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State/Territory Name: Maine

State Plan Amendment (SPA) #: ME-23-0025

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

January 29, 2024

Michelle Probert
Director, Office of MaineCare Services
State of Maine Department of Health and Human Service
221 State Street
Augusta, ME 04333

Dear Michelle Probert:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number ME-23-0025, submitted on November 8, 2023, has been approved. The SPA has an effective date of December 1, 2023.

This SPA establishes a Health Services Initiative (HSI) to provide comprehensive coverage during the 12-month postpartum period for individuals whose newborns had been eligible as targeted low-income children under the from-conception-to-end-of-pregnancy (FCEP) option. The benefits provided during this postpartum period are identical to the benefits provided to pregnant individuals enrolled in Medicaid.

The HSI approval is based on section 2105(a)(l)(D)(ii) of the Social Security Act (the Act) and 42 CFR §§ 457.10 and 457.618, which authorize use of title XXI administrative funding for HSIs that improve the health of children, including targeted low-income children and other low-income children. Consistent with section 2105(c)(6)(B) of the Act and 42 CFR §457.626, title XXI funds used to support an HSI cannot supplant Medicaid or other sources of federal funding. The state's total title XXI administrative expenditures may not exceed 10 percent of its total annual title XXI computable expenditures.

The state shall ensure that the available title XXI administrative funding is sufficient to continue the proper administration of the CHIP program. If such funds become less than sufficient, the state agrees to redirect title XXI funds from the support of this HSI to the administration of the CHIP state plan. The state shall report annually to CMS the expenditures funded by the HSI for each federal fiscal year.

Your Project Officer is Joyce Jordan. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Maine
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name:	Michelle Probert	Position/Title:	MaineCare Director
Name:	Kristin Merrill	Position/Title:	Director of Policy (Acting)
Name:	David Jorgenson	Position/Title:	Director of Data Analytics
Name:	Kristin Merrill	Position/Title:	State Plan Manager
Name:	Sarah Fisher	Position/Title:	CHIP Outreach Coordinator
Name:	Henry Eckerson	Position/Title:	Children's and Behavioral Health Policy Manager

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA (42 CFR Part 457 Subpart A)
In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90-day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure

access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)

8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

1. **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.

2. **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

   Medicaid Expansion- CHIP SPA Requirements
   In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:
   - 1 (General Description)
   - 2 (General Background)

   They will also be required to complete the appropriate program sections, including:
   - 4 (Eligibility Standards and Methodology)
   - 5 (Outreach)
   - 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
   - 10 (Annual Reports and Evaluations).

   Medicaid Expansion- Medicaid SPA Requirements
   States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:
   - 3 (Methods of Delivery and Utilization Controls)
   - 4 (Eligibility Standards and Methodology)
   - 6 (Coverage Requirements for Children's Health Insurance)
   - 7 (Quality and Appropriateness of Care)
   - 8 (Cost Sharing and Payment)
   - 11 (Program Integrity)
   - 12 (Applicant and Enrollee Protections)

3. **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1.1. and 1.1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2. ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3. ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: July 1, 1988 (Title XIX expansion)
Implementation Date: July 1, 1988
Date Plan Submitted: May 19, 1998
Date Plan Approved: August 7, 1998
Effective Date: July 1, 1998 (Title XIX expansion)
August 1, 1998 (Title XXI)

Amendment #1: Cover birth-18 185%-200%; no AI/AN cost sharing
Date Submitted: January 5, 2000
Date Approved: March 1, 2001
Date Effective: October 1, 1999

Amendment #2: Hospice
Date Submitted: April 5, 2001
Date Approved: June 6, 2001
Date Effective: March 30, 2001

Amendment #3: Compliance
Date Submitted: June 28, 2002
Date Approved: September 19, 2002

Amendment #4: Public health initiatives
Date Submitted: January 9, 2003
Date Approved: April 16, 2003
Date Effective: July 1, 2002

Amendment #5: Increase premiums for separate child health program.
Date Submitted: October 6, 2004

