be evaluated at least quarterly or promptly after replacement, whichever is more frequent", to be consistent with 10 CFR § 34.47.
- E.18(D)(E) and (F): update language to be consistent with NRC terminology.
- E.36(D): update terminology in this section to be consistent with E.18.

Part F X-Rays in the Healing Arts
- F.3.A.(1)(J), F.3.B(3), F.3.C(2), F.9.B: update internal references.

Part G Medical Use of Radioactive Material
- G.2: add definitions for *associate radiation safety officer*, *ophthalmic physicist,* and update the definition of *preceptor* to include associate radiation safety officer, to be consistent with 10 CFR §35.2.
- G.2: update an internal reference for the definition of *medical event*.
- G.12.B(1): update application requirements to include associate radiation safety officer(s) and ophthalmic physicists(s), to be consistent with 10 CFR §35.12.
- G.12.C(1): update application requirements to include either HHE Form 850 or a letter containing all the information required by HHE Form 850, to be consistent with 10 CFR §35.2.
- G.12.D: update and add criteria for the application of license or amendment for medical use of radioactive material, to be consistent with 10 CFR §35.2.
- G.13.B: add authorized ophthalmic physicist to license amendments, to be consistent with 10 CFR §35.13.
- G.13.B(1): update internal rule reference to include G.59, to be consistent with 10 CFR §35.13.
- G.13.B(4): add, "ophthalmic physicist" to be consistent with 10 CFR §35.13.
- G.13.I. through K: add conditions prior to obtaining a license amendment, to be consistent with 10 CFR §35.13.
- G.14.A: update notification requirements and information that a licensee must give to the Commission, to be consistent with 10 CFR §35.14.
- G.14.B: update notification requirements and information that a licensee must give to the Department (Agency), to be consistent with 10 CFR §35.14.
- G.15.E: add "ophthalmic physicist" to be consistent with 10 CFR §35.15.
- G.24.B: add supervision requirements and responsibilities assigned to an associate radiation safety officer, to be consistent with 10 CFR §35.24.
- G.40.B(6): add written directives for permanent implant brachytherapy, to be consistent with 10 CFR §35.40.
- G.40.B(7): add date to the written directives to be consistent with 10 CFR §35.40.
- G.41.B(5) and (6): update procedures requiring an administrative directive to include permanent implant brachytherapy, to be consistent with 10 CFR §35.41.
- G.50: add associate radiation safety officer to be consistent with 10 CFR §35.50.

- G.50.A: add language to provide clarity to be consistent with 10 CFR §35.50.
- G.50.B(1)(b): add, "An associate radiation safety office may provide supervision for those areas for which the associate radiation safety officer is authorized on a Commission or an Agreement State license or permit issued by a commission master material license", to be consistent with 10 CFR §35.50.
- G.50.B(2): clarify that as part of the training, a radiation safety officer or an associate radiation safety officer must obtain written attestation of satisfactorily completing training requirements to be consistent with 10 CFR §35.50.
- G.50.C: add experience requirements for an individual fulfilling the responsibilities of the radiation safety officer, to be consistent with 10 CFR §35.50.
- G.51: clarify the training requirements to be an authorized medical physicist, to be consistent with 10 CFR §35.51.
- G.55.A: clarify the training requirements of an authorized nuclear pharmacist, to be consistent with 10 CFR §35.55.
- G.55.B(2): update and clarify the training certification/attestation requirements for an authorized nuclear pharmacist, to be consistent with 10 CFR §35.55.
- G.57: update requirements in this section of the rule for the training of experienced radiation safety officers, teletherapy or medical physicists, authorized medical physicists, authorized users, nuclear pharmacists and authorized nuclear pharmacists, to be consistent with 10 CFR §35.57.
- G.57.B(2): correct the phrase "or a permit issued by a Commission master material license of broad scope on or before October 24, 2005," to "or a permit issued in accordance with a Commission master material broad scope license on or before October 24, 2005,".
- G.65.F(1) and (2): add byproduct material to medical use radioactive material, to be consistent with 10 CFR §35.65.
- G.65.G: add that the licensees do not need to list radioactive material sources when using calibration, transmission and reference sources in accordance with rule requirements, to be consistent with 10 CFR §35.65.
- G.190.B(2)(a) and (b): add and update written attestation requirements for training for uptake, dilution, and excretion studies, to be consistent with 10 CFR §35.190.
- G.204: add strontium-82, and strontium-85, to be consistent with 10 CFR §35.204.
- G.204.B through E: update and clarify licensee requirements for using molybdenum-99, strontium-82, and strontium-85 concentrations, to be consistent with 10 CFR §35.204.
- G.290.C(1)(b): add an authorized nuclear pharmacist who meets the requirements may provide the supervised work experience, to be consistent with 10 CFR §35.290.
- G.290.C(2)(a) and (b): add and update written attestation requirements of training for imaging and localization studies.
- G.300: add reference to section G.390.B(1)(b)(vii) of the rule to be consistent with 10 CFR §35.300.
- G.390.A(1), G490.A(1) and G690.A(1): replace "Committee on Post Graduate Training" with "Council on Postdoctoral Training" to be consistent with 10 CFR §§ 35.390(a)(1), 35.490(a)(1), and 35.690(a)(1).
- G.390.B(1)(b)(viii): clarify the requirements for the administering dosages of radioactive drugs to patients or human research subjects to be consistent with 10 CFR §35.300.
- G.390.B(2)(b): add and update written attestation requirements for training for use of unsealed radioactive material for which a written directive is required, to be consistent with 10 CFR §35.300.
- G.392.C(3): clarify written attestation requirements for training for the oral administration of sodium iodide I-131 requiring a written directive in quantities less

than or equal to 1.22 gigabecquerels (33 Millicuries), to be consistent with 10 CFR §35.392.

- G.394.C(3): clarify written attestation requirements for training for the oral administration of sodium iodide I-131 requiring a written directive in quantities greater than 1.22 gigabecquerels (33 Millicuries), to be consistent with 10 CFR §35.394.
- G.396.B: clarify that these requirements pertain to a physician, to be consistent with 10 CFR §35.396.
- G.396.B(2): add supervising authorized user, to be consistent with 10 CFR §35.396.
- G.396.B(2)(F): update requirements for administering dosages to patients or human research subjects that include at least three cases, to be consistent with 10 CFR §35.396.
- G.396.B(3): clarify written attestation requirements for training for the parenteral administration of unsealed byproduct material requiring a written directive, to be consistent with 10 CFR §35.396.
- G.400.A and B: update the use of sources for manual brachytherapy, to be consistent with 10 CFR §35.400.
- G.433: update this section to add requirements for licensees who use strontium-90 for ophthalmic treatments, to be consistent with 10 CFR §35.433.
- G.490.B(3)(i) and (ii): clarify written attestation requirements for training for use of manual brachytherapy sources, to be consistent with 10 CFR §35.490.
- G.491.B(3): clarify written attestation for training for ophthalmic use of strontium-90, to be consistent with 10 CFR §35.491.
- G.500.A, B and C: update criteria for use of sealed sources and medical devices for diagnosis, to be consistent with 10 CFR §35.500.
- G.590: clarify language in this section for the requirement of training for the use of sealed sources and medical devices for diagnosis, to be consistent with 10 CFR §35.590.
- G.600.A: add clarifying requirements when a licensee can use a sealed source unit to be consistent with 10 CFR §35.600.
- G.600.B: add requirements for clarity when a licensee can use photon-emitting remote afterloader units, teletherapy units, or gamma stereotactic radiosurgery units, to be consistent with 10 CFR §35.600.
- G.610.D(1): update safety procedures for a licensee for the use of remote afterloader units, teletherapy units, and gamma stereotactic radiosurgery units, to be consistent with 10 CFR §35.610.
- G.655.A: update inspection requirements for teletherapy units and gamma stereotactic radiosurgery units, to be consistent with 10 CFR §35.655.
- G.690.B(3)(ii): clarify written attestation requirements for training for the use of remote afterloader units, teletherapy units, and gamma stereotactic radiosurgery units, to be consistent with 10 CFR §35.690.
- G.2040: update internal reference.
- G.2024.C: add record retention requirements for an associate radiation safety officer, to be consistent with 10 CFR §35.2024.
- G.2204.A and B: update and add record keeping requirements for molybdenum-99, strontium-82 and strontium-85 concentrations, to be consistent with 10 CFR §35.2204.
- G.2310: add “the operational and safety instruments required by”, to be consistent with 10 CFR §35.2310.
- G.2655: replace “five year inspection” with “full-inspection servicing”, to be consistent with 10 CFR §35.2655.
- G.3045: update requirements for report and notification of medical events, to be consistent with 10 CFR §35.3045.

- G.3045.G(1)(b): clarify identification number.
- G.3047.F(1)(b): update requirements for report and notification of a dose to an embryo/fetus or nursing child, to be consistent with 10 CFR §3047.
- G.3204: add report and notification for an eluate exceeding permissible molybdenum-99, strontium-82, and strontium-85 concentrations, to be consistent with 10 CFR §35.3204.

