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1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Maine enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of “special needs” beneficiaries (see D.2.iii. - vii. below).

The State also provides an enhanced PCCM benefit called Patient Centered Medical Home Services. This service is available to members who are treated in a practice providing a Patient Centered Home (PCMH) model. Those members receive additional integration of services from a treatment team demonstrating leadership and specially trained in the Patient Centered Home Model of care. Core principles of PCMH treatment include treatment by providers who demonstrate leadership in PCMH delivery of care, a team based approach to care, practice integrated care management, enhanced access to care, behavioral-physical health integration, inclusion of patients and families in treatment, a connection to the community, integration of health information technology, and a commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of health care services.

PCCM providers, following all requirements described in this State plan, may enroll as Patient Centered Medical Home providers if they meet additional provider qualifications to deliver PCMH services to their enrolled PCCM patients (also enrolled as described in this State plan). PCMH is an enhanced PCCM service requiring providers to participate in additional on-going activities including collection of benchmark, clinical and evaluation data. PCMH providers receive a monthly management fee per member per month.

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Members will have all of the enrollment and disenrollment criteria as described in this State plan and will receive the benefit of integrated services, and on-going education and evaluation activities designed to address health care needs of the member.

**B. General Description of the Program and Public Process.**

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)  
1932(a)(1)(B)(ii)  
42 CFR 438.50(b)(1)

1. The State will contract with an
- i. MCO
  - ii. PCCM (including capitated PCCMs that qualify as PAHPs)
  - iii. Both

42 CFR 438.50(b)(2)  
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:
- i. fee for service;
  - ii. capitation;
  - iii. a case management fee;
  - iv. a bonus/incentive payment;
  - v. a supplemental payment, or
  - vi. other. (Please provide a description below).

PCMH providers receive an extra monthly management fee per member per month in addition to the monthly management fee they receive for PCCM services. All payments including the PCMH management fee is described in the provider agreement and must be reviewed and approved by CMS.

1905(t)  
42 CFR 440.168  
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met **all** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

- i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

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	<p><input checked="" type="checkbox"/>_x_ii. Incentives will be based upon specific activities and targets.</p> <p><input checked="" type="checkbox"/>_x_iii. Incentives will be based upon a fixed period of time.</p> <p><input checked="" type="checkbox"/>_x_iv. Incentives will not be renewed automatically.</p> <p><input checked="" type="checkbox"/>_x_v. Incentives will be made available to both public and private PCCMs.</p> <p><input checked="" type="checkbox"/>_x_vi. Incentives will not be conditioned on intergovernmental transfer agreements.</p> <p><input type="checkbox"/>_vii. Not applicable to this 1932 state plan amendment.</p>
CFR 438.50(b)(4)	<p>4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (<i>Example: public meeting, advisory groups.</i>)</p> <p>Public input has been elicited on an ongoing basis from point of design to current implementation. Primary care case management operational guidelines are set forth, and open for public comment, through rule-making under the Administrative Procedure Act. Current operational guidelines can be found in Chapter VI, Section 1 of the MaineCare Benefits Manual, published on the Secretary of State's web site under the heading of the Department of Health and Human Services.</p> <p>In addition, input is elicited on an ongoing process through two venues: the Outreach and Education Task Force and the Physician Advisory Committee.</p> <p>The Outreach and Education Task Force meets every other month and is comprised of representatives of the Office of MaineCare Services, MaineCare Member Services and consumer advocacy organizations within the State. The focus of the Task Force is to share and exchange information regarding primary care case management operational issues, to address areas of concern and to be kept apprised of outreach activities being conducted by advocacy organizations within the State related to primary care case management.</p>

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The Physician Advisory Committee meets quarterly and is comprised of a representative group of Maine licensed physicians who are enrolled as MaineCare providers. In addition to being representative of the practice groups participating in primary care case management, two of the participants also represent two of the major medical associations within the State: the Maine Medical Association and the Maine Osteopathic Association. The purpose of the Committee is to discuss/address clinical issues and policies and to elicit feedback from physicians participating in primary care case management.

