§3173. Powers and duties of department

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

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

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

An application for aid under this chapter must be acted upon and a decision made as soon as possible, but the department may not fail to notify the applicant of its decision within 45 days after receipt of the applicant's application. Failure of the department to meet the requirements of this 45-day time standard, except when there is documented noncooperation by the applicant or the source of the applicant's medical information, must lead to the immediate and automatic issuance of a temporary medical card that is valid only until such time as the applicant receives actual notice of a departmental denial of the applicant's application or the applicant receives a replacement medical card. Notwithstanding an applicant's appeal of a denial of the applicant's application, the validity of the temporary medical card ceases immediately upon receipt of the notice of denial. Any benefits received by the applicant during the interim period when the applicant has actual use of a valid, temporary medical card is not recoverable by the department in any legal or administrative proceeding against the applicant. [RR 2021, c. 2, Pt. B, §155 (COR).]

Whenever an applicant is determined by the department to be ineligible for a program for which the applicant has applied, the applicant must be immediately so notified in writing. Any notification of denial must contain a statement of the denial action, the reasons for denial, the specific rules or regulations supporting the denial, an explanation of the applicant's right to request a hearing and a recommendation to the applicant of any other program administered by the department for which the applicant may be eligible. Whenever an individual's application for Temporary Assistance for Needy Families is denied by the department, the notice of this denial must also include, in a clear and conspicuous manner, a statement that the applicant is likely to be eligible for medical assistance and must include information about the availability of applications for the program upon request to the department either in writing or through a toll-free telephone number. [RR 2021, c. 2, Pt. B, §156 (COR).]

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

and the applicable state maximum. Whenever the applicant incurs sufficient medical expenses to be eligible for the medically needy program and provides reasonable proof thereof to the department, a medical card must be issued within 10 days of the presentation of proof that eligibility has been met. Failure of the department to meet the requirements of this 10-day time standard, except when there is documented noncooperation by the applicant or the source of the applicant's medical information, results in the immediate and automatic issuance of a temporary medical card that is valid only until such time as the applicant receives actual notice of a departmental denial of the applicant's application or the applicant receives a replacement medical card. Any benefits received by the applicant during the interim period when the applicant has actual use of a valid temporary medical card are not recoverable by the department in any legal or administrative proceeding against the applicant. [RR 2021, c. 2, Pt. B, §157 (COR).]

In all situations where prior authorization of the department is required before a particular medical service can be provided, the department shall authorize or deny the request for treatment within 30 days of the completion and presentation of the request to the department. The department's response to the request must be supplied to both the provider and the recipient. Whenever the provider is unable or unwilling to provide the service requested within a reasonable time after approval of the request by the department, the recipient has the right to locate another approved provider whose sole duty is to notify the department of the provider's intention to provide the service subject to the original approval. The department shall vigorously assist any recipient in the recipient's search for an approved provider of a necessary medical service when, through reasonable effort, the recipient has been unable to locate a provider on the recipient's own. [RR 2021, c. 2, Pt. B, §158 (COR).]

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

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

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

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

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

The Department of Health and Human Services may establish fee schedules governing reimbursement for services provided under this chapter. In establishing the fee schedules, the department shall consult with individual providers and their representative associations. The fee

schedules are subject to department review on a regular schedule set by the department. [PL 2021, c. 398, Pt. OOO, §1 (AMD).]

During the department's review of fee schedules required by this section, the department shall consult with individual providers participating in the Medical Assistance Program and their representative associations to consider, among other factors, the cost of providing specific services, the effect of inflation or other economic factors on the adequacy of the existing fee schedule and its obligation under the federal Medicaid program to ensure sufficient provider participation in the program and member access to services. Except as otherwise provided, the department may apply annual cost-of-living increases, as appropriate, to MaineCare reimbursement rates. The department shall post any change to fee schedules from cost-of-living increases on the department's publicly accessible website at the time the change goes into effect. [PL 2021, c. 398, Pt. OOO, §2 (AMD).]

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

The department shall use the multipayor provider database established in section 8719 as its primary source of information to update the department's own data and publicly available information regarding health care provider and service directory information when the information required by the department is already available through the multipayor provider database. [PL 2021, c. 423, Pt. B, §1 (NEW).]

SECTION HISTORY

PL 1973, c. 790, §2 (NEW). PL 1977, c. 582, §2 (AMD). PL 1977, c. 674, §20 (AMD). PL 1977, c. 696, §370 (AMD). PL 1977, c. 712, §F2 (AMD). PL 1977, c. 714, §2 (RPR). PL 1979, c. 127, §144 (RPR). PL 1981, c. 329, §§1,2 (AMD). PL 1985, c. 727 (AMD). PL 1985, c. 785, §B91 (AMD). PL 1991, c. 528, §E23 (AMD). PL 1991, c. 528, §RRR (AFF). PL 1991, c. 591, §E23 (AMD). PL 1997, c. 530, §A34 (AMD). PL 1997, c. 676, §1 (AMD). PL 2003, c. 689, §B6 (REV). PL 2021, c. 398, Pt. OOO, §§1-3 (AMD). PL 2021, c. 423, Pt. B, §1 (AMD). RR 2021, c. 2, Pt. B, §§155-158 (COR).