# 10‑144 DEPARTMENT OF HUMAN SERVICES

 BUREAU OF MEDICAL SERVICES

CHAPTER 103: MAINE HEALTH PROGRAM

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CHAPTER I: DEFINITIONS

 Unless otherwise indicated, the following terms shall have the following meanings:

 1. "AFDC" means the Aid to Families With Dependent Children Program.

 2. "Benefits" means services as set forth in the Maine Health Program Rules, Chapter III, Benefits.

 3. "Bureau" means the Bureau of Medical Services.

 4. "Department" means the Department of Human Services.

 5. "Eligibility Specialist" means a Department of Human Services, Bureau of Income Maintenance worker responsible for determining eligibility.

 6. "Employer supported plan" means a group insurance plan in which the employer makes a contribution on behalf of employees and/or their dependents.

 7. "Federal poverty guidelines" means the federal poverty levels established as required by the United States Omnibus Budget Reconciliation Act of 1981, Public Law 97‑35, Sections 652 and 673 (2), as periodically updated.

 8. "Medicaid" means the program administered by the Department that provides medical assistance to eligible individuals as set forth in Title XIX.

 9. "Premium" means a fee which is required to be paid in order to receive "transition" benefits or the amount the Department contributes toward the recipient's employer‑supported health insurance plan, as the context indicates.

 10. "Primary Care Case Management" is a system wherein primary care providers enter into a written agreement with the Department to deliver or arrange for delivery of a specific set of health care services for a panel of participants.

 11. "Program. means Maine Health Program. This includes the "basic" Program for recipients whose income is at or below 100% of the federal poverty guidelines and the “transition” Program for recipients whose income is more than 100% but less than or equal to 150% of the federal poverty guidelines.

 12. "Recipient" means an individual enrolled in the Program.

 13. "SSI" means Supplemental Security Income.

CHAPTER II: PROGRAM PARTICIPATION

 2.1: Applicants

 The Maine Health Program is closed to new applicants.

 Maine Health Program and certain Medicaid recipients whose eligibility is under review are not considered new applicants. This includes the following:

 ‑ A Maine Health Program recipient who then participates in Medicaid for a period of time and who is determined again eligible for the Program. Eligibility from the Maine Health Program to Medicaid and back to the Maine Health Program must be continuous with no break in coverage;

 ‑ A Maine Health Program recipient in the “basic” Program who is determined eligible for the “transition” Program;

 ‑ Maine Health Program recipient in the “transition" Program who is determined eligible for the “basic” Program; or

 ‑ Maine Health Program recipient terminated from the transition, Program due to failure to pay a premium who is subsequently reinstated.

 2.2 Recipients

 1. Eligibility Period

 Eligibility periods are generally six months.

 It is the responsibility of the recipient to report changes in circumstances which affect eligibility, such as, but not limited to, income, assets, and/or household income, to the Department.

 Such changes are to be reported within 10 days from occurrence. For income purposes “occurrence” will be considered the date the increased income was received. For all other purposes, “occurrence” will be considered the date the change took place.

 All changes reported by the recipient during the six month eligibility period must be reviewed by the Eligibility Specialist to determine the effect of the change on the recipient's eligibility. Within thirty (30) calendar days of receipt of the information, the Department will determine if the recipient remains eligible for the Program.

 If the new information results in Program termination, the Eligibility Specialist must determine the individual's eligibility, if any, for any other medical assistance program.

 2. Eligibility Recall

 The Eligibility Specialist may want to look at specific eligibility factors rather than review the individual' entire situation. In such instances, the Eligibility Specialist may recall the case at any time. The Eligibility Specialist must recall the case when:

 ‑ There is reason to believe the individual's circumstances will change.

 ‑ The countable assets of the household are within $200 of the appropriate standard. If this occurs, the assets must be reviewed every three months.

 ‑ The countable assets of the household are within $100 of the appropriate standard. If this occurs, the assets must be reviewed monthly.

