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**5.01 INTRODUCTION**

On January 31, 2020, the Secretary of the United States Department of Health and Human Services (the “Secretary”) declared a public health emergency (the “Public Health Emergency”) due to COVID-19. On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency (the “Federal Proclamation of Emergency”). On March 13, 2020, pursuant to Section 1135(b) of the *Social Security Act* (the “Act”), the Secretary invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS). The waivers and modifications of the Act shall no longer be in effect upon termination of either the Public Health Emergency or the Federal Proclamation of Emergency, including any extensions.

Maine Governor Janet T. Mills proclaimed a state of emergency due to COVID-19 on March 15, 2020, which was extended by further proclamation on April 14, 2020. On April 28, 2020, the Governor issued Executive Order No. 48 FY 19/20, *An Order Modifying Certain Procedural Requirements for Emergency Rulemaking to Maximize Federal COVID-19 Funding for MaineCare* (the “Executive Order”). Pursuant to 5 M.R.S. §§ 8054 and 8073, and the Executive Order, this single emergency rulemaking implements temporary changes to various sections of the MaineCare Benefits Manual (MBM) in order to expedite and improve access to medical care for MaineCare members in light of the substantial public health threat posed by COVID-19.The following sections of MaineCare policy are affected by this rulemaking: Ch. 1, Section 1 (General Administrative Policies and Procedures); Ch. I, Section 4 (Telehealth Services); Ch. II, Section 17 (Community Support Services); Chs. II and III, Section 31 (Federally Qualified Health Center Services); Chs. II and III Section 40 (Home Health Services); Chs. II and III, Section 45 (Hospital Services); Ch. II, Section 55 (Laboratory Services); Ch. II, Section 60 (Medical Supplies and Durable Medical Equipment); Chs. II and III, Section 65 (Behavioral Health Services); Ch. II, Section 67 (Nursing Facility Services); Ch. II, Section 80 (Pharmacy Services); Ch. II, Section 90 (Physician Services); Ch. II, Section 94 (Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)); Chs. II and III, Section 96 (Private Duty Nursing and Personal Care Services); Chs. II and III, Section 97 (Private Non-Medical Institution Services); Ch. II, Section 101 (Medical Imaging); Chs. II and III, Section 103 (Rural Health Clinic Services); Ch. X, Section 1 (Benefit for People Living with HIV/AIDS); Ch. X, Section 3 (Katie Beckett Benefit).

In the event of conflict between the COVID-19 Public Health Emergency Services rule and any other MaineCare rule, the terms of this rule supersede other rules and shall apply.

Except as otherwise noted herein, CMS approved of these changes through, *inter alia*, (a) a Section 1135 Waiver, approved on April 7, 2020, which is generally effective March 1, 2020; (b) a Disaster State Plan Amendment (SPA), approved April 24, 2020, which is generally effective March 1, 2020; and (c) various blanket waivers of the Act and CMS guidance regarding same. **Unless otherwise noted herein,** **these changes shall be effective retroactive to March 18, 2020.**

The Executive Order suspended and modified the relevant provisions of the MAPA in order for these rule changes to: (1) remain in effect until the later of the end of the Federal Proclamation of Emergency or the end of CMS’s approval of the MaineCare program changes, even if that period exceeds ninety days; and (2) automatically repeal upon termination of the Federal Proclamation of Emergency or the end of CMS’s approval of the MaineCare program changes (whichever is later), without further rulemaking by the Department.

**5.02 CO-PAYMENTS**

The Department waives co-payments for the following MaineCare services for all MaineCare members:

1. **Pharmacy**: All co-payments charged by pharmacies under Section 80, Pharmacy Services.
2. **Clinical Visits**: MaineCare currently requires some members to pay a co-payment for clinical visits based on the member’s eligibility coverage group. All co-payments for clinical visits for MaineCare members, regardless of eligibility coverage group, are waived. This includes, but is not limited to, Hospital Services (Sec. 45), Federally Qualified Health Center Services (Sec. 31)\*, Rural Health Clinic Services (Sec. 103), Physician Services (Sec. 90)\*.
3. **Medical Imaging Services**: All co-payments charged under Section 101, Medical Imaging Services.
4. **Laboratory Services**: All co-payments charged under Section 55, Laboratory Services.
5. **Behavioral Health Services**: All co-payments charged under Section 65, Behavioral Health Services.
6. **Medical Supplies and Durable Medical Equipment**: All co-payments charged under Section 60, Medical Supplies and Durable Medical Equipment.
7. **Home Health Services**: All co-payments charged under Section 40, Home Health Services.
8. **Consumer Directed Attendant Services**: All co-payments charged under Section 12, Allowances for Consumer Directed Attendant Services.\*
9. **Private Duty Nursing and Personal Care Services**: All co-payments charged under Section 96, Private Duty Nursing and Personal Care Services.
10. **Benefit for People Living with HIV/AIDS**: All co-payments charged under Chapter X, Section 1.\*
11. Should COVID-19 specific treatments and/or vaccines become available during the duration of this public health emergency rule, co-payments will be waived.

**\*The Department shall seek and anticipates receiving approval of these changes from CMS retroactive to March 18, 2020. Pending approval, these changes are effective upon adoption.**

**5.03 WAIVER OF PREMIUMS**

The Department waives all enrollment fees, premiums, and similar charges for all beneficiaries.

**5.04 PHARMACY SERVICES**

The Department alters certain provisions of the MBM, Section 80, Pharmacy Services, as follows:

1. **Initial Prior Authorization requirements for asthma and immune-related prescriptions**: Restrictions on asthma related medications like Albuterol are removed to allow all forms of Albuterol without Prior Authorization. Restrictions on Immune-related medications, like Neupogen, are removed for approval with completion of Prior Authorization form, if necessary, for the treatment of COVID-19.
2. **COVID-19 Treatments or Vaccines**: Should COVID-19 specific treatments or vaccines become available during the duration of this emergency rule, Prior Authorization will be waived.
3. **Prescription Refills**: Early refills of prescription medications are allowed in the same days’ supply and quantity as the original prescription; the requirements set forth in Ch. II, Sec. 80.07-7 are waived.
4. **Buprenorphine and Buprenorphine Combination Products for Substance Use Disorder (SUD)**: The physical assessment requirements for Buprenorphine and Buprenorphine Combination Products for SUD set forth in Ch. II, Sec. 80.07-13 are waived.

**5.05 MEDICAL SUPPLIES AND DURABLE MEDICAL EQUIPMENT**

1. **COVID-19-Related Supplies and Durable Medical Equipment**: Prior Authorization approvals currently in effect for Section 60, Durable Medical Equipment (DME), will be extended for individuals with COVID-19 (who should be in quarantine), individuals with pending COVID-19 tests in self-isolation, and individuals in the high-risk category for developing severe complications from COVID-19, and early refills will be temporarily allowed as follows on the following DME items:
2. Glucose supplies;
3. Hearing aid batteries; and
4. The following Continuous positive airway pressure (CPAP) and bi-level positive airway pressure (Bi-PAP) supplies:

Oral/nasal mask – one (1) per three (3) months;

Oral cushion– two (2) per one (1) month;

Nasal pillow – two (2) per one (1) month;

Full face mask – one (1) per three (3) months;

Facemask interface – one (1) per one (1) month;

Nasal interface – two (2) per one (1) month;

Tubing – one (1) per one (1) month;

Tubing (with heating element) – one (1) per three (3) months;

Filter (disposable) – two (2) per one (1) month;

Oral interface – one (1) per three (3) months; and

Water chamber – one (1) per one (1) month.

1. Extension of Prior Authorizations set to end will be temporarily allowed, when applicable, for the following:
2. CPAP and Bi-PAP devices and supplies;
3. Home blood glucose monitors and test strips;
4. Enteral and Parenteral nutritional therapy;
5. Apnea Monitors;
6. External Insulin Infusion Pumps;
7. Infusion Pumps Other than Insulin Pumps;
8. Continuous Glucose Monitors; and
9. Home Use of Oxygen.
10. The Department authorizes and adds Advanced Practice Providers (Physicians Assistants, Nurse Practitioners, and Clinical Nurse Specialists) to Section 60.05-1 (B) to prescribe Durable Medical Equipment.\* \*\*
11. The Department waives the requirement under Section 60.12 K that a qualified MD, DO, PA or APRN must prescribe the order. A note from an audiologist will justify medical necessity when all other criteria are met.\* \*\*

\***The Department shall seek and anticipates receiving approval of these changes from CMS retroactive to March 18, 2020. Pending approval, these changes are effective upon adoption.**

\*\*The Department may implement these changes permanently through separate rulemaking in MBM, Chs. II and III, Section 60 (Durable Medical Equipment).

