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State/Territory Name: Maine

State Plan Amendment (SPA) #: ME-23-0027

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

January 3, 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-23-0027, submitted on November 28, 2023, has been approved. Through this SPA, Maine has demonstrated compliance with the longstanding requirement in regulations at 42 CFR § 457.410(b)(2) and 457.520(b)(4) to cover age-appropriate vaccines. This SPA has an effective date of October 1, 2023.

Current regulations at 42 CFR § 457.410(b)(2) and 457.520(b)(4) require states to cover age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP) without cost sharing. The state provided the necessary assurances to demonstrate compliance with both requirements.

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:		Position/Title:	Director of Policy
Name:	David Jorgenson	Position/Title:	Director of Data Analytics
Name:	Lea Studholme	Position/Title:	Senior MaineCare Program Manager
Name:	Kristin Merrill	Position/Title:	State Plan Manager
Name:	Sarah Fisher	Position/Title:	CHIP Outreach Coordinator

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 Date: August 1, 2022	General Eligibility	CS27	Continuous Eligibility

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 # 23-0027
Purpose of SPA: The state is assuring that it covers age-appropriate vaccines and their administration, without cost sharing.

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

TN No: ME-23-0027 Approval Date: Effective Date: October 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 September 28, 2023. A tribal consultation call between state officials and tribal leaders was held on September 7, 2023.

TN No: ME-23-0027 Approval Date: Effective Date: October 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.

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

Plan amendments, waiver requests, and proposals for demonstration projects will be identified as having a direct effect on Indians, Indian health programs, or urban Indian organizations as part of a two-tier consultation.

The first tier involves written notices of any changes, sent electronically and via email to tribal representatives.

The second tier involves direct consultation (phone conversations, face-to-face meetings, direct email communications) with Tribes when there is any change or update in policy that effect any services that Tribes are reimbursed for through MaineCare. Issues identified as having a direct effect on the Tribes will be raised in monthly meetings or via listserv at least 30 days in advance of submission to CMS.

Tribal representatives are also invited as a MaineCare Advisory Committee (MAC) member, to be part of all policy development and to provide feedback to the Department in an advisory capacity.

Tribal representatives are also assigned a dedicated provider relations specialist to provide technical assistance in claims adjudication.

Section 3. Methods of Delivery and Utilization Controls

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4 (Eligibility Standards and Methodology).

Guidance: In Section 3.1., describe all delivery methods the State will use to provide services to enrollees, including: (1) contracts with managed care organizations (MCO), prepaid inpatient health plans (PIHP), prepaid ambulatory health plans (PAHP), primary care case management entities (PCCM entities), and primary care case managers (PCCM); (2) contracts with indemnity health insurance plans; (3) fee-for-service (FFS) paid by the State to health care providers; and (4) any other arrangements for health care delivery. The State should describe any variations based upon geography and by population (including the conception to birth population). States must submit the managed care contract(s) to CMS' Regional Office for review.

3.1. Delivery Systems (Section 2102)(a)(4) (42 CFR 457.490(a))

3.1.1 Choice of Delivery System

3.1.1.1 Does the State use a managed care delivery system for its CHIP populations? Managed care entities include MCOs, PIHPs, PAHPs, PCCM entities and PCCMs as defined in 42 CFR 457.10. Please check the box and answer the questions below that apply to your State.

☒ No, the State does not use a managed care delivery system for any CHIP populations.

FQHC and RHC are reimbursed for services in accordance with the approved Medicaid State Plan amendment methodology.

Certified Rural Health Clinics

i. Prospective Payment System:

The payment methodology for Certified Rural Health Clinics (RHCs) will conform to all of the requirements of section 702 of the BIPA 2000 legislation, including the BIPA 2000 requirements for Prospective Payment System (PPS).

a) RHCs that existed prior to BIPA 2000

i. RHCs will be reimbursed on the basis of 100% of the average of their reasonable costs of providing Medicaid-covered services during FY 1999 and FY 2000; adjusted to take into account any increase or decrease in the scope of services furnished during FY 2001 (calculating the amount of payment on a per visit basis).

ii. Beginning in CY 2002, and for each CY thereafter. each RHC is entitled to the payment amount (on a per visit basis) to which the clinic was entitled under the Act in the previous calendar year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in the scope of services furnished during that fiscal year.

b) Establishment of payment amount for new RHCs

This section applies to each new RHC site or location with a separate Medicaid number that is opening for the first time, either with or without an affiliation to an existing organization, regardless of previous service delivery.