 3. Eligibility Reviews

 Eligibility will be reviewed at least at the end of each eligibility period. Recipients must complete and submit review forms. If the review form is not received in a Department Regional Office by the end of the month in which the last day of the advance notice period falls it is considered a new application if and when it is received unless there is good cause, in which case it will not be considered a new application.

 Good cause for missing the filing deadline may be established by the Eligibility Specialist. Reasons for good cause include but are not limited to:

 \* mail delay;

 \* illness or death in the family or of other significant people; or

 \* circumstances beyond the control of the recipient.

 4. Eligibility Criteria

 Income

 The 2000 section of the Maine Medicaid Eligibility Manual on treatment of AFDC related income, except for income limits, shall be used to determine countable income.

 Income of recipients in the “basic” Program must be at or below 100% of the federal poverty guidelines. Income of recipients in the “transition” Program must be greater than 100%, or less than or equal to 150% of the federal poverty guidelines See section 2.2‑7 for additional information regarding the “transition” program.

 Monthly Income Limits

 Family 100% of 150% of

 Size Poverty Level Poverty Level

 1 614 920

 2 820 1230

 3 1027 1540

 4 1234 1850

 5 1440 2160

 6 1647 2470

 7 1854 2780

 8 2060 3090

 Each Added

 Person 207 310

 Assets

 The 3000 section of the Maine Medicaid Eligibility Manual on treatment of assets for SSI related, except for the asset limits, shall be used to determine countable assets.

 The asset limits for both “basic” and “transition” Programs are as follows:

 \* Age 20‑64 = $2,000 for the first person $3,000 for two people $100 for each additional individual; or

 \* Age 65+ = $10,000 for each individual or individual living with a spouse.

 5. Conditions Of Participation

 Covered Individuals

 Individuals age twenty (20) and older whose countable income and assets are less than or equal to the Program limits may participate in the Maine Health Program.

 Cooperation With Medicaid

 As a condition of eligibility, recipients must cooperate with the Department to establish whether they qualify for Medicaid. Noncooperation will result in denial or termination of Program coverage.

 When a recipient's medical condition changes so that she may qualify for Medicaid, the recipient is required to cooperate in determining eligibility for Medicaid.

 Verification Of Eligibility Information

 Verification of information needed to determine eligibility must be requested initially from the recipient. If information is requested from other sources (with the exception of public records), the individual must be informed. If collateral contacts are necessary and the individual does not give consent, termination will occur.

 When a decision cannot be made due to inconclusive or conflicting information, the individual will be notified what questions remain and what needs to be resolved. If the Department cannot determine that eligibility exists after contacting the individual or collateral contacts, assistance will be terminated. Termination will be carried out in conformance with the rights of individuals, including an advance notice of adverse action and the right to request a Fair Hearing.

 It is the responsibility of the Department to assist the individual in establishing eligibility for medical assistance. It is the responsibility of the individual to satisfy all eligibility requirements. The individual or the individual's representative is responsible for supplying verification of information to all persons in the household whose circumstances affect eligibility. If this information is not provided, eligibility does not exist.

 Residence

 Recipients must be a resident of Maine.

 Eligibility cannot be terminated because:

 ‑ an individual has not resided in the State for a specified period of time;

 ‑ the individual did not establish residence before entering a medical institution; or

 ‑ an individual is temporarily or involuntarily absent from the State, provided the individual intends to return once the purpose for the absence has been accomplished, unless another state has determined the individual has no intent to return to retain residency in Maine.

 Social Security Numbers

 As a condition of eligibility, an individual is required to:

 ‑ furnish the Department with a Social Security number. If the individual has a Social Security number but is unable to provide it, the Department will contact the Social Security Administration in order to obtain the number. Program coverage will not be withheld or terminated while verification of the individual's Social Security number is being obtained from the Social Security Administration; or

 ‑ apply to the Social Security Administration for a Social Security number if the individual does not have a Social Security number. The recipient must provide the Department with verification that the application for a Social Security number has been made. Program coverage will not be withheld or terminated for lack of a Social Security number as long as the individual provides verification of application for a Social Security number for those requesting assistance.