**5.06 HOME HEALTH SERVICES\***

1. The Department extends the period of time for Home Health Providers to submit Plans of Care to the Department under MBM, Ch. II, Section 40, Home Health Services, §40.02-1,
2. **Authorization Process**. The current requirement of submission within five (5) business days is extended to within thirty (30) business days, including for certifications and recertifications.
3. The Department authorizes Advanced Practice Providers (Physicians Assistants, Nurse Practitioners, and Clinical Nurse Specialists) as qualified providers to order and recertify a Plan of Care as described in Chapter II, Section 40.08-2 A (1).\*\*

\*MBM, Chs. II and III, Section 40, Home Health Services, are major substantive rules.

\*\*The Department may implement these changes permanently through separate major substantive rulemaking in MBM, Chs. II and III, Section 40.

**5.07 TELEHEALTH**

1. **Waiver of Advance Written Notice**

The Department is waiving the requirement under Ch. 1, Section 4, Telehealth, Sec. 4.06-2(B), requiring advance written notice/consent prior to services.

1. **Waiver of Comparability**

The Department, at its discretion, may waive the requirement under Ch. 1, Section 4, Telehealth, Sec. 4.04-1(2), requiring Interactive Telehealth Services be of comparable quality to what they would be were they delivered in person.\* Requests will be handed on a case-by-case basis through a clinical review by the Department to determine whether members may face imminent harm in the absence of a telehealth mode of delivery for a particular service, given the inability due to the public health emergency for that member to receive the service in-person.

\***The Department shall seek and anticipates receiving approval of this change from CMS retroactive to March 18, 2020. Pending approval, these changes are effective upon adoption.**

1. **Telephone-Only Evaluation and Management**

The Department will reimburse providers for telephone evaluation and management services provided to members. The restrictions set forth in the MaineCare Benefits Manual, Ch. I, Sec. 4.04-2 are waived for this purpose.

Telephonic evaluation and management services must be rendered by a qualified professional actively enrolled in MaineCare or contracted through an enrolled MaineCare provider.

Relevant CPT codes are:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CPT/HCPC Code** | **Short Description** | **Long Description** | **Unit** | **Non- Facility Rate** | **Facility Rate** |
| 98966 | nonphysician telephone assessment 5-10 min | Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion | 5-10 minutes of medical discussion | $10.33 | $8.95 |
| 98967 | nonphysician telephone assessment 11-20 min | Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion | 11-20 minutes of medical discussion | $20.59 | $18.29 |
| 98968 | nonphysician telephone assessment 21-30 min | Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion | 21-30 minutes of medical discussion | $33.27 | $29.13 |
| 99421 | online digital e/m svc est pt <7 d 5-10 minutes | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes | 5-10 minutes | $10.33 | $8.95 |
| 99422 | online digital e/m svc est pt <7 d 11-20 minutes | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes | 11-20 minutes | $20.59 | $18.29 |
| 99423 | online digital e/m svc est pt <7 d 21+ minutes | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes | 21 or more minutes | $33.27 | $29.13 |
| 99441 | phys/qhp telephone evaluation 5-10 min | Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion | 5-10 minutes of medical discussion | $11.89 |  |
| 99442 | phys/qhp telephone evaluation 11-20 min | Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion | 11-20 minutes of medical discussion | $23.16 |  |
| 99443 | phys/qhp telephone evaluation 21-30 min evaluation and management service; | Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion | 21-30 minutes of medical discussion | $33.95 |  |
| G2012\* | Brief check in by md/qhp, 5-10 minutes | Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion | (5-10 min) | $9.90 | $8.97 |
| G2010\* | Remot image submit by pt | Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment |  | $8.43 | $6.34 |
| G2061\* | Qual nonmd est pt 5-10 minutes | Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes | 5-10 minutes | $8.32 |  |
| G2062\* | Qual nonmd est pt 11-20 minutes | Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes | 11-20 minutes | $14.67 |  |
| G2063\* | Qual nonmd est pt 21>minutes | Qualified nonphysician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes | 21 or more minutes | $22.99 | $22.76 |
| G0071\* | Comm svcs by rhc/fqhc 5 minutes | Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an rural health clinic (rhc) or federally qualified health center (fqhc) practitioner and rhc or fqhc patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an rhc or fqhc practitioner, occurring in lieu of an office visit; rhc or fqhc only | 5 minutes or more | $9.17 |  |