The State shall provide payment of covered services furnished by the RHC in the first calendar year in which the clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during the calendar year based on the rates established under the Prospective Payment System (at 2(b)(i)) for other such RHCs located in the same or adjacent county with a similar caseload. Similarity of caseload is based on a comparison of type of services provided, total number of visits and total number of members served. In the absence of such a RHC, the initial rate will be established through cost reporting methods based on the Adjusted Cost Per Visit (line 7) from the Medicare cost report Worksheet M-3 containing 12 months of actual costs, or projected costs if actual is not available.

For each fiscal year following the initial fiscal year in which the entity first qualifies as a RHC, the State shall provide the payment amount in accordance with (2)(b)(i)(a)(ii).

a) Change in Scope of Services Adjustments

A "change in the scope of services"' refers to a change in the overall picture of a RHCs services through a change in the type, intensity. duration and/or amount of services.

The following examples are offered as guidance to RHCs to facilitate understanding of the types of changes that may be recognized as a "change in scope of services." These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of "change of scope of services."

i. The addition or a new covered service or deletion of an existing covered service that is present in the existing PPS rate. Covered services are those which meet the definition of RHC services as provided in section 1905(a)(2)(B) of the Social Security Act;
ii. The addition of a new professional staff (i.e. employed or contracted) who is licensed to perform a covered service that no current professional staff is licensed to perform;
iii. A change in the intensity of a service that fundamentally alters the service delivery model and increases or decreases the quantity of labor and materials consumed by an individual during an average encounter. This change may be attributed to changes in the types of patients served.

An increase or decrease in scope of service does not necessarily result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

i. A change in the cost of providing an existing service;
ii. A change of ownership;
iii. A change in status between free-standing and provider-based; 1v. The expansion or an existing service to a new population;
iv. The expansion or the RHC to a new site which provides the same services; v1. The addition or reduction of staff members to or from an existing service;
v. A change in office hours; or,
vi. An increase or decrease in the number of encounters.

It is the RHC's responsibility to notify the Department of any "change in the scope of services" and provide proper documentation to support the rate change request. The RHC must submit either at least six (6) months of actual cost data for changes that have already taken place, or twelve (12) months of projected costs for anticipated changes.

When a site submits projected costs for an anticipated change that amounts to a PPS rate change that is greater than or equal to 5%, the Department may request data for a subsequent rate adjustment when at least six (6) months of actual data becomes available. The site must also submit a narrative describing the change. Requests for a rate adjustment based on a prior change must be received no later than one hundred and fifty (150) days after the RHC's fiscal year end in which the "change in scope of services" occurred. The Department will respond to a rate adjustment request within sixty (60) days of receiving a completed application.

Adjustments to the PPS rate for the increase or decrease in scope of services will be reflected in the PPS rate beginning with services provided the first day of the month immediately following either the date the Department approves the "change in scope of services" adjustment or the date an anticipated change will begin. whichever is later.

ii. Fee for Service-based (FFS) Methodology for RHC's:

The State reimburses for out-of-scope RHC services through a fee for service payment as reflected on a fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of 1/1/2020 and is effective for services provided on or after that date. All fee for service rates are published at: https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx?RootFolder=%2FProvider%20Fee%20Schedules%2FRate%20Setting%2FSection%20103%20%2D%20Rural%20Health%20Clinic%20Services&FolderCTID=0x012000264D1FBA0C2BB247BF40A2C571600E81&View=%7B69CEE1D4%2DA5CC%2D4DAE%2D93B6%2D72A66DE366E0%7D

The services located on this fee schedule may be billed in conjunction with the PPS, APM or as a stand-alone visit based on the provider type that delivers these services.

iii. Encounter-Based Alternate Payment Methodology (APM) for RHC's:

Effective l/l/2020, RHC's may elect to be reimbursed per the PPS methodology at Paragraph 2.b.i and 2.b.iv, with the following changes: 1) reimbursement will be on the basis of 100% of the average of the reasonable cost of providing MaineCare-covered services during fiscal years 2016 and 2017. 2) The scope of service adjustment will be based on services furnished during FY 2018. Reimbursement will be no less than reimbursement received under the prospective payment system described in section 1902(bb) of the United States Social Security Act. Each RHC must be given the option to be reimbursed under the methodology required by this section or under the existing prospective payment system methodology. The individual health centers receiving payment under the APM methodology must agree to receive the APM.

iv. Provider Reimbursement by Payment Methodology:

All services must be provided by individuals appropriately licensed or certified, practicing within their scope of licensure or certification, and in accordance with State rules.

a) Prospective Payment System or Encounter-Based APM Rate Billing

To be eligible to receive the PPS or APM rate for RHC services, there must be a face-to-face service with one of the following PPS-eligible staff members of the RHC: physician, podiatrist, physician assistant, advanced practice registered nurse, psychologist, licensed clinical social worker, licensed clinical professional counselor, and/or dentist and dental hygienist. Visiting nurse services provided by a registered nurse or licensed practical nurse to a homebound member may also receive the PPS

or APM rate.

If an encounter does not involve a covered service by one of the above practitioners, the PPS or APM rate should not be billed.

b) FFS Rate Billing

PPS-eligible providers may also bill FFS for out of scope services in addition to the PPS rate when services are delivered on the same day.

When any other provider (i.e. a non-PPS eligible provider) delivers a FFS APM service, only the FFS reimbursement will be made. This payment will be made regardless of whether a PPS- eligible visit was made on that day.

Federally Qualified Rural Health Centers (FQHC)

v. Prospective Payment System:

a) FQHCs that existed prior to BIPA 2000

i. The payment methodology for FQHCs will conform to all of the requirements of section 702 of the BIPA 2000 legislation, including the BIPA 2000 requirements for Prospective Payment System (PPS), FQHCs will be reimbursed on the basis of 100% of the average of their reasonable costs of providing Medicaid-covered services during FY 1999 and FY 2000, adjusted to take into account any increase or decrease in the scope of services furnished during FY 2001 (calculating the amount of payment on per visit basis).

ii. Beginning In FY 2002; and for each fiscal year thereafter, each FQHC is entitled to the payment amount (on a per visit basis) to which the center was entitled under the Act in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase or decrease in the scope of services furnished during that fiscal year.

b) Establishment of payment amount for new FQHCs

This section applies to each new FQHC site or location with a separate Medicaid number that is opening for the first time, either with or without an affiliation to an existing organization, regardless of previous service delivery.

The State shall provide payment of covered services furnished by the FQHC in the first fiscal year in which the clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during the fiscal year based on the rates established under 2(b)(i) for other such

FQHC located in the same or adjacent area with a similar caseload. In the absence of such a FQHC, the initial rate will be established through cost reporting methods.

For each fiscal year following the initial fiscal year in which the entity first qualifies as a FQHC. the State shall provide the payment amount in accordance with (2)(b)(i)(a)(ii).

c) Change in Scope of Services Adjustments

A "change in the scope of services" refers to a change in the overall picture of a FQHC's services through a change in the type, intensity, duration and/or amount of services

The following examples are offered as guidance to FQHCs to facilitate understanding of the types of changes that may be recognized as a "change in scope of services." These examples should not be interpreted as a definitive nor comprehensive delineation of the definition of "change of scope of services."

i. The addition of a new covered service or deletion of an existing covered service that is present in the existing PPS rate. Covered services are those which meet the definition of RHC services as provided in section l 905(a)(2)(C) of the Social Security Act;

ii. The addition of a new professional staff (i.e. employed or contracted) who is licensed to perform a covered service that no current professional staff is licensed to perform;

iii. A change in the intensity of a service that fundamentally alters the service delivery model and increases or decreases the quantity of labor and materials consumed by an individual during an average encounter. This change may be attributed to changes in the types of patients served;

An increase or decrease in scope of service does not necessarily result from any of the following (although some of these changes may occur in conjunction with a change is scope of service):

i. A change in the cost of providing an existing service:
ii. A change of ownership;
iii. A change in status between free-standing and provider-based:
iv. The expansion of an existing service to a new population;
v. The expansion of the FQHC to a new site which provides the same services;
vi. The addition or reduction of staff members to or from an existing service;
vii. A change in office hours; or.
viii. An increase or decrease in the number of encounters.