- 1932(a)(1)(A) 5. The state plan program will  /will not \_\_\_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory \_\_\_ / voluntary \_\_\_ enrollment will be implemented in the following county/area(s):
- i. county/counties (mandatory) \_\_\_\_\_
  - ii. county/counties (voluntary) \_\_\_\_\_
  - iii. area/areas (mandatory) \_\_\_\_\_
  - iv. area/areas (voluntary) \_\_\_\_\_

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

- 1932(a)(1)(A)(i)(I)  
1903(m)  
42 CFR 438.50(c)(1) 1. \_\_\_ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
- 1932(a)(1)(A)(i)(I)  
1905(t)  
42 CFR 438.50(c)(2)  
1902(a)(23)(A) 2.  The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
- 1932(a)(1)(A) 3.  The state assures that all the applicable requirements of section 1932

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42 CFR 438.50(c)(3)	(including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. <input checked="" type="checkbox"/> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. <input checked="" type="checkbox"/> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. <input type="checkbox"/> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)	7. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.
45 CFR 74.40	8. <input checked="" type="checkbox"/> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. <u>Eligible groups</u>
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis.  A MaineCare member must participate in primary care case management if he/she is in one of the following categories:  a. Receiving Temporary Assistance for Needy Families (TANF) - Adults and Children;  b. Children under the age of twenty-one (21); parents of children under age eighteen (18) who receive MaineCare; pregnant women; and those members eligible for transitional MaineCare;  c. Women who have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Title XV Program and are found to need treatment for breast or cervical cancer,

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	including pre-cancerous conditions, as defined in Section 2150.03 of the MaineCare Eligibility Manual;
	d. Members eligible for SSI who do not meet exclusion criteria listed in B, below.
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.
	Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. <input type="checkbox"/> Recipients who are also eligible for Medicare.  If enrollment is voluntary, describe the circumstances of enrollment. <i>(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)</i>
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. <input checked="" type="checkbox"/> Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.  *Native Americans, while not automatically exempted from participation, may choose to participate on a voluntary basis. Indian Health Service facilities can serve as PCPs under the program and no claims are denied for Native Americans who access MaineCare services without approval of a PCP.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. <input checked="" type="checkbox"/> Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. <input checked="" type="checkbox"/> Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. <input checked="" type="checkbox"/> Children under the age of 19 years who are in foster care or other out-of-the-home placement.

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Citation	Condition or Requirement
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. <input checked="" type="checkbox"/> Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. <input type="checkbox"/> Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

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E. Identification of Mandatory Exempt Groups

- 1932(a)(2)  
42 CFR 438.50(d)
1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (*Examples: children receiving services at a specific clinic or enrolled in a particular program.*)
- 1932(a)(2)  
42 CFR 438.50(d)
2. Place a check mark to affirm if the state's definition of title V children is determined by:
- i. program participation,
  - ii. special health care needs, or
  - iii. both
- 1932(a)(2)  
42 CFR 438.50(d)
3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.
- i. yes
  - ii. no
- 1932(a)(2)  
42 CFR 438.50 (d)
4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (*Examples: eligibility database, self-identification*)
- 1. Children under 19 years of age who are eligible for SSI under title XVI;  
By aid category
  - ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;  
By aid category
  - iii. Children under 19 years of age who are in foster care or other out-

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1932(a)(2) 42 CFR 438.50(d)	of-home placement;  By aid category  iv. Children under 19 years of age who are receiving foster care or adoption assistance.  By aid category  5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. <i>(Example: self-identification)</i>  See Exemption information on page 16.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: <i>(Examples: usage of aid codes in the eligibility system, self-identification)</i>  1. Recipients who are also eligible for Medicare.  The State receives enrollment information from Medicare.  11. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.  Please see D(2)ii.
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u>  1. Individuals with other forms of comprehensive health insurance;  2. Individuals with an eligibility period of less than three (3) months, or one that is only retroactive;

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42 CFR 438.50	3. Individuals residing in a nursing facility or intermediate care facility for the mentally retarded (ICF-MR); and  4. Members receiving Home and Community Benefits.
1932(a)(4) 42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u>  H. <u>Enrollment process.</u>  1. Definitions  i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.  ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default.  When a member is unable or unwilling to select a MaineCare primary care case management PCP within twenty-eight (28) calendar days of the date in which the enrollment packet was mailed, the member will be assigned to a PCP who has an opening on his/her panel. Members will be assigned to a PCP based on age and gender appropriateness and in accordance with the travel time standard. To the extent possible, members will be assigned in consideration of the following: (a) individuals (including individuals within family units) will be assigned to their existing participating PCPs; (b) family units will be assigned to the same participating PCP or to a PCP the enrolled member has selected, if that PCP is appropriate based on age and gender parameters.  Describe how the state's default enrollment process will preserve:  1. the existing provider-recipient relationship (as defined in H.1.i).