Date Approved: January 5, 2005
Date Effective: November 1, 2004

Amendment #6: DirigoChoice
Date Submitted: June 29, 2005
Date Effective: January 1, 2005

Amendment #7: Expand eligibility to lawfully residing immigrant children (notwithstanding the 5-year bar);
Personnel changes; Departmental name changes;
DirigoChoice has been eliminated as a viable delivery system;
Health services initiatives (HSI);
Income disregard (effective September 1 2009);
Coverage option for legal immigrant children;
Enhanced Match for translation services (effective September 1, 2010);
Technical corrections and clarifications.
Date Submitted: June 29, 2010
Date Effective: July 1, 2009,
September 1, 2009,
September 1, 2010
Date Implemented: July 1, 2009,
September 1, 2009,
September 1, 2010
Date Approved: July 2, 2012

Transmittal Number	SPA Group	PDF #	Description
ME-13-0021 Effective/Implementation Date: January 1, 2014	MAGI Eligibility & Methods	CS15 CS7	MAGI-Based Income Methodologies Eligibility – Targeted Low Income Children
ME-13-033 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program
ME-13-0022 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

Transmittal Number	SPA Group	PDF #	Description
ME-13-0023 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process
ME-13-0024 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17 CS18 CS19 CS20 CS21 CS27	Non-Financial Eligibility – Residency Non-Financial Eligibility – Citizenship Non-Financial Eligibility – Social Security Number Non-Financial Eligibility – Substitution of Coverage Non-Financial Eligibility – Non-Payment of Premiums General Eligibility – Continuous Eligibility

SPA# ME-15-0012
Purpose of SPA: Update the Federal Poverty Level (FPL) for which MaineCare will provide Title XXI funding for eligible children and for CubCare to comply with the Affordable Care Act.

Clarify the eligibility standards for children with coverage under other health insurance plans to reflect that children must be uninsured to be eligible for Tittle XXI and Title XIX funded coverage.

Date Submitted: June 29, 2015
Date Effective: July 1, 2014

SPA # ME-15-0015
Purpose of SPA: Removed named vendors from the body of the CHIP State Plan.
Date Submitted: September 4, 2015
Date Effective: July 1, 2015

SPA # ME-18-0014-CHIP
Purpose of SPA: MHPAEA

Date Submitted: July 2, 2018
Proposed Effective Date: July 1, 2018
Proposed Implementation Date: October 2, 2017

SPA # ME-17-003
Date Submitted: December 5, 2017
Date Effective: January 1, 2017

SPA # ME-20-0006 & ME-2-0006-B
Purpose of SPA: Disaster Relief - To implement provision for temporary adjustments to enrollment and redetermination policies and cost sharing requirements for children in families living and/or working in Governor or FEMA declared disaster areas. In the event of a disaster, the State will notify CMS that it intends to provide temporary adjustments to its enrollment and redetermination policies and cost sharing requirements, the effective and duration date of such adjustments, and the applicable Governor or FEMA declared disaster areas.

Non-Financial Eligibility - Non-Payment of Premiums submitted through MMDL with this amendment, adds an exception to the lock-out period for individuals in disaster areas.

Proposed Effective Date: March 1, 2020
Maine is seeking to implement the plan outlined within Sections 4.3, 8.2, and 8.7 until the State or Federal emergency has been lifted, whichever is later.
Proposed Implementation Date: March 1, 2020

SPA# ME-20-0026
Purpose of SPA: SUPPORT Act – This SPA is updated to answer specific questions on Maine's behavioral health and substance use disorder programming to be in compliance with the SUPPORT Act.

Proposed Effective Date: July 1, 2019
Maine has updated the template in Sections 1.4, 1.4-TC, 6.2.22, 6.2.1-BH, 6.3-BH, 6.4-BH, 6.2.5-BH.
Proposed Implementation Date: July 1, 2019

SPA# ME-20-0027
Purpose of SPA: CHIP Health Services Initiatives (HSI) coverage. Maine is seeking coverage for two new Health Service Initiatives and refunding an existing initiative aimed at improving the health and wellness of low-income youth by leveraging federal funding for current child health programs and to increase access to EPSDT required developmental screens.

