§254-D. Elderly low-cost drug program

The Department of Health and Human Services may conduct the elderly low-cost drug program to provide low-cost prescription and nonprescription drugs, medication and medical supplies to disadvantaged, elderly and disabled individuals. [PL 2005, c. 401, Pt. A, §2 (NEW).]

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Beneficiary under Medicare Part D" means a person who is enrolled in Medicare Part D. [PL 2005, c. 401, Pt. A, §2 (NEW).]

B. "Enrollee" means a person who receives benefits under the program. [PL 2005, c. 401, Pt. A, §2 (NEW).]

C. "Household income" means family income as defined by the department for the purposes of this section. [PL 2005, c. 401, Pt. A, §2 (NEW).]

D. "MaineCare member" means a person who receives benefits under the MaineCare program under chapter 855. [PL 2005, c. 401, Pt. A, §2 (NEW).]

E. "Manufacturer" means a manufacturer of prescription drugs and includes a subsidiary or affiliate of the manufacturer or a person or entity that receives prescription drugs from a manufacturer or wholesaler and repackages those drugs for later retail sale and has a labeler code from the federal Food and Drug Administration under 21 Code of Federal Regulations, 207.20 (1999). [PL 2005, c. 401, Pt. A, §2 (NEW).]

F. "Medicare Part D" means the prescription drug benefit program provided under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173. [PL 2005, c. 401, Pt. A, §2 (NEW).]

G. "Program" means the elderly low-cost drug program authorized in this section. [PL 2005, c. 401, Pt. A, §2 (NEW).]

H. "Wholesale price" means the average price paid by a wholesaler to a manufacturer for a product distributed for retail sale. "Wholesale price" includes a deduction for any customary prompt payment discounts. [PL 2005, c. 401, Pt. A, §2 (NEW).]

[PL 2005, c. 401, Pt. A, §2 (NEW).]

2. Administration. The commissioner shall provide sufficient personnel to ensure efficient administration of the program. The commissioner shall determine the extent and the magnitude of the program on the basis of the calculated need of the recipient population and the available funds. The department may not spend more on this program than is available through appropriations from the General Fund, dedicated revenue, federal or other grants and other established and committed funding sources. The commissioner may accept, for the purposes of carrying out this program, federal funds appropriated under any federal law relating to the furnishing of free or low-cost drugs to disadvantaged, elderly or disabled individuals and may take such action as is necessary for the purposes of carrying out that federal law and may accept from any other agency of government, individual, group or corporation such funds as may be available to carry out this chapter. The department may establish priorities of coverage and cost-sharing with available funds. Funds appropriated from the General Fund to carry out the purposes of this section may not lapse but must carry from year to year.
[PL 2005, c. 401, Pt. A, §2 (NEW).]

3. Applications. The commissioner shall make available suitable applications for benefits under the program with instructions for applicants. Individuals who are eligible for benefits under both MaineCare and Medicare Part D may be deemed eligible for the program without the need for application.
[PL 2005, c. 401, Pt. A, §2 (NEW).]

4. Conduct of program. This subsection governs the conduct of the program, including the basic, supplemental and catastrophic components, by the department.

A. Prescription and nonprescription drugs, medications and medical supplies of manufacturers that enter into rebate agreements pursuant to paragraph H may be available under the program. The department may create and implement a preferred drug list. Drugs may be made available through the operation of the basic and supplemental components of the program as follows.

(1) The basic component of the program must provide drugs and medications for cardiac conditions and high blood pressure, diabetes, arthritis, anticoagulation, hyperlipidemia, osteoporosis, chronic obstructive pulmonary disease and asthma, incontinence, thyroid diseases, glaucoma, parkinson's disease, multiple sclerosis and amyotrophic lateral sclerosis. The basic component must also provide over-the-counter medications that are prescribed by a health care provider and approved as cost-effective by the department.

(2) The supplemental component of the program must provide all prescription drugs and medications of manufacturers that enter into rebate agreements pursuant to paragraph H other than those prescription drugs and medications provided under subparagraph (1). [PL 2005, c. 401, Pt. A, §2 (NEW).]

B. An individual is eligible for the program if that individual:

(1) Is a legal resident of the State;

(2) Meets the income eligibility criteria set forth in this section or is eligible for both MaineCare and Medicare Part D;

(3) Does not receive full MaineCare pharmaceutical benefits; and

(4) Is at least 62 years of age, or is 19 years of age or older and determined to be disabled by the standards of the federal social security program. A person who was eligible for the program at any time from August 1, 1998 to July 31, 1999 and who does not meet the requirements of this subparagraph at the time of application or renewal retains eligibility for the program if that person is a member of a household of an eligible person. [PL 2023, c. 412, Pt. EEEEE, §§1-3 (AMD).]

C. The department may require that an enrollee or applicant for the program who is otherwise eligible for Medicare Part D become a beneficiary under Medicare Part D unless the department determines that good cause exists for the person not to participate in Medicare Part D. [PL 2005, c. 401, Pt. A, §2 (NEW).]