 No individual can receive Program benefits until the requirements in (1) or (2) above have been met. The Eligibility Specialist should explain that the application for a Social Security number requires the individual to provide a valid birth certificate or other proof of age and verification of identity. The Department must assist the individual in obtaining verification information necessary to apply for a Social Security number. This includes obtaining documents to prove date of birth, citizenship or identity. The Department cannot pay any costs incurred by the individual in obtaining this information.

 Individuals must be informed that their Social Security number will be utilized in the administration of the Program and will be used for verification of information such as wages, unemployment benefits and bank accounts.

 Citizenship

 An individual must be a citizen of the United States or a lawfully admitted alien. An individual who is not a citizen of the United States must be an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under the color of law (including any alien who is lawfully present in the United States as the result of the application of the provisions of Section 203 (a) (7), (207) (c), 208 and 212 (d) (s) of the Immigration and Nationality Act). An individual who has resided in the United States continuously from any date before January 1, 1972, is considered a legally admitted alien.

 Each individual who is not a citizen must provide either (1) documents from the Immigration and Naturalization Service or (2) other documents which prove the person is a lawfully admitted alien. Alien status is subject to verification by the Immigration and Naturalization Services.

 As a condition of eligibility, recipients must declare their citizenship or alien status, in writing on Department forms.

 6. Determining Eligibility

 Determine Household Size And Financial Responsibility

 The financial responsibility of relatives is limited to spouse for spouse (living together) and parents for minor children living with them. All members who reside in the household and among whom a legal responsibility for support exists will be included in the household when determining eligibility.

 Examples: Mr. Jones, age 35 Mrs. Jones, age 33 Daughter Jones' age 14 Son Jones, age 10

 Household size is a family of four (4) in determining the eligibility for the adults. For adults, countable income is compared to 100% of federal poverty level for a size of four (4).

 Since financial responsibility does not exist from children to parents, those children with income which affects eligibility may be removed from the household unit. Such children are considered to be self‑sufficient and no allocation of the parent's income may be made.

 Countable Income And Assets

 The individual's countable income and assets shall be compared to the income and asset limits.

 7. “Transition” Program

 Only recipients who have participated in the "basic" Program are eligible to participate in the “transition” Program. Recipients whose household income exceeds the basic Program's income eligibility standards by no more than 50% may participate in the “transition” Program provided the recipients pay a premium to the Department. See Chapter V, Premiums.

 “Transition” coverage is available for up to twelve (12) months.

 The “transition” period begins the first month the change from the Basic" Program can be effective with twelve (12) day notice when a change in circumstance(s) is reported timely. Recipients must agree to participate in the "transition" Program in the first month in which they are eligible for coverage or lose the opportunity to participate in the “transition” Program. Recipients who become ineligible for the “transition”, Program for reasons other than non‑payment of fees (e.g. move out of State or income increases more than 50%) are not eligible for reinstatement in the "transition" Program.

 "Transition" recipients whose household income decreases are eligible for "basic" Program coverage again. If, subsequently, they become eligible for the “transition” Program because of an increase in household income, they are eligible to receive "transition" coverage again.

CHAPTER III: BENEFITS

 3.1 Covered Services

 The following services are covered when medically necessary. Services are subject to the conditions and limitations described in the appropriate sections of Chapters II and V of the Maine Medical Assistance Manual (MMAM) as well as these rules, except that no copayment will be charged to Maine Health Program participants.