Part H Radiation Safety Requirements For Analytical and Other Industrial Radiation Machines

- H.8.C: update internal reference.

Part N Regulation and Licensing of Technologically Enhanced Naturally Occurring Radioactive Materials (Tenorm)

- N.3: add clarifying language to the definition of Technologically enhanced naturally occurring radioactive material (TENORM)

Part S (New) Physical Protection of Category 1 and Category 2 Quantities of Radioactive Material

- Add new section to rule, Part S, "Physical Protection of Category 1 and Category 2 Quantities of Radioactive Material. Standards" to be consistent with 10 CFR Part 37, which became effective March 19, 2013.

Fiscal impact of rule:

These rule changes pose no fiscal impact to the Department, counties or municipalities.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 (Maine CDC)**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §1341(2)
Chapter number/title:	**Ch. 252**, Syringe Services Programs Rule
Filing number:	**2022-168**
Effective date:	9/1/2022
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

The Department adopts these emergency amendments in response to the October 6, 2021 renewal of the nationwide opioid public health emergency, the increased number of drug-related deaths and injuries, the recent decrease in use of certified exchange programs, which provide education, new syringes, and proper disposal of used syringes, as well as PL 2021 ch 434, *An Act to Promote Public Health by Eliminating Criminal Penalties for Possession of Hypodermic Apparatuses*, and PL 2022 ch 545, *An Act to Amend Syringe Services Programs*, which became effective on August 8, 2022. These emergency changes reflect these most recent public laws to implement a change to the distribution model that is based on research showing that less restrictive distribution models, based on Consumers' needs, can lead to lower syringe re-use and minimize the spread of blood-borne diseases. Reusing syringes increase the risk of transmitting bloodborne pathogens like HIV and viral hepatitis, as well as increased exposure to bacterial infections like cellulitis, endocarditis, or sepsis. This amendment to allow certified Syringe Services Programs to expand the one-to-one exchange of syringes follows best practice guidelines for current syringe service programs. The Department replaced "hypodermic apparatus exchange" with "syringe services" throughout the rule, including a change to the rule title. The Department has determined that these rule changes are necessary to provide greater protection to people who inject drugs in Maine. Pursuant to 5 MRS §8054, the Department finds that the emergency adoption of 10-144 CMR Ch. 252 is necessary to avoid an immediate threat to public health, safety or general welfare.

Basis statement:

The Department originally adopted this rule to meet the requirements of 22 MRS §1341, which mandates the Department to establish a rule for Syringe Services Programs to facilitate the prevention of HIV and other blood borne pathogens, due to the opioid epidemic, leading to an increase in the number of people who use syringes to inject drugs. The U.S. Department of Health and Human Services Secretary Xavier Becerra renewed the federal public health emergency on October 6, 2021, as a result of the continued consequences of the opioid crisis affecting the United States and after consultation with public health officials, pursuant to Secretary Becerra's authority under section 319 of the Public Health Services Act. The US CDC's National Center for Health Statistics reported an estimated 109,247 drug overdose deaths in the United States during the 12-month period ending in March 2022, an increase of 9.7% from the 99,567 deaths during the same period the year before. Within Maine, the provisional death counts increased 19.69% in reported cases to CDC. Provisional mortality data is based on death certificate data received but not fully reviewed by the CDC National Center for Health Statistics' (NCHS) National Vital Statistics System (NVSS); however, due to the time needed to investigate certain causes of death and process and review death data, this early estimate reveals trends before the release of final data, which typically is reported 11 months after the end of the calendar year. The number of suspected and confirmed fatal overdoses rose 36% from 2020 to 2021, with 77% of those deaths caused by nonpharmaceutical fentanyl, which is 9% higher than the rate in 2020, according to the Maine

Drug Death Report in 2021. Maine CDC reports that the rate of drug deaths continue to be high in 2022.

Additionally, Maine experienced a 300% increase in the rate of acute Hepatitis A and C from 2019 to 2020, with current year-to-year data in 2021 showing a continued increase rate from before the COVID-19 pandemic. From 2019 to 2020, the proportion of acute Hepatitis A cases among individuals who use drugs (injection or non-injection) increased from 27% to 52% of cases. In 2021, 33% of all reported acute hepatitis C cases reported injection drug use. Though new cases of HIV are down nationwide, the CDC reports that about 10% of new HIV cases in the United States are people who inject drugs.

Emergency changes to this rule are based on research showing that less restrictive distribution models, based on a Consumer's need, can lead to lower syringe re-use and minimize the spread of blood-borne diseases. Reusing syringes can increase transmission of HIV, viral hepatitis, as well as lead to an increase in exposure to bacterial infections like cellulitis, endocarditis, or sepsis. The Department is promoting a needs-based distribution model, in order to follow best practice guidelines for current syringe service programs and in response to An Act to Promote Public Health by Eliminating Criminal Penalties for Possession of Hypodermic Apparatuses, PL 2021, ch 434, which e decriminalized possession of more than 10 syringes. Without the fear of committing crime, Syringe Service Programs may encourage consumers to use a trusted source for new syringes. In addition, the resources provided by these programs increase the safe disposal of used syringes, which keeps them out of community spaces.

The Department has determined that the adoption of this rule is necessary to provide a continuity and consistency of services that will support people who inject drugs in Maine. While the Department is lifting the strict one-for-one exchange requirements, it is imposing a limit of 100 syringes per Consumer, due to the recent public law at PL 2021, ch. 545 which now allows the Department to limit the number of syringes provided by certified programs. The Department set a reasonable limit of 100 syringes per Consumer per exchange event that a Syringe Services Program could provide, in order to avoid interfering with the needs-based distribution model encouraged by the Department in this rule change.

Findings of Emergency: The emergency adoption of 10-144 CMR Ch. 252 is necessary to avoid an immediate threat to public health, safety or general welfare, based on the nationwide opioid public health emergency renewed on October 6, 2021, the reports of drug-related injuries and deaths in Maine, the decrease in people accessing syringe services programs, and recent changes in Maine law that decriminalize possession of over 10 syringes and allow the Department to impose reasonable limitations on the number of syringes that are introduced into the community. The emergency adoption of this rule will allow increased access to Syringe Services. This emergency rule, the Syringe Services Programs Rule, 10-144 CMR Ch. 252, will be effective immediately upon filing with the Secretary of State for 90 days. During this 90-day time period, the Department will propose non-emergency standard routine technical rulemaking, to allow for public comment and permanently adopt these changes, as well as other non-emergency changes.

Fiscal impact of rule:

These emergency amendments pose no fiscal impact to the Department, counties or municipalities.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 (Maine CDC)**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §1341(2)
Chapter number/title:	**Ch. 252**, Syringe Services Programs Rule
Filing number:	**2022-229**
Effective date:	11/30/2022
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rulemaking aligns with the Department's recently adopted emergency amendments effective September 1, 2022, to address the October 6, 2021 renewal of the nationwide opioid public health emergency; the increased number of drug-related deaths and injuries; the recent decrease in use of certified exchange programs, which provide education, new syringes, and proper disposal of used syringes; PL 2021 c. 434, *An Act to Promote Public Health by Eliminating Criminal Penalties for Possession of Hypodermic Apparatuses*; and PL 2021 ch 545, *An Act to Amend Syringe Services Programs*, which became effective on August 8, 2022. In accordance with these recently enacted laws and emergency rule adoption, the rule permits certified Syringe Services Programs to, according to their respective policies, expand the previous one-to-one exchange of syringes and follow best practice guidelines for current syringe service programs, provided that distribution is limited to no more than 100 syringes per Consumer per Exchange Event. In addition to Maine CDC proposing that all recent emergency changes become a permanent part of this rule, the agency proposes rule changes to further clarify that the length of a Syringe Services Program certification period is five years, which is set in statute (22 MRS §1341(2)(H)), as well as update definitions, internal references, and rule format for consistency with agency standards.

Basis statement:

This rule is administered by the Department of Health and Human Services – Maine Center for Disease Control and Prevention and governs Syringe Services Programs established to facilitate the prevention of HIV and other blood borne pathogens, pursuant to 22 MRS §1341. Amendments are adopted for continuity of rule changes recently implemented on an emergency basis to revise program requirements, including syringe exchange and dispensing requirements, in response to the national opioid epidemic and the increase in injectable drug use in Maine.