It is the FQHC's responsibility to notify the Department of any "change in the scope of services'· and provide proper documentation to support the rate change request. The FQHC must submit either at least six (6) months or actual cost data for changes that have already taken place. or twelve (12) months of projected costs for anticipated changes.

When a site submits projected costs for an anticipated change that amounts to a PPS rate change that is greater than or equal to 5%. the Department may request data for a subsequent rate adjustment when at least six (6) months of actual data becomes available. The site must also submit a narrative describing the change. Requests for a rate adjustment based on a prior change must be received no later than one hundred and fifty (150) days after the FQHC's fiscal year end in which the ··change in scope of services·· occurred. The Department will respond to a rate adjustment request within sixty (60) days of receiving a completed application.

Adjustments to the PPS rate for the increase or decrease in scope of services will be reflected in the PPS rate beginning with services provided the first day of the month immediately following either the date the Department approves the "change in scope of services" adjustment or the date an anticipated change will begin, whichever is later.

vi. Alternate Payment Methodology (APM):

The State reimburses for asthma education provided by non-physician providers. diabetes outpatient self-management. tobacco cessation classes, contraception (injectable, implantable capsules. intrauterine devices), and the administration of influenza and pneumococcal vaccines through an alternate payment methodology as reflected on a fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as or 11/05/14 and is effective for services provided on or after that date. All rates are published at http://www.maine.gov/dhhs/audit/rate-setting/docurnents/S3 l FQHC.pdf.

The services located on this fee schedule may be billed in conjunction with the PPS or as a stand alone visit based on the provider type that delivers these services.

vii. Provider Reimbursement by Payment Methodology:
All services must be provided by individuals appropriately licensed or certified. practicing within their scope of licensure or certification. and in accordance with State rules.

d) Prospective Payment System Rate
To be eligible to receive the PPS rate for FQHC services, there must be a face-to-face service with one of the following PPS-eligible staff members of the FQHC: physician, podiatrist, physician assistant, advanced practice registered nurse. psychologist, licensed clinical social worker, licensed clinical professional counselor, dentist, dental hygienist, dental extern, dental resident. and/or physical therapist or any other provider that has been incorporated into the FQHCs PPS through a Department-approved change of scope of services request. Visiting nurse services provided by a registered nurse or licensed practical nurse to a homebound member may also receive the PPS rate.

If an encounter does not involve a covered service by one of the above practitioners. the PPS rate should not be billed.

e) Alternate Payment Methodology FFS Rates
PPS-eligible providers may also bill FFS for APM services in addition to the PPS when the APM services are delivered on the same day.

When any other provider (i.e. a non-PPS eligible provider) delivers an APM service. only the FFS reimbursement will be made. This payment will be made regardless of whether a PPS eligible visit was made on that day.

☐ Yes, the State uses a managed care delivery system for all CHIP populations.

☐ Yes, the State uses a managed care delivery system; however, only some of the CHIP population is included in the managed care delivery system and some of the CHIP population is included in a fee-for-service system.

If the State uses a managed care delivery system for only some of its CHIP populations and a fee-for-service system for some of its CHIP populations, please describe which populations are, and which are not, included in the State's managed care delivery system for CHIP. States will be asked to specify which managed care entities are used by the State in its managed care delivery system below in Section 3.1.2.

Guidance: Utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42 CFR 457.490(b))

If the State does not use a managed care delivery system for any or some of its CHIP populations, describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of:

- The methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102(a)(4); 42 CFR 457.490(a))
- The utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102(a)(4); 42 CFR 457.490(b))

Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42 CFR 457.490(b))

1. Primary Care Plus (PCPlus) – PCPlus is MaineCare's value-based payment initiative designed to support primary care. PCPlus is voluntary for both Primary Care Providers and MaineCare members. PCPlus transitions away from a volume-based (fee-for-service) payment system that has little connection to value, toward an approach that provides Population-Based Payments (PBP) tied to cost- and quality-related outcomes. PBPs and the delivery of quarterly quality measure performance reports support and incent primary care provider care management activities to improve health outcomes and ensure appropriate utilization of medically necessary care, while reducing avoidable acute care utilization and Total Cost of Care (TCOC).