Proposed Effective Date: October 1, 2020

Maine has updated the template in Sections 1.4, 1.4-TC, Section 2.2, and Section 9.10.

Proposed Implementation Date: October 1, 2020

SPA #: ME-22-0019

Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing, and vaccinations for COVID-19 without cost sharing in CHIP.

Proposed effective date: March 11, 2021
Proposed implementation date: March 11, 2021

SPA# ME-22-0020 (Paper SPA) and ME-22-0021 (MMDL)
Purpose of SPA: CHIP Unborn Child Option (UCO) Pregnant persons who are not eligible for MaineCare due to unsatisfactory immigration status receive pregnancy coverage. During pregnancy the federal share of funding for this benefit is through the CHIP Unborn Child Option (UCO). This coverage would mirror existing pregnancy coverage for MaineCare recipients but end with the birth of the child (no postpartum coverage).

Proposed Effective Date: July 1, 2022
Proposed Implementation Date: July 1, 2022

Transmittal Number	SPA Group	PDF #	Description
ME-22-0021 Effective/Implementation Date: July 1, 2022	General Eligibility	CS9	Coverage From Conception to Birth

SPA # ME-22-0022
Extended postpartum for Targeted Low Income Children (TLIC)
Extends postpartum coverage to 12 months for pregnant persons eligible as targeted low-income children in CHIP.

Proposed Effective Date: August 1, 2022
Proposed Implementation Date: August 1, 2022

Transmittal Number	SPA Group	PDF #	Description
ME-22-0022 Effective/Implementation	General Eligibility	CS27	Continuous Eligibility

Date: August 1, 2022			

SPA # 23-0006
Purpose of SPA: Transition the majority of children enrolled in separate CHIP to a Medicaid expansion program. The state will continue to cover the conception to birth population (also known as "unborn" option) in its separate CHIP after the transition.

Proposed Effective Date: March 1, 2023
Proposed Implementation Date: March 1, 2023

Transmittal Number	PDF #	Description
ME-23-0007 Effective Date: March 1, 2023	CS3	Eligibility for Medicaid Expansion Program Updates ages and income levels of children that will be eligible for Medicaid expansion.
ME-23-0007 Effective Date: March 1, 2023	CS20	Non-Financial Eligibility – Substitution of Coverage Removes references to waiting periods for coverage and updates strategies to monitor substitution of coverage.
ME-23-0007 Effective Date: March 1, 2023	CS21	Non-Payment of Premiums Revised to remove premium requirements and related lock-out period.
The following SPAs will become obsolete: • CS7 – Targeted Low-Income Children • CS10 – Children with Access to Public Employee Coverage • CS14 – Establish 2101(f) group • CS18 – Citizenship and Lawfully Residing Immigrants • CS19 – Social Security Number		

SPA # 23-0025
Purpose of SPA: CHIP Health Services Initiatives (HSI) coverage. Maine is seeking coverage for a new Health Service Initiative to use additional CHIP funds to extend postpartum coverage to 12 months postpartum for individuals whose pregnancies were eligible for the CHIP FCEP population. The CHIP FCEP population includes pregnant persons who are not otherwise eligible for MaineCare.

Proposed Effective Date: December 1, 2023
Proposed Implementation Date: December 1, 2023

TN No: ME-23-0025 Approval Date: Effective Date: December 1, 2023

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Notice of the proposed change was mailed to tribal leadership on October 27, 2023. A tribal consultation call between state officials and tribal leaders was held on September 7, 2023.

TN No: ME-23-0025 Approval Date: Effective Date: December 1, 2023

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

2.1. Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other groups of children specified) identified, by income level and other relevant factors, such as race, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Currently, no public-private partnerships exist in Maine.