The U.S. Department of Health and Human Services Secretary Xavier Becerra renewed the federal public health emergency pertaining to the nationwide opioid epidemic on September 29, 2022, pursuant to his authority under Section 319 of the *Public Health Service Act*, 42 USC §247d, effective October 3, 2022. This renewal is a result of the continued consequences of the opioid crisis affecting the United States and after consultation with public health officials. The US CDC's National Center for Health Statistics reported an estimated 109,247 drug overdose deaths in the United States during the 12-month period ending in March 2022, an increase of 9.7% from the 99,567 deaths during the same period the year before. The State continues to take steps to confront the epidemic of substance use disorder, including expanding access to sterile syringes, education and treatment. Within Maine, the provisional death counts increased 19.69% in reported cases to CDC. Provisional mortality data is based on death certificate data received but not fully reviewed by the CDC National Center for Health Statistics' (NCHS) National Vital Statistics System (NVSS); however, due to the time needed to investigate certain causes of death and process and review death data, this early estimate reveals trends before the release of final data, which typically is reported 11

months after the end of the calendar year. The number of suspected and confirmed fatal overdoses rose 36% from 2020 to 2021, with 77% of those deaths caused by nonpharmaceutical fentanyl, which is 9% higher than the rate in 2020, according to the Maine Drug Death Report in 2021. Maine CDC reports that the rate of drug deaths continue to be high in 2022.

Additionally, Maine experienced a 300% increase in the rate of acute Hepatitis A and C from 2019 to 2020, with current year-to-year data in 2021 showing a continued increase rate from before the COVID-19 pandemic. From 2019 to 2020, the proportion of acute Hepatitis A cases among individuals who use drugs (injection or non-injection) increased from 27% to 52% of cases. In 2021, 33% of all reported acute hepatitis C cases reported injection drug use. Though new cases of HIV are down nationwide, the CDC reports that about 10% of new HIV cases in the United States are people who inject drugs.

Rule changes are based on research showing that the less restrictive distribution models that factor consumer need can lead to lower syringe re-use and minimize the spread of blood-borne diseases. Reusing syringes can increase transmission of HIV and viral hepatitis, as well as lead to an increase in exposure to bacterial infections like cellulitis, endocarditis or sepsis. Where the Executive Orders that permitted unrestricted dispensing allowances during the public health crisis have been lifted, the Department's rule is shifting from the previous strict one-to-one exchange requirement to allow an expanded dispensing of new syringes, consistent with the emergency rule. Rule changes are partially in response to Public Law 2021, chapter 434, *An Act to Promote Public Health by Eliminating Criminal Penalties for Possession of Hypodermic Apparatuses*, which decriminalized possession of more than 10 syringes. Without the fear of committing crime, Syringe Service Programs may encourage consumers to use a trusted source for new syringes. Maintaining that syringes may be dispensed only at the SSP site aids the oversight of Programs and manages public perception. Resources provided by these programs offer support services, education and referrals through in-person contacts and increase the safe disposal of used syringes, a public health concern.

The current emergency rule remains effective from September 1, 2022, for 90 days until November 30, 2022. (5 MRS §8054(3).) The adoption of this rule is necessary to provide continuity and consistency of services for people who use injectable drugs in Maine. While the Department is not requiring a one-for-one syringe exchange, programs must have a distribution policy that allows for the one-to-one exchange of used syringes for new syringes. In addition, the Department is imposing a limit of 100 syringes per encounter, when the Consumer does not have a used syringe to exchange, as authorized by 22 MRS § 1341(1)(A). Additionally, Programs are permitted to implement policies that further limit the number of syringes dispensed to a Consumer. The Department has determined that, while dispensing is restricted to SSP sites and the age eligibility remains in place, permitting the flexibility of 1:1 exchanges and up to 100 syringes per encounter when used syringes are not returned by the Consumer, is a reasonable approach to implementing a less restrictive distribution model, striking a balance that considers Consumer needs while safeguarding Program capacity to serve Consumers.

Fiscal impact of rule:

No fiscal impact to the Department, counties or municipalities.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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 (Maine CDC)**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 1531 - 1533; 22-A MRS §210
Chapter number/title:	**Ch. 283**, Newborn Bloodspot Screening Rule
Filing number:	**2022-037**
Effective date:	4/13/2022
Type of rule:	Major Substantive
Emergency rule:	No

Principal reason or purpose for rule:

Chapter 283 is a routine technical rule, except for Section 14 (Fees), which is major substantive, pursuant to 5 MRS §8071(3)(B). On March 24, 2021, the Department provided notice for its proposed Major Substantive rule change to increase the filter paper fee from $110 to $220 per infant tested. These changes were provisionally adopted May 24, 2021, in accordance with 5 MRS §8073. On February 17, 2022, the 130th Maine Legislature authorized the final adoption of changes to the major substantive portions of the rule (Resolve 2022 chapter 124). The Department plans to finally adopt this rule change within 60 days of this emergency legislation to permanently implement the increase to the filter paper fee from $110 to $220 per infant tested. The finally adopted Major Substantive rule will take effect 30 days after the date it is filed with Secretary of State; the emergency major substantive rule will expire when this rule takes legal effect, resulting in no lapse in the Department's ability to collect the increased fee (5 MRS §8072(8).)

Basis statement:

Maine's *Newborn Bloodspot Screening Rule* (10-144 MRS Ch. 283) is a routine technical rule, except for Section 14 - Fees, which is a major substantive rule provision, pursuant to 5 MRS §8071(3)(B).

On March 24, 2021, the Department provided notice through the Secretary of State's Office and Maine CDC a proposed rulemaking to permanently implement changes established by a March 11, 2021 hybrid Emergency Routine Technical/Major Substantive rule. The Routine Technical rule changes were adopted and became effective June 1, 2021. The Department provisionally adopted the Major Substantive rule changes on May 24, 2021 and submitted them to the Legislature for review in accordance with 5 MRS §8073.

The June 1, 2021 Routine Technical rule added four conditions to Maine's newborn bloodspot screening panel:(1) Spinal Muscular Atrophy (SMA); (2) Mucopolysaccharidosis Type 1 (MPS-1); (3) Pompe; and (4) X-linked Adrenoleukpdystrophy (X-ALD). The addition of these conditions is consistent with the U.S. DHHS Recommended Universal Screening Panel (RUSP) and is supported by the Joint Advisory Committee to further reduce mortality and morbidity from certain heritable conditions and ensure a level of support for children and families affected by these conditions. This Major Substantive rulemaking increases the fee for newborn bloodspot filter paper from $110 to $220 to off-set costs corresponding to these four additional conditions (i.e. genetic clinic contracts, resource material, follow-up services and other related program operations).

On February 17, 2022, the 130th Maine Legislature authorized the final adoption of changes to the major substantive portions of the rule (Resolve 2022 chapter 124, *Resolve, Regarding Legislative Review of Portions of Chapter 283: Newborn Bloodspot Screening Rule, Section 14, a Major Substantive Rule of the Department of Health and Human Services, Maine Center for Disease Control and Prevention.*) As emergency legislation, the Resolve became effective immediately on February 17, 2022. The Department is authorized to finally adopt

this Major Substantive rule change within 60 days of the effective date of the Resolve. The finally adopted Major Substantive rule will take effect 30 days after the date it is filed with Secretary of State; the emergency major substantive rule will expire when this rule takes legal effect, resulting in no lapse in the Department's ability to collect the increased fee.

Fiscal impact of rule:

The additional conditions will increase the costs for contracted NBS testing services. Consistent with the national cost for lab services, the 100% increase in the cost to purchase the required NBS filter paper is to offset additional laboratory charges that the Department estimates to be close to $500,000, and other related cost increases (i.e. genetic clinic contracts, resource material, follow- up services and other related program operations) corresponding to the additional new conditions on the bloodspot screening panel.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
Prepared by the Secretary of State pursuant to 5 MRS §8053-A sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3104; 5 MRS §8054
Chapter number/title:	**Ch. 301**, Supplemental Nutrition Assistance Program: **SNAP Rule #224E**, **Section 999-3**, Charts
Filing number:	**2022-031**
Effective date:	3/1/2022
Type of rule:	Routine Technical
Emergency rule:	Yes

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

Basis statement:
Each state agency is charged with determining standard utility allowances and having those approved by the United States Department of Agriculture (USDA). Each year, Maine proposes figures based on the best available data in July for implementation in October. The utility allowance values for Federal Fiscal Year 2022 were calculated to increase using The Consumer Price Index (CPI) of 240.778% for June 2021 published by the Bureau of Labor Statistics of the Department of Labor, and were submitted to and approved by USDA. Between June and October 2021, the CPI increased another 11.88 percentage points. This increase is indicative of an additional $2 per month in phone expenses, an additional $14 per month in utility expenses for households without a heating or cooling expense, and an additional $42 per month in utility expenses for household with a heating or cooling expense. To accurately reflect the expense of Maine families, the Department has submitted and the USDA has approved updated standard utility allowances for the remainder of Federal Fiscal Year 2022.

Findings of Emergency
Pursuant to 5 MRS §8054, the Department finds that emergency rulemaking is necessary for the health, safety, and general welfare in order to ensure that SNAP benefits are issued appropriately and accurately taking into account the high utility expenses experienced by Maine residents as verified by the Maine Public Utilities Commission and attested to by various media outlets.