2. Prior Authorization – Prior authorization is required for certain MaineCare covered services obtained in-state and all MaineCare covered services provided out-of-state

(with the exception of emergency services and services furnished by providers located within 15 miles of the New Hampshire border and 5 miles of Canadian border who are treated as in-state providers). All services requiring prior authorization are reviewed for medical necessity. Prior authorization for services rendered out-of-state is provided only when a member's continuity of care must be preserved for medical reasons and only after it is determined that the needs of the member cannot be met in the State of Maine.

3. Utilization Review – Ongoing monitoring of health care received by MaineCare members is provided by staff of the Program Integrity Unit within the Division of Audit. Ongoing sampling is conducted to review the utilization of care and services received by MaineCare members and also to evaluate necessity, quality, quantity and timeliness of services provided to MaineCare members.

4. Emergency Department Collaborative: MaineCare has a team of nurses, behavioral health specialists, and care coordinators who work with health care providers and MaineCare members to reduce avoidable, non-emergent emergency department (ED) use and improve health outcomes for MaineCare members. The goals of the team are to:
   • Reduce non-emergent ED use and improve health outcomes through statewide care management efforts.
   • Increase availability of ED for true emergency situations.
   • Improve continuity of care for the MaineCare member.
   • Educate the member of alternative ways to meet their needs, such as urgent care and connection to a Primary Care Provider (PCP).
   • Reduce costs by the use of cost-effective resources.

5. Member Restriction – Member restriction is an administrative procedure that may be established for MaineCare members with a history of over utilization of benefits. Under this procedure, participants must receive their primary medical care from one (or multiple specified providers). Primary purposes for restricting members to specified provider(s) are: 1) to decrease and control over utilization and/or abuse of covered health care services/benefits and to minimize medically unnecessary and addictive drug usage; 2) to establish a method of monitoring non-emergency health care services for members who have utilized health care services or benefits at a frequency or amount that is not medically necessary; and 3) to assist members through education and referral towards appropriate health care service and benefit use.

6. Perinatal Opioid Use Disorder Treatment: MaineCare's Opioid Health Home (OHH) Program establishes a tier of perinatal services, titled MaineMOM OHH, for members who are pregnant or one-year postpartum living with an opioid use disorder. MaineMOM expands comprehensive, coordinated care focused on serving pregnant and postpartum MaineCare beneficiaries with opioid dependency. MaineMOM additionally includes coordination with obstetric providers and

community supports to align care for opioid use disorder with the perinatal needs of the beneficiary.

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☒ **Medicaid Expansion**

4.0.1. Ages of each eligibility group and the income standard for that group:

Age	Above FPL %	Up to and Including FPL %
0 – 1	191	208
1 – 6	140	208
6 – 19	132	208

4.1. ☒ **Separate Program** Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☐ Describe how the State meets the citizenship verification requirements.

4.1.1 ☒ Geographic area served by the Plan if less than Statewide:
Statewide

4.1.2 ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:
Superseded by CS9 SPA

4.1.2.1-PC Age: Confirmed positive pregnancy through birth (SHO #02-004, issued November 12, 2002) see approved CS9 template which supersedes section 4.1.9 of the current state plan.

4.1.3 ☒ Income of each separate eligibility group (if applicable):
The upper income limit for Title XXI is 208% FPL

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through 208% of the FPL (SHO #02-004, issued November 12, 2002)

4.1.4 ☐ Resources of each separate eligibility group (including any standards

relating to spend downs and disposition of resources):

4.1.5 ☒ Residency (so long as residency requirement is not based on length of time in state):
Residency requirements are described in CS17 Non-Financial Eligibility - Residency

4.1.6 ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7 ☐ Access to or coverage under other health coverage:
Members must be uninsured to be eligible for Title XXI funded coverage.