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1932(a)(4) 42 CFR 438.50	<p data-bbox="690 485 1451 579">As noted above, any member unable or unwilling to select a PCP is assigned, to the extent possible, to their existing (participating) PCP.</p> <p data-bbox="597 625 1333 684">ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).</p> <p data-bbox="690 722 1451 819">All PCPs participating in PCCM are also MaineCare providers providing services to MaineCare members who receive benefits under the fee-for-service system.</p> <p data-bbox="597 856 1451 1037">iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). <i>(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</i></p> <p data-bbox="690 1075 1451 1171">Where maintaining existing provider-member relationship is not possible, members are enrolled in consideration of equitable distribution of members among qualified, available PCPs.</p> <p data-bbox="537 1199 1451 1743">3. As part of the state's discussion on the default enrollment process, include the following information:</p> <p data-bbox="597 1293 1451 1352">i. The state will ___/will not <input checked="" type="checkbox"/> use a lock-in for managed care managed care.</p> <p data-bbox="597 1390 1451 1449">ii. The time frame for recipients to choose a health plan before being auto-assigned will be <u>28</u> calendar days _____.</p> <p data-bbox="690 1486 1451 1743">Prior to the end of the twenty-eight (28) calendar days, the member must complete and return the provider choice form by mail or call MaineCare Member Services to enroll by phone. The member must also, as a part of the enrollment process, provide the names of three providers (in order of preference) as choices for a PCP. In the event a member does not elect a provider, a Primary Care Case Management PCP is selected for the member, as described above.</p>

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	<p>iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. <i>(Example: state generated correspondence.)</i></p> <p>The member is notified of the auto-assignment by mail.</p>
	<p>iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. <i>(Examples: state generated correspondence, HMO enrollment packets etc.)</i></p> <p>MaineCare Member Services is responsible for notifying all individuals at the time of enrollment of their right to disenroll within 90 calendar days of a PCP selection without cause.</p>
	<p>v. Describe the default assignment algorithm used for auto-assignment. <i>(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)</i></p> <p>Please see above.</p>
	<p>vi. Describe how the state will monitor any changes in the rate of default assignment. <i>(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)</i></p> <p>The State tracks the number of PCP transfers each month due to auto assignment.</p>

1932(a)(4)  
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1.  The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.
2.  The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

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3.  The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

This provision is not applicable to this 1932 State Plan Amendment.

4.  The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

This provision is not applicable to this 1932 State Plan Amendment.

5.  The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)  
42 CFR 438.50

J. Disenrollment

1. The state will /will not  use lock-in for managed care.
2. The lock-in will apply for  months (up to 12 months).
3. Place a check mark to affirm state compliance.

The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

MaineCare members enrolled in primary care case management may elect to disenroll with their PCP within 90 calendar days of a PCP selection without cause and at any time for good cause. Good cause is defined as a documented situation in which there is an inability, after reasonable effort, to establish or maintain a satisfactory member/PCP relationship.

4. Describe any additional circumstances of "cause" for disenrollment (if any).

The State may also disenroll a MaineCare member enrolled in primary care case management from a PCP panel for, but not limited to, the following reasons:

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	<p>a. contract with the PCP is terminated;</p> <p>b. a PCP dies, retires, closes his/her practice or leaves the area;</p> <p>c. member loses MaineCare eligibility;</p> <p>d. member moves to an area in which the primary care provider is no longer located within 30 minutes of the member;</p> <p>e. member's eligibility changes to a category of assistance that is excluded from participation;</p> <p>f. member's status changes such that he/she meets criteria for exclusion from participation;</p> <p>g. other situations as determined appropriate by the State.</p> <p>A PCP may request disenrollment of a member from his/her panel for the reasons noted below. The State must approve a PCP request for disenrollment of a member.</p> <p>a. the member is in the process of being formally discharged or was previously formally discharged;</p> <p>b. there is a pending lawsuit between the member and the PCP or there was a past lawsuit;</p> <p>c. there is good cause, as approved by the State. Good cause is defined as a documented situation in which there is an inability, after reasonable effort, to establish or maintain a satisfactory PCP/member relationship; or</p> <p>d. other situations as determined appropriate by the State.</p> <p>K. <u>Information requirements for beneficiaries</u></p> <p>Place a check mark to affirm state compliance.</p> <p><u>  x  </u> The state assures that its state plan program is in compliance with 42 CFR</p>

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Citation	Condition or Requirement
42 CFR 438.50 42 CFR 438.10	438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. <u>List all services that are excluded for each model (MCO &amp; PCCM)</u>  Most MaineCare covered services are included in this service as being coordinated by the PCCM or PCMH provider. Exclusions are detailed in provider contracts and in the MaineCare Benefits Manual
1932 (a)(1)(A)(ii)	M. <u>Selective contracting under a 1932 state plan option</u>  To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.  1. The state will ___/will not___ intentionally limit the number of entities it contracts under a 1932 state plan option.  2. ___ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.  3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (Example: a limited number of providers and/or enrollees.)  4. <u>  x  </u> The selective contracting provision in not applicable to this state plan.

Certain MaineCare members may request an exemption from participation in primary care case management on the basis of individual conditions. Conditions supporting an exemption are listed below. Those MaineCare members identified as exempt, but otherwise eligible for participation in primary care case management, may voluntarily choose to participate in primary care case management.

An individual is eligible to request an exemption if she/he:

a. Administrative Exemptions

1. has to travel more than thirty (30) minutes to a participating PCP (if not in an established relationship with a participating PCP);

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	<ol style="list-style-type: none"><li>2. is homeless;</li><li>3. is a migrant or a family member accompanying a migrant;</li><li>4. has specific language barriers or cultural needs which may not be addressed by an available PCP. Culturally appropriate care is care that is provided with sensitivity, understanding and respect for the member's culture. Each of these cases will be reviewed by the Office of MaineCare Services for cultural sensitivity/medical necessity for exemption;</li><li>5. is required to follow member restriction provisions;</li><li>6. is residing out of State;</li><li>7. does not have an updated address;</li><li>8. is residing in a jail or State or private mental institution;</li><li>9. is an inpatient of a hospital on the date of enrollment. These individuals will be enrolled automatically after hospital discharge; or</li><li>10. may qualify for a temporary exemption including:<ol style="list-style-type: none"><li>i. Non-English speaking members. Members who are identified by the Office of MaineCare Services (OMS) as using English as a second language will be granted a temporary exemption from participation in primary care case management. A temporary exemption will be granted in the event MaineCare Member Services is unsuccessful in contacting these individuals during the first twenty-eight (28) calendar days of eligibility. The exemption will be granted until such time as contact can be made with the individual to elicit a voluntary choice of PCPs. Duration of the exemption may not exceed sixty (60) calendar days.</li><li>ii. A member who has a PCP pending. Temporary exemption from participation in primary care case management will be granted to an individual whose provider is not currently enrolled in primary care case management, but the provider is eligible and has expressed a</li></ol></li></ol>

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willingness to enroll. Duration of the exemption may not exceed forty five (45) calendar days. Additionally, the exemption will expire and the individual will be required to select another PCP if, for any reason, the individual's provider does not enroll in primary care case management.

b. Clinical Exemptions

- i. has a terminal illness and has an established relationship with a qualified health care provider who is not a qualified MaineCare primary care case management PCP. Each of these cases will be reviewed by the MaineCare Medical Director for medical necessity for exemption;
- ii. has a chronic and debilitating condition which requires managed services from a qualified primary care health provider who is not a MaineCare primary care case management PCP. Each of these cases will be reviewed by the MaineCare Medical Director for medical necessity for exemption; or
- iii. is receiving hospice care.