D. Income eligibility of individuals must be determined by this paragraph and by reference to the federal poverty guidelines for the 48 contiguous states and the District of Columbia, as defined by the federal Office of Management and Budget and revised annually in accordance with the United States Omnibus Budget Reconciliation Act of 1981, Section 673, Subsection 2, Public Law 97-35, reauthorized by Public Law 105-285, Section 201 (1998). If the household income is not more than 185% of the federal poverty guideline applicable to the household, the individual is eligible for the basic program and the supplemental program. Individuals are also eligible for the basic and the supplemental program if the household spends at least 40% of its income on unreimbursed direct medical expenses for prescription drugs and medications and the household income is not more than 25% higher than the levels specified in this paragraph. For the purposes of this paragraph, the cost of drugs provided to a household under this section is considered a cost incurred by the household for eligibility determination purposes. [PL 2019, c. 343, Pt. ZZ, §1 (AMD).]

E. Specifications for the administration and management of the program may include, but are not limited to, program objectives, accounting and handling practices, supervisory authority and evaluation methodology. [PL 2005, c. 401, Pt. A, §2 (NEW).]

F. The method of prescribing or ordering the drugs under paragraph A may include, but is not limited to, the use of standard or larger prescription refill sizes so as to minimize operational costs and to maximize economy. Unless the prescribing physician indicates otherwise or the department determines that it would not be cost-effective, the use of generic or chemically equivalent drugs is required, as long as these drugs are of the same quality and have the same mode of delivery as is provided to the general public, consistent with good pharmaceutical practice. [PL 2005, c. 401, Pt. A, §2 (NEW).]

G. The commissioner may establish the amount of payment to be made by the program and by enrollees toward the cost of drugs and medications furnished under the program, including covered prescription and nonprescription drugs, medications and medical supplies, under the following terms.

(1) For the basic component of the program, the total cost to an enrollee for the purchase of any covered drug or medication may not exceed the sum of $2 plus 20% of the price allowed for that drug or medication under program rules.

(2) For the supplemental component of the program, the total cost to an enrollee for the purchase of any covered drug or medication may not exceed:

(a) For a brand name drug or medication, the cost to the program for that drug or medication minus the $2 paid by the program; and

(b) For a generic drug or medication, the sum of $2 plus 20% of the price allowed for that drug or medication under program rules.

(3) For the catastrophic component of the program, the commissioner shall establish annual limits on the costs incurred by enrollees for drugs and medications covered under the program on or prior to May 31, 2001. After the limit is reached, the program must pay 80% of the cost of each drug and medication covered by the supplemental component of the program on May 31, 2001 minus $2. Any remaining amount is paid by the enrollee. The limits must be set by the commissioner by rule as necessary to operate the program within the program budget. [PL 2005, c. 401, Pt. A, §2 (NEW).]

H. Payment must be denied for drugs from manufacturers that do not enter into a rebate agreement with the department.

(1) Each agreement must provide that the manufacturer make rebate payments for both the basic and supplemental components of the program to the department according to the following schedule.

(a) From October 1, 1992 to October 1, 1998, the rebate percentage is equal to the percentage recommended by the federal Center for Medicare and Medicaid Services of the manufacturer's wholesale price for the total number of dosage units of each form and strength of a prescription drug that the department reports as reimbursed to providers of prescription drugs, provided payments are not due until 30 days following the manufacturer's receipt of utilization data supplied by the department, including the number of dosage units reimbursed to providers of prescription drugs during the period for which payments are due.

(b) Beginning October 1, 1998, the department shall seek to achieve an aggregate rebate amount from all rebate agreements that is 6 percentage points higher than that required by division (a), provided such rebates result in a net increase in the rebate revenue available to the elderly low-cost drug program.

(2) Upon receipt of data from the department, the manufacturer shall calculate the quarterly payment.

(a) If a discrepancy is discovered, the department may, at its expense, hire a mutually agreed-upon independent auditor to verify the manufacturer's calculation.

(b) If a discrepancy is still found, the manufacturer shall justify its calculation or make payment to the department for any additional amount due.

(c) The manufacturer may, at its expense, hire a mutually agreed-upon independent auditor to verify the accuracy of the utilization data provided by the department. If a discrepancy is discovered, the department shall justify its data or refund any excess payment to the manufacturer.

(d) If the dispute over the rebate amount is not resolved, a request for a hearing with supporting documentation must be submitted to the department's division of administrative hearings. Failure to resolve the dispute may be cause for terminating the drug rebate agreement and denying payment to the manufacturer for any drugs.

(3) A prescription drug of a manufacturer that does not enter into an agreement pursuant to this paragraph is reimbursable only if the department determines the prescription drug is essential.