Telephone evaluation management services are not to be billed if clinical decision-making dictates a need to see the member for an office visit within 24 hours or at the next available appointment. In those circumstances, the telephone service shall be considered a part of the subsequent office visit. If the telephone call follows an office visit performed and reported within the past seven (7) days for the same diagnosis, then the telephone services are considered part of the previous office visit and are not separately billable.

**5.08 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)**

The Department, under Bright Futures Health Assessment Visits under Chapter II, Section 94.06-1, will allow for one additional health assessment visit per member within a year following an initial assessment via Telehealth for each age shown on the MaineCare Bright Futures periodic health assessment schedule (MBM, Ch. II, Section 96, Appendix 1).\*

\***The Department shall seek and anticipates receiving approval of these changes from CMS retroactive to March 18, 2020. Pending approval, these changes are effective upon adoption.**

**5.09 HOSPITAL SERVICES**

The Department will allocate a special supplemental pool for COVID-19 among the Acute Care Non-Critical Access hospitals and Critical Access hospitals operating in the State of Maine. Effective April 16, 2020, the total pool shall equal ten million dollars ($10,000,000). It will be allocated proportional to the 2016 MMIS base data distribution of MaineCare payment for inpatient and outpatient services to Acute Care Non-Critical Access hospitals and Critical Access hospitals, not to exceed the total supplemental pool amount and not to exceed allowable aggregate upper payment limits. This emergency supplemental payment will not be subject to cost settlement by the Department.

* 1. **PRIVATE NON-MEDICAL INSTITUTION SERVICES**

A. Reimbursement for Section 97 Private Non-Medical Institution Appendix B Substance Abuse Treatment Facilities is increased uniformly by 23.9% effective 3/1/2020 to 5/31/2020.\*The increased reimbursement under this section may not duplicate any other reimbursement a provider receives for COVID-related costs under current or future state or federal funding opportunities.

1. The Department may cease paying the rate increase to any provider it determines has received such duplicate funding, per Sec. 5.10(B), after providing advance notice of that decision to the provider. This increased funding is also subject to audit by the Department.

**5.11 UNINSURED INDIVIDUALS**

Effective retroactive to March 18, 2020, individuals who are uninsured, as defined in Section 6004(a)(3) of the federal *Families First Coronavirus Response Act* (Public Law 116-127) and Section 1902(ss) of the *Social Security Act*, shall receive coverage for testing and diagnosis of COVID-19. Detailed eligibility requirements are set forth in the MaineCare Eligibility Manual, 10-144 C.M.R. Ch. 332.

**5.12 COMMUNITY SUPPORT SERVICES**

1. **Determination of Eligibility.**

Under Chapter II, Section 17.02-4 (B), Members who require annual verification shall retain eligibility through previously-rendered diagnoses and clinical judgment.

1. **Community Integration Services Eligibility Verification.**

Retroactive to April 15, 2020, for Community Integration Services only, providers will verify that a member meets specific eligibility requirements under 17.02-3 within sixty (60) days of the start date of services. If eligibility verification is not submitted by close of business on day sixty (60), MaineCare will cease payment for services under this section on day sixty-one (61).

**5.13 PRIVATE DUTY NURSING AND PERSONAL CARE SERVICES**

Under MBM, Ch. II, Section 96.07-6(G)(2), the period of time for an individual without the required training to enroll in a certified training program for Personal Support Specialist (PSS) shall be extended from sixty (60) days to one-hundred twenty (120) days from date of hire. The period of time in which an individual must complete and pass the training requirements shall be extended from nine (9) months to twelve (12) months from date of hire.

**5.14 NURSING FACILITY SERVICES**

The federal Preadmission Screening and Resident Review (PASRR) requirements under the MBM, Ch. II, Section 67.05-1, Nursing Facility Services are waived for 30 days. All new admissions can be treated like exempted hospital discharges. After thirty (30) days, new admissions with mental illness or intellectual disability should receive a Resident Review as soon as resources become available.