 1. Ambulatory Care Clinic Services (MMAM, Chapter II, Section 3)

 2. Ambulatory Surgical Center Services (MMAM, Chapter II, Section 4)

 3. Ambulance Services (MMAM, Chapter II, Section 5)

 4. Audiology Services (MMAM, Chapter II, Section 10)

 5. Certified Family and Pediatric Nurse Practitioner Services (MMAM, Chapter II, Section 14)

 6. Chiropractic Services (MMAM, Chapter II, Section 15)

 7. Clozaril Monitoring Services (MMAM, Chapter II, Section 16)

 8. Community Support Services (MMAM, Chapter II, Section 17)

 9. Day Habitation Services For Persons With Mental Retardation (MMAM, Chapter II, Section 24)

 10. Dental Services (MMAM, Chapter II, Section 25)

 11. Preventive Health Program Agency Services (MMAM, Chapter V, Section 1)

 12. Family Planning Agency Services (MMAM, Chapter II, Section 303

 13. Federally Qualified Health Center Services (MMAM, Chapter II, Section 31)

 14. Hearing Aids and Services (MMAM, Chapter II, Section 35)

 15. Home Based Mental Health Services (MMAM, Chapter II, Section 37)

 16. Home Health Services (MMAM, Chapter II, Section 40)

 17. Hospital Services MMAM, Chapter II, Section 45)

 18. Psychiatric Facility Services (MMAM, Chapter II, Section 46)

 19. Laboratory Services (MMAM, Chapter II, Section 55)

 20. Licensed Clinical Social Worker Services (MMAM, Chapter II, Section 5B)

 21. Medical Supplies and Durable Medical Equipment (MMAM, Chapter II, Section 60)

 22. Mental Health Clinic Services (MMAM, Chapter II, Section 65)

 23. Occupational Therapy Services (MMAM, Chapter II, Section 63)

 24. Optician Services (MMAM, Chapter II, Section 70)

 25. Optometry Services (MMAM, Chapter II, Section 75)

 26. Pharmacy Services (MMAM, Chapter II, Section 80)

 27. Physical Therapy Services (MMAM, Chapter II/ Section 85)

 28. Physician Services (MMAM Chapter II, Section 90)

 29. Podiatry Services (MMAM, Chapter II, Section 95)

 30. Private Non‑Medical Institution Services (MMAM, Chapter II, section 97)

 31. Psychological Services (MMAM, Chapter II, Section 100)

 32. Medical Imaging Services (MMAM, Chapter II, Section 101)

 33. Rehabilitative Services (MMAM, Chapter II, Section 102)

 34. Rural Health Clinic Services (MMAM, Chapter II, Section 103)

 35. Speech and Hearing Agencies (MMAM, Chapter II, Section 105)

 36. Speech Pathology Services (MMAM, Chapter II, Section 110)

 37. Substance Abuse Treatment Services (MMAM, Chapter II, Section 111)

 38. Transportation Services (MMAM, Chapter II, Section 113)

 39. Nurse‑Midwife Services (MMAM, Chapter II, Section 120)

 40. STD Screening Clinic Services (MMAM, Chapter II, Section 150)

 41. Other services as added to Chapter II of the Maine Medical Assistance Manual unless specifically excluded by these rules.

 3.2: Limitations On Substance Abuse And Inpatient Psychiatric Services

 1. Inpatient Psychiatric

 Payment is limited to three (3) days per episode with up to twenty‑one (21) additional days per episode.

 2. Substance Abuse

 Detoxification services ‑ payment is limited to three (3) days per episode with a maximum of three (3) episodes per year and up to two (2) additional days per episode.

 Rehabilitation services ‑ payment is limited to three (3) days for a maximum of one episode per year and additional days, up to a maximum total of seventeen (17) days which includes any detoxification days immediately before the rehabilitation days.

 A year is defined as twelve (123 months beginning with the date the recipient receives the first service. Hospital utilization review (UR) committees will be responsible for determining medical necessity for additional days beyond the three (3) day limit.

 3.3 Medicare Part A and B

 The Medicare Part A and B deductible and co‑insurance and the Part B premium are covered services.