(4) All prescription drugs of a manufacturer that enters into an agreement pursuant to this paragraph that appear on the list of approved drugs under the program must be immediately available and the cost of the drugs must be reimbursed except as provided in this paragraph. The commissioner may impose prior authorization requirements on drugs under the program. If the commissioner establishes maximum retail prices for prescription drugs pursuant to section 2693, the department shall adopt rules for the program requiring the use of a drug formulary and prior authorization for the dispensing of certain drugs to be listed on a formulary.

(5) The names of manufacturers who do and do not enter into rebate agreements pursuant to this paragraph are public information. The department shall release this information to health care providers and the public on a regular basis and shall publicize participation by manufacturers that is of particular benefit to the public. [RR 2015, c. 1, §16 (COR).]

I. The eligibility determination made by the department is final, subject to appeal in accordance with the appeal process established in the MaineCare program. [PL 2005, c. 401, Pt. A, §2 (NEW).]

[PL 2023, c. 412, Pt. EEEEE, §§1-3 (AMD).]

5. Relationship to federal Medicare program. To the extent permitted by federal law and to the extent that funds are available, the department may:

A. Serve as the authorized representative for enrollees for the purpose of enrollment in a Medicare Part D plan; [PL 2005, c. 401, Pt. A, §2 (NEW).]

B. Apply for Medicare Part D benefits and subsidies on behalf of enrollees; [PL 2005, c. 401, Pt. A, §2 (NEW).]

C. Establish rules by which enrollees may opt out of the procedures under paragraphs A and B; [PL 2005, c. 401, Pt. A, §2 (NEW).]

D. At its discretion, file exceptions and appeals pertaining to Medicare Part D eligibility or benefits on behalf of enrollees who are beneficiaries under Medicare Part D. The department may identify a designee for this function; [PL 2005, c. 401, Pt. A, §2 (NEW).]

E. Identify objective criteria for evaluating Medicare Part D plans for the purposes of assisting or enrolling persons in those plans; [PL 2005, c. 401, Pt. A, §2 (NEW).]

F. Deem eligible for and enroll in the program without the need for application individuals who are eligible for both MaineCare and Medicare Part D; [PL 2005, c. 401, Pt. A, §2 (NEW).]

G. For enrollees who are also beneficiaries under or eligible for Medicare Part D:

(1) Provide coverage of drugs to the same extent that coverage is available to enrollees who are not eligible for Medicare Part D; and

(2) Provide assistance with premiums and other cost-sharing requirements of Medicare Part D; and [PL 2005, c. 401, Pt. A, §2 (NEW).]

H. For enrollees who are MaineCare members and who are also beneficiaries under or eligible for Medicare Part D:

(1) Provide coverage of drugs to the same extent that coverage is available to enrollees who are MaineCare members who are not eligible for Medicare Part D; and

(2) Provide assistance with the cost of prescription drugs and premiums and other cost-sharing requirements of Medicare Part D. [PL 2005, c. 401, Pt. A, §2 (NEW).]

[PL 2005, c. 401, Pt. A, §2 (NEW).]

6. Education, outreach and materials to increase access. The department shall provide education and outreach services to applicants and enrollees in the program, MaineCare members and beneficiaries under Medicare Part D to increase access to needed prescription and nonprescription drugs and fully use other private, state and federal programs. The department shall provide materials, which must cover the availability of benefits and the application process and must include brochures, posters for pharmacies and flyers for pharmacists to distribute with prescription drug purchases.
[RR 2005, c. 1, §4 (COR).]

7. Rulemaking. The commissioner may adopt rules to implement the program. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[PL 2005, c. 401, Pt. A, §2 (NEW).]

8. Emergency drug coverage. The department shall provide emergency drug coverage to an enrollee when:

A. A medically necessary drug prescribed for the enrollee is not on the enrollee's Medicare Part D prescription drug plan formulary, is not provided for in the dosage or amount necessary or is on the formulary as a nonpreferred drug; [PL 2005, c. 519, Pt. AAA, §1 (NEW).]

B. The enrollee's initial prior authorization request was not approved by the Medicare Part D prescription drug plan; and [PL 2005, c. 519, Pt. AAA, §1 (NEW).]

C. The drug is available as a preferred drug under either the program or MaineCare or is available from these programs with prior authorization and the enrollee has received or would receive prior authorization approval. [PL 2005, c. 519, Pt. AAA, §1 (NEW).]

[PL 2005, c. 519, Pt. AAA, §1 (NEW).]

SECTION HISTORY

RR 2005, c. 1, §4 (COR). PL 2005, c. 401, §A2 (NEW). PL 2005, c. 519, §AAA1 (AMD). PL 2007, c. 240, Pt. RR, §1 (AMD). PL 2011, c. 657, Pt. HH, §1 (AMD). RR 2015, c. 1, §16 (COR). PL 2015, c. 267, Pt. TT, §1 (AMD). PL 2019, c. 343, Pt. ZZ, §1 (AMD). PL 2023, c. 412, Pt. EEEEE, §§1-3 (AMD).