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

Fiscal impact of rule:
Direct costs to the Department include the cost of rulemaking activity, and necessary technology changes such as changes to ACES (all of which are covered by the existing budget for such changes). State funded SNAP benefits are estimated to cost an additional $42,247 per year. These same changes will result in an estimated $6,401,112 in federal funds flowing to Maine residents and grocers.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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
Chapter number/title:	**Ch. 301**, Supplemental Nutrition Assistance Program (SNAP) Rules: **SNAP Rule #224A**, March 2022 Standard Utility Allowance Updates; **Section 999-3**, Charts
Filing number:	**2022-086**
Effective date:	5/30/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This rule implements increases to the standard utility allowances. As a result, SNAP benefits will increase for some households.

Each state agency is charged with determining standard utility allowances and having those approved by the United States Department of Agriculture (USDA). Each year, Maine proposes figures based on the best available data in July for implementation in October. The utility allowance values for Federal Fiscal Year 2022 were calculated to increase using The Consumer Price Index (CPI) of 240.778% for June 2021 published by the Bureau of Labor Statistics of the Department of Labor, and were submitted to and approved by the USDA. Between June and October 2021, the CPI increased another 11.88 percentage points. This increase is indicative of an additional $2 per month in phone expenses, an additional $14 per month in utility expenses for households without a heating or cooling expense, and an additional $42 per month in utility expenses for households with a heating or cooling expense. To accurately reflect the expense of Maine families, the Department has submitted and the USDA has approved updated standard utility allowances for the remainder of Federal Fiscal Year 2022. These same changes were incorporated into the Supplemental Nutrition Assistance Program (SNAP) Rules, in emergency rule making number 2022-031. This rulemaking makes those changes permanent to ensure that SNAP benefits are issued appropriately and accurately taking into account the high utility expenses experienced by Maine residents as verified by the Maine Public Utilities Commission and attested to by various media outlets.

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

Fiscal impact of rule:
Direct costs to the Department include the cost of rulemaking activity, and necessary technology changes such as changes to ACES (all of which are covered by the existing budget for such changes). State funded SNAP benefits are estimated to cost an additional $42,247 per year. These same changes will result in an estimated $6,401,112 in federal funds flowing to Maine residents and grocers.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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) and (8) and 1161; PL 2021 Ch. 472 §4
Chapter number/title:	**Ch. 323**, Maine General Assistance Manual, Sections II, IV, V, VI
Filing number:	**2022-157**
Effective date:	9/1/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:

PL 2021 Ch. 472 sets requirements and limits on municipalities related to the use of housing assistance for individuals living in Recovery Residences. The chapter further required the Department to establish in this manual appropriate maximum housing assistance levels for said individuals. Based on a survey of actual expenses for Recovery Residences, the Department has set this level at 75% of the one-bedroom allowance. This rulemaking proposes to comply with those requirements by— making edits to the definitions of "Household" and "Pooling of Income" and the addition of a definition of "Recovery Residence" in Section II, adding Subsection O to Section IV, adding Paragraph 4 to Section V(D), and making edits to Section VI(B)(3)(b)(ii).

Consistent with PL 2021 Ch. 472, the changes listed above are to be applied retroactively to July 1, 2022. Retroactive rulemaking is permitted under 22 MRS §42(8). None of the changes below would be applied retroactively.

The Department regularly reviews rules for clarity and accessibility. Throughout these sections, modifications would be made to use gender neutral language. Uses of similar terms (such as "individual", "applicant", and "recipient") were reviewed and changes proposed to provide clarity and specificity. Language would be modernized. E.g., references to "Food Supplement" would be updated to "SNAP". Citations were reviewed and would be updated for accuracy, specificity, and consistency of format. The enumeration of some subsections, paragraphs, etc. would be updated for clarity and ease of reference.

Within Section II, the following modifications are adopted to enhance the clarity of the chapter. The definition of "available resources" would be modified to more explicitly distinguish them from potential resources. A definition of "Department of Health and Human Services" would be added to clarify that uses of this term, "DHHS", and "The Department" throughout the manual are references to the Maine Department of Health and Human Services. Definitions of "earned income" and "unearned income" would be added to specify what income fits each category and that all income fits one of these categories. Clarification would be added to the definition of "eligible person" to specify that the 24-month limit applies only to those pursuing a lawful process to apply for immigration relief. The definitions of "Family Development Accounts" and "household" would be simplified to avoid discrepancies as the statutory definitions are updated. The definition of "federal poverty level" would be removed as that term is no longer used in this chapter. The definition of "homelessness" would be modified to include individuals who do not have a permanent residence upon exiting an institution. The definition of "misspent income" would be moved from Section IV to Section II for consistency and ease of reference. A definition of "rehabilitation facility" would be added to help distinguish between this type of facility and a recovery residence. The definition of "Resident" would be clarified to include individuals who intend to keep a particular town as

their permanent residence even if they are temporarily absent. A definition of "Supplemental Nutrition Assistance Program" would be added.

Within Section IV the following modifications are adopted to enhance clarity. Subsection A(2) would be modified to clarify that recipients are not required to reapply every 30 days unless they are seeking further assistance. In Subsection B reiterations of definitions provided in Section II would be removed for brevity and to avoid potential future conflicts. In Subsection F, reiterative language would be removed. Furthermore, in light of current health insurance laws and regulations, Paragraph 1(b) would be modified to acknowledge that all employer offered health and dental insurances are considered cost effective for the purposes of General Assistance budgeting. Additionally, Paragraph 2(b) would have language added clarifying that each municipality sets their mileage rate cap. Language would be added to Subsection H Paragraph 4 (parallel to the language used in the preceding paragraphs) to spell out that it addresses the verification of expenses. Language would be added to Subsection I(6)(b)(i) specifying that the greater of the state or federal minimum wage would be used in the calculation of the value of workfare hours (consistent with Subsection L(4)). Subsection J(1) would be broken into two paragraphs to more clearly articulate the financial responsibilities of parents and spouses as it relates to General Assistance budgeting. Subsection K was modified to clarify that a minor does not need to be pregnant or a parent to be eligible. Subsection L(5) would be reworded to use language more consistent with the rest of the section and more immediately state the circumstances under which this paragraph would apply. Furthermore, Paragraph 13 would have language added specifying that piece work standards are set by employers and that General Assistance administrators will adopt good cause determinations made by the Department of Labor, not apply their standards. Subsection M would be amended to clarify that Emergency General Assistance is a subset of General Assistance, not a separate benefit. Furthermore, the start date of 120-day disqualification period in Paragraph 3(b) would be clarified to the date of the disqualification determination. Additionally, Paragraph 4 would be amended to specify that the disqualification would only apply to a member of a recipient household. Paragraph 5 would, also, be amended to specify that the process to appeal a decision is by requesting a fair hearing.

Section VI(B)(5) would be amended to cover all applicants experiencing homelessness.

This rule will have an impact on municipalities. Changes to rent reimbursement for residents of Recovery Residences is estimated to cost an additional $36,000 annually. The State General Fund will pay $25,200 of that expense. The remaining $10,800 will be incurred by municipalities administering the GA program. The full amount will be seen as income for local small businesses and non-profit organizations.

Fiscal impact of rule:

Direct costs to the Department include the cost of rulemaking activity and updating staff and municipal training and resources (all of which are covered by the existing budget for such changes).

Changes to rent reimbursement for residents of Recovery Residences is estimated to be minimal and can be absorbed by current funding.

This rule will have an impact on small businesses. For a copy of the small business impact statement, please contact: Sara Denson, General Assistance Program Manager, Department of Health and Human Services, Office for Family Independence, 109 Capitol Street, Augusta, ME 04333-0011. Phone: (207) 624-4193. Fax: (207) 287-3455. TT Users Call Maine Relay – 711. Email: Sara.Denson@Maine.gov.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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) and (8), 3790-A(6)
Chapter number/title:	**Ch. 330**, Higher Opportunity for Pathways to Employment (HOPE) Program Rule, Sections 1, 2, 3, 4, 5, 7
Filing number:	**2022-062**
Effective date:	4/25/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This rule provides a necessary support for HOPE participants required to engage in remote learning and provides clarification on eligibility requirements and limits for certain supports already being applied. Department staff will continue to determine eligibility for the HOPE Program and all supports according to current guidance.

The original HOPE rules did not anticipate the need to provide Internet access when establishing the support service funding cap on technology supports. In the interest of public health, Maine's institutions of higher learning suspended their in-person activities during the spring of 2020 due to the COVID-19 pandemic, while continuing to provide education and career training programs online. Some of Maine's most vulnerable people did not have sustained access to Internet connections necessary to avail themselves of those programs. This rule change allows funding of Internet access for HOPE participants when other cost-effective Internet options are not feasible. Furthermore, the Department regularly reviews policies for clarity, and applicability.