According to the Kaiser Family Foundation, the breakdown of health insurance coverage for children 0-18 in 2021 in Maine was:

- 57% of children have employer sponsored health coverage
- 7% of children have individually purchased health coverage
- 31% of children have Medicaid coverage (CHIP is included)
- 3% of children are uninsured.

Maine's rate of uninsured children 0-18 is 7% for children under 200% of Federal Poverty Level.

Maine is not as racially and ethnically diverse as most other states as 90% of the population is identified as white. The poverty rate by race/ethnicity is 12% for individuals identified as white, 30% for individuals identified as Black, 14% for individuals identified as "multiple races." Maine is considered to be the most rural state in the nation.

The information above is taken from the Kaiser Family Foundation's State Health Facts (2021).

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

Lead Abatement:

The Department plans to use HSI funds to expand the reach of lead abatement activities in Maine, to improve the well-being of families with children, and to maintain access to affordable housing that is lead safe. State law (P.L. 2018, Ch. 460) requires that the Department inspect every housing unit in a multi-unit dwelling building when a lead poisoned child is found in any individual unit. If lead hazards are identified, they must be abated using State licensed abatement contractors who permanently remove lead hazards using methods established by state and federal regulations.

This HSI would expand Maine's current state-funded lead abatement efforts established by law in 2018 (Public Law 2018 Chapter 460). This abatement program is administered by Maine Housing and provides grants for up to 90% of the cost to abate lead paint hazards in residential housing units or housing projects. State law restricts this grant program to households with incomes up to 100% of the area median income and requires that grant funding prioritize abatement projects for housing in which a child has been determined to be lead poisoned. Information on Area Median Income calculations is located at https://www.mainehousing.org/docs/default-source/homeimprovement/2020-100-median-income-limits.pdf?sfvrsn=37e38d15.

It is well established that there is no safe level of lead in children's blood. Maine has been proactive in addressing childhood lead poisoning by being one of the first states to

require full environmental inspections (presence of lead paint in poor condition, dust lead hazards, soil lead hazards, water lead hazards) whenever a child is identified with a blood lead level that is at or above the revised CDC blood lead reference level of 5 ug/dL. In 2018, an estimated 350 children under 6 years of age were identified as having a blood lead level of 5 ug/dL or above. Nearly 75% of Maine children identified as having an elevated blood lead level are enrolled in Maine's Medicaid program, and about 70% of children with high blood lead levels live in rental housing, with the rest in single-family owner-occupied housing.

State law requires the issuance of orders to abate identified lead hazards in rental properties and provides discretionary authority with respect to single-family owner-occupied homes. With increased inspection activity has come an increase in lead abatement orders, resulting in an increased need for funds to abate identified lead hazards so that housing can be made lead-safe and remain affordable. This program will improve the health and well-being of children by increasing the availability of housing that has been made lead safe, resulting in fewer children needing specific services, including special education services, as a result of lead poisoning. It will also improve the well-being of families with children by maintaining access to affordable housing, as the grant program requires a four-year commitment by the owner to lease units to households at or below 100% of the area median income and that rent not exceed 30% of the area median income. Lead abatement activities will be supported state-wide. This said, particular attention will be paid to the Lewiston/Auburn area, which has the highest rates of lead poisoning which is impacting a racially and ethnically diverse population. The state has received a HUD Choice Award with a goal of supporting the Lewiston/Auburn area being lead free by 2043. This HSI would support achieving the state's goal.

To be eligible for this HSI, Maine Housing Authority works with the client requesting lead abatement funds to determine which lead program (federal or state) works best for the client project. Households with income above 80% AMI and not above 100% AMI are enrolled in the State Lead Program. Maine CDC and Maine Housing Authority will establish an MOU to specifically govern eligibility to target MaineCare (including State Medicaid and CHIP) eligible children. Priority will be given to dwellings associated with referrals from Maine CDC based on the identification of children with elevated blood lead levels (.5ug/dL). Eligibility will be determined in the same manner as currently conducted under U.S. HUD Lead Hazard Control Grant funds.