 3.4 Non‑Covered Services

 The following services are not covered by the Program.

 1. Long Term Care Services

 ICF‑MR Services (MMAM, Chapter II Section 50)

 Home and Community Based Waiver Services for the Elderly, (MMAM, Chapter II, Section 19)

 Home and Community Based Waiver Services for

 Persons with Mental Retardation (MMAM, Chapter II, Section 21)

 Home and Community Based Waiver Services for the Physically Disabled (MMAM, Chapter II, Section 22)

 Home and Community Based Waiver Services for Adults With Disabilities (MMAM, Chapter II, Section 18)

 Private Duty Nursing and Personal Care Services (MMAM, Chapter II, Section 67)

 Nursing Facility Services (MMAM, Chapter II, Section 67)

 2. Targeted Case Management Services (MMAM, Chapter II Section 13)

 3. Pregnancy Related Services

 Pregnancy related services means the benefits provided to pregnant women under the Medicaid Program.

 4. Broken Appointments

 5. Day Health Services (MMAM, Chapter II, Section 26)

 6. Developmental and Behavioral Evaluation Clinic Services (MMAM, Chapter II, Section 23)

 7. Early Intervention Services (MMAM, Chapter II, Section 27)

Chapter IV: EMPLOYER SUPPORTED GENERAL PLANS

 4. 1 General

 As a condition of eligibility, Program recipients must participate in available employer supported health plans if the Department determines that it is cost effective for it to pay the cost of the plans on behalf of the recipients. If the Department determines that it is not cost effective to contribute toward the cost of the plans, the Department shall not be obligated to contribute toward the cost of the plans.

 Enrollment in the plan is a condition of Program eligibility except for an individual who is unable to enroll on his/her own behalf. For example, if a spouse is unable to enroll freely on his/her own behalf, the failure to enroll does not affect the spouse's eligibility for Program benefits.

 A recipient who is participating in an employer supported plan must remain enrolled in the plan until the Department completes its cost effectiveness determination. The Department will begin paying premiums as soon as arrangements can be made to do so. The Department will pay the recipient's premium until it completes its cost effectiveness determination at which time it will notify the recipient, in writing, of its determination to continue or discontinue payment.

 A recipient who is not participating in an available employer supported plan will be required to enroll if the Department determines it is cost effective to contribute toward the cost of the plan of behalf of the recipient. Recipients must provide the Department with proof of enrollment no later than thirty (30) days from the date of the cost effectiveness determination. Recipients who are unable to enroll in an employer supported plan must notify the Department no later than thirty (30) days from the date of behalf effectiveness determination notice as to their reason for not enrolling. Recipients will have the opportunity to claim good cause (e.g. enrollment period not open) for not enrolling. Good cause will be established by the Bureau of Medical Services' Third Party Liability Unit.

 The recipient is responsible for reporting any changes in employer supported health plan benefits or premiums to the Department as soon as they are known.

 4.2 Cost Effectiveness Determination

 As a condition of eligibility, recipients must cooperate with the Department in providing the information necessary for the Department to determine cost effectiveness.

 The Department's criteria for determining cost effectiveness include, but are not limited to, the following:

 ‑ administrative feasibility,

 ‑ comparison of benefits,

 ‑ review of deductible and co‑pay requirements, and

 ‑ amount of employer contribution.

 The Department may pay either the insurer or the employer on behalf of the Program recipient. The Department will make payments on a monthly basis. Payments will be made prospectively only.

 In the event the Department is unable to pay the insurer or employer, the Department may reimburse the recipient. Recipients may be required to submit documentation that they paid the premium, e.g., pay stubs, to the Department monthly. Payment will be made retroactively except, if good cause exists, the Department shall provide a one time advance payment at the time a recipient is required to enroll in an employer plan. Good cause will be established by the Bureau of Medical Services Third Party Liability Unit.