PL 2021 Ch. 149 amended 22 MRS §3790-A(2)(C) so that the reference to acceptable target jobs more closely matches the language used by the Maine Department of Labor, and relaxed the criteria for acceptable post-secondary degree programs. This rule change brings the manual in compliance with those changes. These changes include the addition of definitions of "Adequate Job Outlook," "Career Pathway," "Substantial Improvement in Earnings and Benefits," and "Universally Recognized and Accepted"; the removal of the term "Average Job Outlook"; and related modifications to eligibility and verification criteria (the updates to the third sentence of Section 2, Section 3(A)(10)(b)(iv), and Section 7 Subsections B(1)(e) and E(1)(i)(vi) and the addition of Section 7(E)(1)(i)(v)). Although Subsection 1 of 22 MRS §3790-A was not amended, the Department has decided to move forward with rulemaking as it has determined that the passage of this amendment is an implied repeal of the inconsistent language contained there. "[T]he legislature cannot be supposed to have intended that there should be two distinct enactments embracing the same subject matter in force at the same time, and that the new statute, being the most recent expression of the legislative will, must be deemed a substitute for previous enactments, and the only one which is to be regarded as having the force of law." State v. Taplin, 247 A.2d 919, 921–22 (Me. 1968). These changes are effective Monday, October 18, 2021, the effective date of the legislation. Retroactive rulemaking is permissible under 22 MRS §42(8) as the change affords this benefit to more residents of the State of Maine and does not adversely impact applicants, participants, beneficiaries, or providers.

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
Prepared by the Secretary of State pursuant to 5 MRS §8053-A sub-§5

PL 2021 Ch. 398 Part BBB amended 22 MRS §3790-A to expand the number of individuals who may be enrolled in the HOPE program from 500 to 800. This rule change brings the manual in compliance with that change effective Thursday, July 1, 2021. Retroactive rulemaking is permissible under 22 MRS §42(8) as the change affords this benefit to more residents of the State of Maine and does not adversely impact applicants, participants, beneficiaries, or providers.

The following changes are not being implemented retroactively:

In Section 1, "Definitions", a number of terms are added or have their definitions updated. The definition of "Application" is updated to allow for electronically signed submissions. This change improves access especially at times that in-person contact is discouraged for health reasons. A definition of "Credential" is added to clarify this term as distinct from "High-Value Credential." The definition of "Matriculation" is simplified and standardized. This change is necessitated by the vast spectrum of definitions of "Matriculation" used by various institutions, and the fact that some do not use the term at all. It is further amended to allow for test preparation courses when a HOPE participant has graduated from their primary Training or Education program but is using such a course to prepare for an exam necessary to achieve the related credential. A definition of "Outstanding Tuition and Fees" is added to help clarify what bills can and cannot be paid by HOPE supports. A definition of "Specified Relative" is added for consistency with other TANF funded OFI programs. A definition of "Stackable Credential" is added to facilitate a lifelong education, training, and employment program that leads to improved employability or increased earnings potential in a specific job sector. The definition of "Working Age" is simplified to avoid a potential conflict should the CWRI change its definition in the future.

In Section 3, "Eligibility", the following items are clarified. Paragraphs 6, 8 and 10 of Subsection A are changed to provide more clarity and specificity to the eligibility criteria for Participants, Institutions, and Programs. A list of TANF programs that do not include cash payments is added to A(6). A(8) is modified to clarify that the individual must have aptitude for the career not just the training or education program. The standards of accreditation are added to A(10)(a)(i). In addition to modifications related to PL 2021 Ch. 149, A(10)(b) is amended to expand the criteria for cost effectiveness of a training or education program. Amendments to Subsection B(2) clarify the treatment or exclusion of certain income types.

In Section 4, "Services", the following items are amended. Subsection B(1)(a) is amended to clarify that the Outstanding Tuition and Fees support does not apply to student loan payments or prior payments made to payment plans entered into before HOPE enrollment. The mileage reimbursement rate in Subsection B(3) is increased from 44 to 45 cents per mile consistent with the MSEA rate at https://www.maine.gov/osc/travel/mileage-other-info and the rate used by other OFI supports such as the Additional Support for People in Retraining and Employment (ASPIRE), Food Supplement Employment and Training (FSET) and Transitional Transportation programs. Paragraphs 3 and 7 of Subsection B are amended to specify that these supports are available only for vehicles being operated in accordance with Maine law. Subsection B(5) is amended to clarify that Technology and Software supports are only considered necessary if the Participant does not have sustained access to Technology and Software at their home. Subsection B(6) is added to allow funding of Internet access for HOPE participants who do not have other available, cost-effective Internet resources.

Section 7, "Policies and Procedures", has the following modifications. Subsection B(1) is amended to allow for electronically signed submissions. Subsection B(1) is

amended to clarify that applicants can have their denial reconsidered if they provide verifications within the month of denial or the month following. Finally, Subsection B(1) is amended to allow the same timeframe for waitlisted applicants to be reconsidered. These changes provide improved access. Subsections C and D are amended to clarify the end date of eligibility for supports. Subsection C(2) is amended to clarify that a change to an eligibility factor expected to last at least 30 days or a change to HOPE funded services expected to last at least 14 days needs to be reported. Subsection D is corrected to reflect the location of the caps for Supports as Section 4(B). Subsection D(3) is amended to clarify the timeframe during which Participants can request reimbursements. This change reduces the administrative burden on Participants and the Department. Subsection E is amended to reflect the clarifications made to Section 3(A)(6), (8), and (10) detailed above including detailing the acceptable verifications for the clarified eligibility criteria. Subsection E(1)(g) is amended for greater consistency with the terminology and requirements in Section 3(A)(9). Subsection E(1)(i)(v) is further amended to allow other documentation similar to those specified as evidence of acceptability of an online program.

Other changes are part of a standardization of practice across all OFI rules. Enumeration and lettering of subsections, paragraphs, etc. is updated as part of a general effort to make these systems consistent throughout OFI rules and as necessary to accommodate the addition and deletion of material. References to Maine law or regulations are reformatted for standardization within the document and consistency with the conventions detailed in *Uniform Maine Citations* by Michael D. Seitzinger, Charles K Leadbetter, and Sara T.S. Wolff. (https://digitalcommons.mainelaw.maine.edu/uniform-maine-citations). References to various website URLs are updated to reflect instances where the owner of the information changed the URL. Some references to other parts of this manual are corrected for clarity. Changes include using gender inclusive pronouns. Other grammatical and typographical errors are corrected. Redundant terms are removed. References to “Caretaker Relative” are changed to “Specified Relative” for consistency with other TANF funded Office for Family Independence (OFI) programs.

As proposed, this rule would only have authorized technology and software supports if they were not available to the participant. As a result of public comments, the adopted version of this rule clarifies that these supports are authorized if the participant does not have access to them at their home.

As a result of comments, clarification was added related to employability aptitude. The adopted rule specifies that verification of employability aptitude will only be requested if the Department receives information that the individual would not meet the standards defined by the professional licensing or regulatory board for the individual’s chosen industry, and provides added specificity as to what documentation is acceptable.

On the advice of the OAG, information was added on how to acquire the current income standards from the Department.

Fiscal impact of rule:

No annual fiscal impact is anticipated. The addition of the Internet support will, likely, only result in participants using this support in a given year as opposed to the Technology and Software or Other Support categories. Any increases in cost related to the changes in eligibility criteria or the increased caseload cap can be absorbed in the existing allocation.

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

Annual List of Rulemaking Activity
Rules Adopted January 1, 2022 to December 31, 2022
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) and (8); 3762(3)(A) and (8)(B)(C); 3769-A; 3769-C(C) and (D); and 3786
Chapter number/title:	**Ch. 331**, Public Assistance Manual (TANF); **TANF #119**, Expansion of Transitional Transportation, and Adjustments to TANF Budgeting
Filing number:	**2022-234**
Effective date:	12/10/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:

The adoption of this final rule amends Chapter III to clarify the exclusion of certain non-recurring payments as assets, including one-time cash assistance such as the Build HOPE Project. Updates to Chapter III Section (B) increase the excluded gift threshold in recognition of inflation since the original figure was established.

This rulemaking updates Chapter V Section B to extend the Transitional Transportation benefit to working families with income below 200% of the federal poverty level (FPL) even if they did not participate in ASPIRE-TANF, or lost TANF for a reason other than employment.

Pursuant to PL 2021 ch. 1 §N-1, this adopted rule restricts eligibility for this group to $1,400,000 per year.

This adopted rulemaking effectuates changes related to Chapter V Sections B(4) and (5) regarding payment of TT supports. It also applies the $20 cap uniformly to all months rather than reduce it to $15 for the second six months. In addition, it also clarifies that this benefit is available so long as transportation is incurred regardless of the mode of transportation.

Chapter V(B)(6)(a)(v) is amended to clarify that households only need to report increases in income that put them over the applicable limit.

Appendix Charts page 1, The Table of Percentages for First Month Payment, corrects the rate for the 31st day of the month from 3.20 percent to 3.23 percent.