Funding for this HSI will be $954,000 total state and federal funds annually. The HSI funds would provide financing for approximately fifty additional houses to be lead abated, which includes a six percent admin cost necessary for lead abatement. State match will be provided through dedicated funds for lead abatement through the Fund for Healthy Maine.

The state will track and report key metrics related to the lead abatement program to CMS quarterly or at another approved interval.

Lead Testing:

In June of 2019, Maine law required universal lead testing of children at one and two years of age. For children enrolled in MaineCare, these testing rates have been low: 52-55% of children at age one and 35-36% of children at age two. The lead program has noticed a decrease in testing during the COVID-19 pandemic due to operational challenges, reduced well visits, and inability to do point of care testing in office due to a lack of appropriate testing equipment on site.

The HSI will focus on increasing lead testing rates by conducting a quality improvement project between MaineCare and the Maine CDC's Childhood Lead Poisoning Prevention Unit. MaineCare and the Maine CDC will identify primary care practices with both low testing rates and large numbers of children enrolled in MaineCare. HSI funds will allow for the purchase of ten point-of-care lead level testing machines to distribute to these high priority practices. The Childhood Lead Poisoning Prevention Unit will provide quality improvement (QI) support to the practices, including QI education, review of practice data, and assistance with workflow.

Funding for this HSI will be $30,000 total state and federal funds annually. State match will be provided by private philanthropy supporting state child health initiatives. HSI funds will be used to finance ten point of care LeadCareII lead level testing machines valued at $3,000 each. Eligible health practices for the point of care lead testing machine will be those practices that serve a high percentage of MaineCare and CHIP eligible children in their communities, a volume of between 200 and 400 children ages one to two years of age, and for which the purchasing of a LeadCareII machine is a barrier (i.e., greater than a two-year payback period).

Communication and Media to Promote Tobacco Prevention – This HSI provides grants to a contractor to develop a statewide marketing campaign for the Partnership for a Tobacco-Free Maine to promote tobacco prevention among children and youth.

Funding for this HSI will be $200,000 total state and federal funds annually. The HSI funding will support financing prevention materials and quitting materials, and will allow for a broader implementation of the campaign to reach more low income youth. State match will be provided through general fund dollars.

School Based Health Centers – This HSI provides grants to schools and/or medical providers to build or expand capacity at school based health centers where the school based health centers provide support for public health functions: educating future adult health care consumers on healthy behaviors and on the use of health care; providing diagnosis and treatment of acute illness and management of chronic conditions; and education, assessment, counseling, and referrals to community-based providers. Mental health, reproductive health and oral health services may also be provided in a school-based health center.

Family Planning, Adolescent Pregnancy Prevention Services - This HSI provides grants to providers to conduct outreach campaigns to promote family planning among

adolescents where the providers support family life education consultation programs for schools and communities as well as community based adolescent pregnancy prevention projects. Outreach educators provide comprehensive family life education that includes information about abstinence and information on preventing sexually transmitted diseases and birth control. Examples of activities include: interactive workshops for youth, educational displays at health fairs for teens, and office hours at teen centers.

This HSI can also include a grant to a provider who, along with delegate agencies across the state, provides clinical reproductive health services to adolescents and low income women. Services include: contraceptives, screening, diagnosis and treatment of sexually transmitted infections, and breast and cervical cancer screening. This grantee also provides funds, training/technical assistance and resources to communities with high teen pregnancy rates to help them select and implement evidence-based teen pregnancy prevention programs. In addition, they provide professional development opportunities, technical assistance and support to community and school health educators on topics such as puberty, healthy relationships, contraception, sexually transmitted infections and parent involvement.

Maine Families Home Visiting Program – This HSI provides funding to community agencies for the provision of home visiting services for first time families and pregnant and parenting adolescents. This Home Visiting Service (The Maine Families Program) is housed and run by the Office of Child and Family Services (OCFS). The statewide network of these programs is called Maine Families (Home Visiting) and funded entirely by the Fund for Healthy Maine special revenue.