 The Department will discontinue paying premiums when a recipient is no longer eligible to participate in the Program except the Department may continue premium payments for a one month grace period once the recipient ceases to be eligible for the Program.

 4.3 Review

 The Department shall review the cost effectiveness of continuing to pay premiums for recipients when eligibility is redetermined and will notify recipients in writing of its decision to continue or discontinue paying premiums prior to the beginning of the new eligibility period.

 The Department will also evaluate continuing payment of premiums during the eligibility period if additional information becomes more available that indicates the recipient's circumstances or employer supported health plan has changed. The Department will notify recipients, in writing, of its decision to discontinue paying premiums.

 4.4 Wraparound

 Recipients enrolled in available employer supported health plans that do not provide all of the Program benefits or the same level of Program benefits shall be provided with a medical card that entitles them to receive Program benefits that are not covered by their employer supported plan.

 4.5 Consolidated Omnibus Budget Reconciliation Act of 1985 {COBRA)

 COBRA provides that certain qualified beneficiaries who would otherwise lose their group health coverage due to termination of employment or long term disability may elect to continue coverage under the same group plan for up to 36 months. COBRA allows the employee to buy the same coverage by paying monthly premiums equal to 102% of the original group insurance premium. The two percent is allowed for administrative expenses. COBRA applies to all private companies and state and local governments with at least 20 employees.

 If a recipient for whom the Department is paying a premium terminated his/her employment and COBRA coverage is available, the Department will determine if it is cost effective to contribute to the COBRA premium.

CHAPTER V: PREMIUMS

 5.1 Overview

 Recipients in the "transition" Program are required to pay a premium as a condition of eligibility.

 When two (2) members of a household are required to pay a premium, the household may opt to not pay a premium for one of those individuals. Coverage will be closed or denied for that individual electing not to pay a premium.

 The Department will provide 12 day advance written notification to recipients informing them of the monthly premium amount. Recipients must sign, date and return the notice form by the end of the month in which the 12 day notice period ends, agreeing to pay the premium to the Department. If the signed and dated form is not returned, coverage will be denied or closed.

 Example: A recipient in the basic. Program is determined eligible for the “transition” Program on August 5th effective for September. The individual is provided with the 12 day written notice that s/he is required to pay a premium effective for the month of September.

 The signed and dated notice must be returned to the Department by August 30th. The September payment is due September 1st.

 5.2 Changes In Circumstances That Affect Payment Of Premiums

 Recipients are required to report changes in circumstances that may affect payment of a premium. If changes in circumstances that would have resulted in payment of a premium are not reported timely, past due premiums must be paid in order for coverage to continue or be reinstated.

 Example: The income of a recipient increases from <100% of the poverty guidelines to 135% of the guideline. The increase is received on August 25th but the information is not reported to the Department. The Department learns of the increase in income and notifies the individual of fee requirements with a 12 day notice ending October 18th. The recipient is eligible for "transition” Program coverage in November only if s/he pays a premium for October that would have been required if the change hand been reported timely. Since the change was not reported timely, the first month in which the premium is due is determined by allowing for the 12 day notice from the date the change occurred (increased income was received).

 5.3 Payment

 Payment is due on the first day of each month for which coverage is being granted. A grace period to the end of the month is allowed for late payment. If payment is not received on or before the premium due date, the recipient will be notified that i$ the premium is not received by the end of the grace period, eligibility will end the last day of the month unless good cause is established. Good cause can be established by the Eligibility Specialist.

 Example: A recipient is determined eligible for the “transition” Program for the month of June. The June premium payment is due June 1st. The grace period ends June 30th. If payment is not received by June 30th, the recipient is terminated for nonpayment of the premium effective June 30th.

 The premium must be paid by check or money order payable to the Treasurer, State of Maine and sent or delivered to the Medical Assistance Unit at the Department's Regional Office which covers the area in which the recipient lives. Cash will not be accepted.