This adopted rulemaking includes minor changes such as correcting typographical errors, enumeration and formatting changes necessitated by more substantive changes, adding clarifying language, and reducing the use of stigma inducing language as well as modernizing the asset type list to include crypto currency.

All of the above changes are effective upon adoption of this rule.

Updates to Chapter V Section B(4) increases the mileage reimbursement to maintain consistency with the rate afforded to those covered under the Maine State Employees Association (MSEA) contract. This change is effective retroactive to October 1, 2022, consistent with the MSEA contractual change.

Pursuant to 22 MRS §3769-C(1)(D), this adopted rule increases Appendix Charts, page 2, Standard of Need and Maximum Grant, each October based on the Cost of Living Increase, used by the Social Security Administration effective retroactive to October 22, 2022.

To comply with 22 MRS §3762(8)(C), Appendix Charts page 3, Worksheet For Calculating Transitional Child Care (TCC) Parent Fees and Subsidy Payments, is updated based on Federal Poverty Level (FPL) figures published in the Annual Update of the HHS Poverty Guidelines, Federal Register 87:14 (January 21, 2022) p. 3315.

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https://www.federalregister.gov/documents/2022/01/21/2022-01166/annual-update-of-the-hhs-poverty-guidelines effective retroactive to February 1, 2022.
Retroactive rulemaking is authorized by the Legislature in accordance with 22 MRS § 42(8) because this rule provides a benefit to recipients or beneficiaries and does not have an adverse financial effect on either providers or beneficiaries or recipients.
The adopted rule differs from the proposed rule in the following ways:
Chapter V Section (B)(a)(i) is updated to Transitional Transportation (TT) is available for up to 18 months when requested within twelve months of TANF/PaS closure.

This adopted rule effectuates additional supports for working families and reduces complexity of the program for them and Department staff. Additional changes to the adopted rule are intended to improve readability and contemporariness of the sections. Families receiving TANF may see an increase in their benefits. In addition, some families not previously eligible for TANF may be eligible under the new income guidelines.

The Department does not anticipate that this rulemaking will cause any specific, actual or any potential points of public controversary for stakeholders, businesses, or municipalities.

Fiscal impact of rule:

Direct costs to the Department include the cost of rulemaking activity, updating staff training and resources, and necessary technology changes such as changes to the Automated Client Eligibility System (ACES) (all of which are covered by the existing budget for such changes).

The increases to the TANF Standard of Need and Maximum Benefit amounts will result in an anticipated additional expenditure of $1,522,236 per year from the Federal TANF Block Grant for federally funded benefits and $119,412 per year in state General Funds for state funded benefits. The expansion of the Transitional Transportation support will result in an increased expenditure of the TANF Block Grant of $1,400,00 per year. As a result of the updated income eligibility guidelines for Transitional Child Care there is an anticipated increase to TANF Block Grant expenditures, but this increase is minimal and unable to be determined for currently enrolled households. Additional households may also become eligible, but that number cannot be predicted. These expenditures will primarily be realized as income for Maine landlords and businesses where they are spent.

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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 for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1) and (8), 3173, 3174(G), 3174-FFF
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manual, Parts 2, 3, 5: Changes to Post-Partum Coverage, and Coverage for Young Adults
Filing number:	**2022-218**
Effective date:	11/6/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
PL 2021 Ch. 461 amended 22 MRS § 3174-G to incrementally increase the period of time an individual can receive postpartum coverage. PL 2022 Ch. 519 adjusted the timeframe of those extensions to comply with 42 USC §§ 1396a(e) and 1397gg(e)(1) as amended by PL 117-2, the *American Rescue Plan Act of 2021*. This rulemaking incorporates those extended timeframes into Part 2 §13.1(III) and Part 3 §2.3(I) effective August 1, 2022.

PL 2021 Ch. 461 further amended 22 MRS §3174-G to provide MaineCare coverage to non-citizens during their pregnant/postpartum period or under the age of 21 to the extent allowable under federal law. This rulemaking incorporates that coverage into Part 3 §2.3(III). Consistent with amendments made by PL 2022 Ch. 519, and State Plan Amendments ME 22-0020 and ME-20-0021 these changes are, also, effective July 1, 2022.

PL 2021 Ch. 398 Part DDD established 22 MRS §3174-FFF to provide state-funded MaineCare and CubCare to non-citizens under age 21 who would be eligible for the federally-funded program if not for their immigration status. This rulemaking incorporates that program in the definitions of "Cub Care" and "Coverage for Noncitizens Under Age 21" in Part 2 §1, Part 3 §2.1(V), and Part 5 §3(C) effective July 1, 2022 consistent with the timeframe in law.

Consistent with 8 USC §1612(b)(2)(G) as established by the *Consolidated Appropriations Act*, 2021, PL 116-260, §208, this rulemaking extends MaineCare coverage to otherwise eligible non-citizens with Compact of Free Association (COFA) status. This addition of Subparagraph P to Part 2 §3.4(I) is effective December 27, 2020.

The Department is adopting the preceding changes retroactively to the dates indicated. Retroactive rulemaking is permissible under 22 MRS §42(8) as these changes afford benefits to more residents of the State of Maine and do not adversely impact applicants, participants, beneficiaries, or providers. The following changes are not adopted retroactively.

This rulemaking clarifies the requirements in Part 2 §§ 3.1, 3.2, 3.3, and 3.4 for applicants and the Department as they relate to non-citizen eligibility. These requirements are consistent with 42 USC §1320b-7 and 42 CFR §435.956(a).

The Department is updating Part 2 §11, and Part 5 §§ 1, 9, and 10 to reflect online application avenues that have changed.

The Department is removing language from Part 3 §2.4 and Part 5 §3 that was necessary immediately after the adoption of other rule changes, but no longer applies.

The following additional updates are being made to Part 2. Section 7.1 is amended to include a more accurate list of programs that do not require cooperation in obtaining medical support from a non-custodial parent. The Department is removing redundant language from Section 12.2. Additionally, general verification requirements in Section 12.1 are modified to specify that the Department must use electronic verifications systems when available. Only if

eligibility cannot be determined based on those systems is verification required of the individual. These changes are necessary to comply with 42 CFR §435.949. Section 13.1 is amended to more clearly articulate that while a child may be eligible for continuous coverage for 12 months, the category of eligibility may change. Section 13.3 is reworded to be more consistent with other sections that address change reporting. The Department is removing ambiguous language from Section 13.4. Clarity is added to Section 15 related to the types of computer matches that require timely noticing.

The following additional updates are being made to Part 3. A definition of Federal Poverty Level is added to Section 1. The Department is removing an unnecessary redundant definition in Section 2.1. Section 2.2 is corrected to indicate an individual is still considered to live with their parent or caretaker if they attended the Governor Baxter State School for the Deaf if services cannot be found in their home community. Section 2.3(II) is amended to clearly state that providers must communicate a decision to the Department as a whole, not to a specific regional office. It is further amended to clarify that Presumptive Eligibility ends the earlier of the date the Department renders a decision or the end of the month following the month the provider renders a decision. Section 4.1.1 is amended to more clearly state which coverage groups may move to Transitional MaineCare. Section 4.2.2 is amended to reflect that recipients who are no longer employed must request a good cause determination before the Department can establish one.

The Department is removing redundant language from Part 5 Section 9.

Finally, some non-substantive changes are being made for clarity and inclusivity. Where possible, similar terms that may have carried stigma or are now out of date are replaced with "noncitizen." The Department is using person first language except where it would create inconsistency in terminology used in other parts of the manual. Language is rendered gender neutral where possible. The Department is converting some language to the active voice for clarity. Some instances of bulleted items are converted to a more consistent outline style. Citations and cross references are updated as needed for accuracy, clarity, and consistency of format. Minor corrections to punctuation, grammar, and spelling are being made. Whole numbers zero through ten are being represented in word form with all other numbers being represented numerically (consistent with the method being applied to all Office for Family Independence Manuals). Date format is being made consistent throughout these parts. Part 2 §8 is reorganized. These changes improve the readability of the manual without changing its meaning.

The adopted rule differs from the proposed rule in the following ways: Amendments have been made to clarify that the SAVE requirements do not apply to citizens or noncitizens who do not declare a qualifying status; the reference to individuals being limited to Emergency Services if SAVE verification could not be completed within the reasonable opportunity period has been removed; the section on Emergency Services has been updated to clarify it does not apply to individuals under 21 or or pregnant individuals eligible for full coverage; references to the "Mountain View Youth Development Center" have been modernized to refer to the "Mountain View Correctional Facility"; and the CHIP coverage for pregnant individuals was updated to— include the correct effective date of July 1, 2022, eliminate language that may have been interpreted to limit the type of care covered, and clarify that coverage continues until the end of the month the pregnancy ends or longer if necessary to allow for adequate and timely notice.

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

Fiscal impact of rule:

Direct costs to the Department include the cost of rulemaking activity, updating staff training and resources, and necessary technology changes such as changes to the Automated

Client Eligibility System (ACES) (all of which are covered by the existing budget for such changes).