12-Month Postpartum Coverage for the From Conception to End of Pregnancy (FCEP) Population: Effective December 1, 2023, Maine will use additional CHIP funds, up to 10 percent of the Federal expenditures (after administrative costs for the CHIP population for other child health assistance as authorized under 2105(a)(2) of the Act) to extend postpartum coverage to twelve months postpartum for individuals whose pregnancies were eligible under the CHIP FCEP population. The CHIP FCEP population includes pregnant persons who are not otherwise eligible for MaineCare, as described in SPA# ME-22-0020 (Paper SPA) and ME-22-0021 (MMDL). Postpartum coverage through the HSI will be available to the birthing parent and will last through the end of the twelfth month of the postpartum period regardless of any subsequent changes in household income.

The postpartum services covered are consistent with the comprehensive benefits package provided under Maine's Medicaid program under Title XIX in terms of the amount, duration, and scope of services. The state is not making any changes to the delivery system during the 12-month postpartum period. This postpartum coverage HSI will directly benefit children's health. Research shows that when the parent does not have access to care for mental health, substance use disorder, or other medical conditions, they have limited resources to fully respond to their child's health needs. Untreated postpartum depression or substance use disorder can lead to child abuse and neglect, disruption in parental attachment, and adversely impact the child's development.

Children are less likely to access preventive care, attend well-child visits, and complete immunization schedules, and are more likely to experience avoidable hospitalizations when their parent does not have access to coverage.

No individuals receiving benefits under this provision will be subject to cost sharing.

HSI Assurances

1. Maine provides assurances that these HSIs will only target children under the age of 19 or pregnant individuals.
2. Maine provides further assurances that funds under these HSIs will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.
3. Maine provides further assurances that the State will report on agreed upon metrics at regular intervals to CMS on the progress of these HSIs.

9.10. Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42 CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc.
  - All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

CHIP Budget

STATE: ME	**FFY Budget**
Federal Fiscal Year	2024
State's enhanced FMAP rate	enhanced for duration of PHE 1st Quarter: 74.91% 2nd Quarter: 73.86% 3rd Quarter: 73.86% 4th Quarter: 73.86%
Benefit Costs	
Insurance payments	$0
Managed care	$0

STATE: ME	FFY Budget
per member/per month rate	$4,423,918
Fee for Service	$58,019,304
Total Benefit Costs	**$62,443,222**
(Premiums)	$0
(Rebates)	($5,760,981)
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	**$56,682,241**
Administration Costs	
Personnel	$31,336
General administration	$935,884
Contractors/Brokers	$170,651
Claims Processing	
Outreach/marketing costs	$3,955
Health Services Initiatives	$1,444,108
Other	$0
Total Administration Costs	**$2,585,934**
10% Administrative Cap	$5,667,379
Cost of Proposed SPA Changes	$145,920
Federal Share	$107,777
State Share	$38,143
Total Costs of Approved CHIP Plan	**$59,268,175**

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds:

Below is the breakdown of funding for Health Services Initiatives:

Note: Funds under the HSIs will not supplant or match CHIP Federal funds with other Federal funds, nor allow other Federal funds to supplant or match CHIP Federal funds.

Communication and media to Promote Tobacco Prevention - Not currently funded.

School Based Health Centers – Not currently funded.

Family Planning, Adolescent Pregnancy Prevention Services – Not currently funded.

Maine Families Home Visiting Program – Not currently funded.

Lead Abatement:

STATE: ME			FFY Budget
Activity	State Share	Federal Share	Total
Houses to be lead abated	$189,720	$710,280	$900,000
Administrative expenses	$11,383	$42,617	$54,000

Lead Testing:

Activity	State Share	Federal Share	Total
Purchase Point of Care testing machines 10x$3000	$6,324	$23,676	$30,000

12-Month Postpartum Coverage for FCEP Population:

Activity	State Share	Federal Share	Total
12-Month Postpartum Coverage for FCEP Population	$45,860	$129,244	$175,104