 5.4 Reinstatement After Non‑Payment

 When a recipient has been terminated due to failure to pay a premium, s/he will not be eligible for reinstatement for one month from the termination date. Reinstatement(6) is possible for any remaining months of eligibility. The recipient must apply and must pay any premiums due for past coverage and the first reinstatement month premium prior to being reinstated. Coverage is not provided for bills incurred during periods of non‑enrollment.

 Example: A recipient receives coverage for June but fails to pay the June premium prior to June 30th and is terminated from the Program effective June 30th. In October, the recipient wants to be reinstated. Since the individual received coverage for June the premium for June is required before current coverage can be granted. Also the individual must pay the October premium prior to reinstatement. Upon payment of the June, and October premiums, the individual is enrolled for October. Coverage for medical bills incurred in July, August and September is not provided.

 5.5 Premium Schedule

 The premium schedule is based on the federal poverty guidelines and will be revised annually to reflect adjustments in the federal poverty guidelines. Premium contributions are based on the countable income amount calculated to determine eligibility and the number of household members to be enrolled.

 MONTHLY PREMIUM CONTRIBUTION PER RECIPIENT

 Family

 Size 101‑125% 126‑150%

 First Individual $10.30 $16.80

 Each Added

 individual $ 3.45 $ 5.65

CHAPTER VI: GENERAL ADMINISTRATIVE POLICIES

 6.1 Maine Medical Assistance Manual

 The following Maine Medical Assistance Manual (MMAM) provisions apply to Maine Health Program recipients.

 1. Provider Participation (MMAM Chapter I, Section 1.03)

 2. Recipient Eligibility (MMAM Chapter I, Section 1.04, except 1.04‑1)

 3. Supplementation By Recipients (MMAM Chapter I, Section 1.05)

 4 Services Covered And Non‑covered (MMAM Chapter I, Section 1.06, except 1.06‑2‑C)

 5. Third Party Liability (MMAM Chapter I, Section 1.07, except 1.07‑23

 6. Submittal of Claims (MMAM Chapter I, Section 1.08)

 7. Payment Process (MMAM Chapter I, Section 1.09)

 8. Claims Adjustments (MMAM Chapter I, Section 1.10)

 9. Inquiry Process (MMAM Chapter I, Section 1.11)

 10. Audits (MMAM Chapter I, Section 1.123

 11. Utilization Review (MMAM Chapter I, Section 1.133

 12. Surveillance (MMAM Chapter I, Section 1.14)

 13. Prior Authorization (MMAM Chapter I, Section 1.15)

 14. Provision of Necessary Transportation to Medical Services (MMAM Chapter I, Section 1.16)

 15. Sanctions Against Providers (MMAM Chapter I Section 1.17)

 16. Provider Fraud/Abuse (MMAM Chapter I, Section 1.18, except 1.18‑2)

 17. Provider Appeals (MMAM Chapter I, Section 1.19)

 18. Recipient Appeals (MMAM Chapter I, Section 1.20)

 19. Enrollee Restriction Program (MMAM Chapter IV, Section 1)

 20 Primary Care Case Management (MMAM Chapter VI Section 1)

 6.2 Maine Medicaid Eligibility Manual

 The following Maine Medicaid Eligibility Manual provisions apply to Maine Health Program recipients.

 1. Referrals to Child and Adult Protective Units (Maine Medicaid Eligibility Manual, Section 1131)

 2. Referrals to the Fraud Investigation Unit (Maine Medicaid Eligibility Manual, Section 1132)

 3. Confidentiality (Maine Medicaid Eligibility Manual, Section 1140)

 4. Record Retention (Maine Medicaid Eligibility Manual, Section 1150)

 5. Replacement of Medical Identification Cards (Maine Medicaid Eligibility Manual, Section 1170)

 6. Fair Hearings (Maine Medicaid Eligibility Manual, Sections 1180 and 1181)

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