Extended postpartum eligibility is anticipated to cost an additional $279,720 in General Funds for State Fiscal Year 2023 and each subsequent year. It is, also, expected to bring an additional $497,280 in federal funds into the state for State Fiscal Year 2023 and each subsequent year.

Expanded eligibility for noncitizens is anticipated to cost an additional $430,811 in General Funds for State Fiscal Year 2023 and $2,070,971 for each subsequent year. It is, also, expected to bring an additional $1,278,757 in federal funds into the state for State Fiscal Year 2023 and each subsequent year.

All of these funds would primarily be realized as income for Maine businesses where they are spent.

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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 Child and Family Services**
Umbrella-Unit:	**10-148**
Statutory authority:	22 MRS §§ 7702-B(11), 7703(6), 7704, 7707(3), 7802(7), 8301(8), 8302-A(2), 8303-A(l)
Chapter number/title:	**Ch. 33** *(Repeal and replace)*, Family Child Care Provider Licensing Rule
Filing number:	**2022-069**
Effective date:	5/27/2022
Type of rule:	Major Substantive
Emergency rule:	No

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

Basis statement:
The Department of Health and Human Services (the "Department") finally adopts major substantive portions of 10-148 CMR Chapter 33, *Family Child Care Provider Licensing Rule* and repeals 10-144 CMR Chapter 33, *Family Child Care Provider Licensing Rule*. The Maine Legislature designated portions of the Family Child Care rule as major substantive, per 22 MRS §§ 8302-A(2)(G)-(J) and 8303-A(1). Other sections are designated as routine technical, per 22 MRS §§ 7702-B, 7703, 7802, 8301-A and 8302-A (2)(A)-(F). On May 20, 2021, the Commissioner finally adopted the routine technical portions of the rule and provisionally adopted the major substantive portions. On May 27, 2021, the Commissioner adopted an identical rule on an emergency basis. Pursuant to 5 MRS §8073, the emergency rule expires on May 27, 2022. This rule has been reviewed and approved by the legislature (LD 1864 (130th Legis. 2021)) with an emergency resolve effective March 31, 2022. Resolves 2021 ch. 138. The resolve authorizes the Department to finally adopt Chapter 33: *Family Child Care Provider Licensing Rule*, only if the following changes are made:

1. The rule must be amended to remove the definition of critical violation in Section 1.B.11 as a category of violation by providers that do not meet licensing requirements;
2. The rule must be amended to remove all references to "CV" for critical violations from the margins;
3. In section 2.G.12, the rule must be amended to require providers to enroll rather than register with the Quality Rating and Improvement System within the Office of Child and Family Services;
4. In section 6.F.4, the rule must be amended to remove the requirement for providers to notify the department of a critical violation within 24 hours of occurrence;
5. In section 7.F.5 and 7.F.6, the rule must be amended to specify that the immunization records of providers and staff members document immunity against tetanus, pertussis and diphtheria;
6. In section 8.A.10, the rule must be amended to clarify that training for staff members on transportation of children is required biennially rather than biannually;
7. In section 12.A.1.a, the rule must be amended to update the child care immunization standards from those published in September 2019 to those published on August 8, 2021;
8. In section 14.M, the rule must be amended to remove the requirement for both hot and cold running water in toilet facilities and only require running water; and

9. The rule must be amended to remove administrative fines from section 20.D as an option for noncompliance with licensing rules and removed from Section 20.P.1.c.v from actions that are afforded the right to appeal.

The finally adopted rule includes these required changes from the provisionally adopted rule.

The Department determined that adoption of this rule, 10-148 CMR Ch. 33, *Family Child Care Provider Licensing Rule*, is necessary to fully comply with the federal requirements of the 2014 reauthorization of the Child Care and Development Block Grant (CCDBG), which provides significant funding annually to improve access to and quality of child care in Maine. The new provisions in the rule are required to remain in compliance with CCDBG. Additionally, the rule includes provisions necessary to meet the health and safety needs of children who are served by licensed family child care providers. The rule also removes and modifies provisions of the current rule in order to streamline requirements and processes. Finally, statutory requirements omitted from the current rule have been reincorporated for clarity and improved transparency of requirements.

Significant major substantive changes adopted in this rulemaking include: clarifying definitions; requiring compliance with comprehensive background checks pursuant 10-148 CMR Ch. 34; adding requirements for provider handbook and staff manual; increasing record retention from two years to three years; updating immunization requirements; clarifying and adding requirements for notifications to the Department; adding staff qualifications and requirements; specifying orientation and ongoing training requirements; adding a requirement for registration with Maine's Professional Development Network; adding child and parent rights; adding time requirements for active outdoor play; reducing screen time, adding a requirement for a carbon monoxide detector; changing temperature requirements, adding swimming requirements; adding healthy meal and snack requirements; adding disqualifying driving offenses prohibiting provider transport of children; prohibiting swaddling; and modifying requirements for nighttime care.

Fiscal impact of rule:

The Department does not anticipate any fiscal impact as the changes are cost neutral.

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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 Child and Family Services**
Umbrella-Unit:	**10-148**
Statutory authority:	22 MRS §§ 42(1), 8302-A(1)(J), 2(K); 42 USC §9858(b)
Chapter number/title:	**Ch. 34** *(New)*, Child Care Provider (Child Care Facilities and Family Child Care Providers Background Check Licensing Rule
Filing number:	**2022-059**
Effective date:	5/12/2022
Type of rule:	Major Substantive
Emergency rule:	No

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

Basis statement:
The Department of Health and Human Services (the "Department") finally adopts 10-148 CMR Chapter 34, *Child Care Provider (Child Care Facilities and Family Child Care Providers) Background Check Licensing Rule*. This is a major substantive rule pursuant to 22 MRS §8302-A (1), (2). On September 25, 2020, the Commissioner adopted a substantively identical rule on an emergency basis. However, pursuant to 5 MRS §8073, that emergency rule expired on September 24, 2021. In order to avoid a lapse in the legal application of the rule, the Department provisionally adopted Chapter 34 on September 17, 2021 and proposed the rule with a legal applicability date of September 25, 2021. This Rule has been reviewed and approved by the legislature (LD 1865 (130th Legis. 2021) with an emergency resolve effective March 16, 2022. Resolves 2021 ch. 130.

The rule implements 22 MRS §8302-A(1)(J) and (2)(K), which requires that the Department adopt rules for child care facilities and family child care providers which require a criminal background check that meets the requirements of 42 USC §9858f. The rule thus provides necessary protection to children who receive child care in licensed child care settings. It also provides protection to the child care facilities and family and child care providers. The Maine Legislature has provided that the criminal background checks be paid by the Department from the funds available under the federal *Child Care and Development Block Grant Act of 1990*, as amended by the federal *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, Public Law 104-193, 110 Stat 2105. 22 MRS §8302-A(3). The Child Care Providers and staff members bear no cost for the expense of the criminal background checks under the finally adopted rule.

The finally adopted rule is also necessary for continued compliance with the federal background check requirements of the 2014 reauthorization of the *Child Care and Development Block Grant (CCDBG)*, 42 USC §9858f(b) and 22 MRS §8302-A(1)(J), (2)(K). CCDBG provides significant funding annually to improve access to and quality of child care. Maine will receive a financial penalty of approximately $800,000.00 if the components of the comprehensive background check established by means of emergency major substantive rulemaking lapse.

On September 21, 2021 the Department adopted 10-148 CMR ch. 32, *Child Care Facility Licensing Rule - Child Care Centers, Nursery Schools, Small Child Care Facilities, Other Programs*. This rule includes a provision - Section 2(D) - requiring compliance with 10-148 CMR ch. 34, *Child Care Provider Background Check Licensing Rule*. Additionally, the Department adopted 10-148 ch. 33, *Family Child Care Provider Licensing Rule*, by means of an emergency major substantive adoption on May 27, 2021 and this rule also includes a provision - Section 2(D) - requiring compliance with 10-148 ch. 34, *Child Care Provider*

Background Check Licensing Rule. The Department provisionally adopted the *Family Child Care Provider Licensing Rule* on May 20, 2021, and it is currently before the Legislature for review pending final adoption. LD 1864 (130th Legis. 2021).

The final rule makes no substantive changes to the rule provisionally adopted September 17, 2021. This rule adds requirements to pre-employment and pre-licensure comprehensive background checks for Child Care Providers to include:

- Mandatory fingerprinting with search of the Federal Bureau of Investigation (FBI) and State Bureau of Identification (SBI), as well as the National Crime Information Center (NCIC) National Sex Offender Registry.
- Searching state criminal repositories, state child abuse and neglect registries/databases, and state sex offender registries in each state where the individual has resided in the previous five years.
- Prescribing specific disqualifying offenses for determining whether an individual is deemed eligible or ineligible to work for or as a licensed child care provider.
- Requiring (1) all current and prospective staff members, (2) all adult household members in a family child care, and (3) any other individual whose activities involve the care or supervision of children or who has unsupervised access to children to receive a qualifying result pursuant to a comprehensive background check as provided for in the *Child Care Provider Background Check Licensing Rule.*

Fiscal impact of rule:

22 MRS §8302-A sub-§3 requires that fees for criminal background checks must be paid by the Department from the funds available under the federal *Child Care Development Block Grant Act of 1990* as amended by the federal *Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, Public Law 104-193, 110 Stat. 2105. The fees for the criminal background checks reimbursed under this subsection may not exceed the actual costs for processing and administration.

Fingerprint-based background checks are valid for five years and will continue to be provided at no cost to the individual and no cost to the Child Care Provider.

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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 Child and Family Services**
Umbrella-Unit:	**10-148**
Statutory authority:	22 MRS §§ 42, 4008(7), 5601-5610; PL 2015 ch. 501
Chapter number/title:	**Ch. 201**, Procedures for the Child Abuse or Neglect Findings, Appeals from Findings, and Appeals from Denial of Access in Certain Confidential Records
Filing number:	**2022-030**
Effective date:	2/28/2022
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:

The Department of Health and Human Services (the "Department") proposed rulemaking to amend 10-148 CMR ch. 201, currently called “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”. There was no hearing held for this rule. The comment period following publication ended on November 20, 2021. No comments were received.

Maine law requires the Department to investigate allegations of child abuse or neglect and determine whether the child has been harmed, as well as the degree of harm or threatened harm, and decide whether the allegations arc unsubstantiated, indicated, or substantiated, 22 MRS §§ 4004(2), 8354. "Substantiated" means a finding of high severity abuse or neglect or present threat thereof, while "indicated" means a finding of low to moderate severity abuse or neglect and no further threat of harm. The current rule provides for administrative hearings of appeals only in the case of substantiated findings because of the substantial difference in impact of an indicated finding versus a substantiated one. Substantiated findings are reported out on child protective background checks and as a result may prohibit an individual from working in their chosen field, Indicated findings are not reported out on background checks, but may nonetheless still impact the indicated individual-for example, as part of a so-called "Clifford Order" whereby the Department is ordered by a court to produce records in a civil or criminal proceeding, or as part of the Department's decision to issue certain licenses to individuals.

The Department therefore adopts this rule to allow a person indicated for abuse or neglect of a child to request a "paper review" and, if the finding is upheld on paper review, an administrative hearing to appeal the finding following a determination by the Chief Administrative Hearing Officer that the person bas experienced or is likely to experience collateral consequences as a result of the indicated finding. The adopted rule requires the Department to provide notice of the right to request an administrative hearing to appeal an indicated finding after it is upheld on paper review, and that collateral consequences must be proven to the Chief Hearing Officer for a hearing to be granted. The adopted rule also provides a process for those who were previously indicated for abuse or neglect of a child to appeal the indication if they are now suffering collateral consequences of the finding. The adopted rule also allows a person who was substantiated for abuse or neglect of a child before November l, 2003, and never previously afforded notice of an opportunity for paper review or an administrative hearing, to request a paper review or administrative hearing.

The adopted rule makes several other changes to the current rule, which the Department in its judgment has determined are necessary to the successful operation of the rule. The adopted rule extends the deadlines for the Department to complete paper reviews of findings. The adopted rule changes the time in which the Department must conduct a paper review from sixty to ninety days from the request for paper review, changes the time an appellant may respond to new information in the paper review from seven to ten days, and extends the Department's obligation to notify the appellant of the result of the paper review from five to ten business days.

The adopted rule clarifies that although the Department must substantiate a specific allegation of child abuse or neglect if the Department was a party to a case in which a court found as a factual matter that the specific conduct did occur, a court finding that a child is not in circumstances of jeopardy does not require the Department to change an indicated or substantiated finding against a person with respect to that child.

The adopted rule also gives the paper reviewer the ability to lower a finding from substantiated to indicated during paper review, and the hearing officer authority to recommend the Commissioner lower a substantiated finding to an indicated finding.

Finally, the adopted rule adds a new section XVII, "Time Limits", clarifying the computation of time periods provided for in the rule.

Fiscal impact of rule:

No fiscal impact anticipated.

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Rules Adopted January 1, 2022 to December 31, 2022
Prepared by the Secretary of State pursuant to 5 MRS §8053-A sub-§5

Agency name:	Department of Health and Human Services, **Office of Aging and Disability Services (OADS)**
Umbrella-Unit:	**14-197**
Statutory authority:	PL 2021 ch. 284; 22 MRS §3089(3); 34-B MRS §5605
Chapter number/title:	**Ch. 1** *(New)*, Rights and Basic Protections of Persons with an Intellectual disability, Autism Spectrum Disorder or Acquired Brain Injury
Filing number:	**2022-223**
Effective date:	11/18/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This new rule sets forth the rights and basic protections of persons with an intellectual disability, Autism Spectrum Disorder or acquired brain injury in accordance with 22 MRS §3089 and 34-B MRS §5605.

PL 2021 ch. 284 extended certain rights and basic protections set forth in 34-B MRS §5605 to persons with an acquired brain injury; directed the Commissioner to convene a task force to make recommendations on rules and procedures regarding the rights and basic protections of persons with acquired brain injuries; and directed the Department to consider the task force's recommendations and to adopt rules regarding the rights and basic protections of individuals with an acquired brain injury.

Because the Department had not previously undertaken rulemaking regarding the rights and basic protections of persons with an intellectual disability or Autism Spectrum Disorder, the rule also states the statutory rights and basic protections of these persons. Most of these rights and basic protections apply to all persons with an intellectual disability, Autism Spectrum Disorder, or acquired brain injury – not just those who receive services from a provider that is funded or licensed by the Department. This distinction is reflected in the rule.

The rule also describes the procedures for notifying persons receiving services of their rights and basic protections, and states the remedies available for alleged violations of rights and basic protections.

OADS drafted this rule relying on the following: PL 2021 ch. 284; 22 MRS § 3089; 34-B MRS §§ 5603-5606 and 5610, including the statutory rights for individuals with an intellectual disability, Autism Spectrum Disorder, or acquired brain injury; the January 2022 Task Force Recommendations; other stakeholder in put; Department staff's knowledge of and experience with educating individuals receiving services of their rights; and the administration's guidance and vision for educating individuals receiving services about their rights and basic protections.

The Department held a virtual public hearing on July 15, 2022. Nine commenters submitted comments during the comment period and the public hearing. The Department made some changes to the final rule from the proposed rule in response to the comments and on the advice of the Office of the Attorney General.

Fiscal impact of rule:
This rulemaking will not impose any costs on municipal or county government or on small businesses.

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Rules Adopted January 1, 2022 to December 31, 2022
Prepared by the Secretary of State pursuant to 5 MRS §8053-A sub-§5

Agency name:	Department of Health and Human Services, **Office of Aging and Disability Services (OADS)**
Umbrella-Unit:	**14-197**
Statutory authority:	22 MRS §206(4); 34-B MRS §5604(3)
Chapter number/title:	**Ch. 8**, Grievance Process for Persons with an Intellectual Disability, Autism Spectrum Disorder or Acquired Brain Injury
Filing number:	**2022-224**
Effective date:	11/18/2022
Type of rule:	Routine Technical
Emergency rule:	No

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

Basis statement:
This rule establishes the procedures by which a recipient of services with an intellectual disability, autism spectrum disorder, or an acquired brain injury may grieve and seek resolution of complaints regarding actions or inactions of the Department or providers affecting the recipient's statutory rights, or services.

The Department is adopting this rule to update and clarify requirements for its grievance procedure rule. Specifically, this rule implements PL 2021 ch. 284, *An Act to Improve the Rights and Basic Protections of Persons with Acquired Brain Injuries,* §§ A-2, A-8, which provide individuals with an acquired brain injury the right to submit a grievance. This rule revises the definition of grievance and provides new deadlines for the resolution of grievances and includes a six-month savings clause for grievances that accrued prior to the effective date of the proposed rule. Further, the Department is clarifying the grievance procedure for a person receiving services if an individual has a grievance against his or her case manager. This rule also clarifies the role of Maine's Protection and Advocacy Agency and affords the Commissioner discretion whether to issue an Order of Reference when an administrative hearing is requested, and thus reserve the final decision for herself.

OADS drafted this rule relying on the following: existing grievance procedures for persons with an intellectual disability or Autism Spectrum Disorder; stakeholder input; Department staff's knowledge of and experience with grievance procedures; and the administration's guidance and vision for grievance procedures for these populations.

The Department held a virtual public hearing on July 14, 2022. Seven comments were submitted during the comment period and the public hearing. The Department made some non-substantive changes to the final rule from the proposed rule in response to the comments and on the advice of the Office of the Attorney General.

Fiscal impact of rule:
This rulemaking will not impose any costs on municipal or county government or on small businesses.