4.1.8 ☒ Duration of eligibility, not to exceed 12 months:
An unborn child who has been determined eligible for MaineCare shall remain eligible from conception to birth.

4.1.9 ☒ Other Standards- Identify and describe other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

The Office for Family Independence MaineCare Eligibility Manual sets for the eligibility policies for Titles XIX and XXI.

The state provides coverage for services to the gestational parent that may impact the health of the parent's fetus in households with income up to 208% FPL where the gestational parent is not otherwise eligible for Medicaid. The fetus is counted as if born and living with the gestational parent in determining family group size.

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children, indicate that the unborn children are exempt from providing a SSN. Other standards include but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☐ States should specify whether Social Security Numbers (SSN) are required.
for CHIP applicants, with exceptions outlined in CS19 Non-Financial Eligibility – Social Security Number.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☐ Continuous eligibility

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Maine does not elect the pregnant person option for CHIP.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1- LR ☐ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is:

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;
(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
(vi) Aliens currently in deferred action status; or
(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. §1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

☐ Elected for pregnant women.
☐ Elected for children under age

4.1.1-LR ☐ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and 9.10 when

electing this option.

4.2. **Assurances** The State assures by checking the box below that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS ☐ These standards do not discriminate on the basis of diagnosis.

4.2.2-DS ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3-DS ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology.** Describe the methods of establishing and continuing eligibility and enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350)

Superseded by CS24

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitation on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists, and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

In order to provide health coverage to as many children as possible within the fiscal

constraints of the program budget (as defined in the Balanced Budget Act of 1997), the maximum eligibility level is subject to adjustment by the Commissioner of the Department dependent on the fiscal status of the program. If program expenditures are anticipated to exceed the program budget, the Commissioner shall reduce the maximum eligibility level to the extent necessary to bring the program expenditures within the program budget. If expenditures are expected to fall below the program budget, the Commissioner shall increase the maximum eligibility level to the extent necessary to provide coverage to as many children as possible within the fiscal constraints of the program budget.

Children of higher income may not be covered unless children of lower income are also covered. If the Commissioner has reduced the maximum eligibility level, children of higher income may be disqualified at the end of the twelve month enrollment period, but not during the twelve-month period.

☒ Check here if this section does not apply to your State.

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. ☐ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☐ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the

determination under the Express Lane option.

4.3.3.3-EL List the component/components of CHIP eligibility that are determined under the Express Lane.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. Eligibility screening and coordination with other health coverage programs
States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a State health benefits plan) are furnished child health assistance under the plan. (Sections 2102(b)(3)(A), 2110(b)(2)(B)) (42 CFR 457.310(b), 42 CFR 457.350(a)(1) and 42 CFR 457.80(c)(3)) Confirm that the State does not apply a waiting period for pregnant women.
Superseded by CS9 and CS20 SPAs.

Children with other coverage are not eligible for XXI.

4.4.2. ☒ children found through the screening process to be potentially eligible for medical assistance under the State Medicaid plan are enrolled for assistance

under such plan; (Section 2102(b)(3)(B)) (42CFR, 457.350(a)(2))
Superseded by CS24 SPA

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP; (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))
Superseded by CS24 SPA

4.4.4. ☒ the insurance provided under the State child health plan does not substitute for coverage under group health plans. (Section 2102(b)(3)(C)) (42CFR, 457.805)
Superseded by CS20 SPA

4.4.4.1. ☐ (formerly 4.4.4.4) If the State provides coverage under a premium assistance program, describe: 1) the minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost-effectiveness is determined. (42CFR 457.810(a)-(c))

4.4.5. ☒ Child health assistance is provided to targeted low-income children in the State who are American Indian and Alaska Native. (Section 2102(b)(3)(D)) (42 CFR 457.125(a))

Any eligible child who is American Indian or Alaskan Native is enrolled in MaineCare under Title XIX or Title XXI and treated as any other eligible child, with the exception that the child is not required to pay a premium or other cost sharing.

Under the provisions enacted in CHIPRA for Title XIX or Title XXI, MaineCare accepts tribal enrollment documents issued by a Federally-recognized Indian tribe evidencing membership or affiliation with such tribe, as proof of U.S. citizenship; and encourages outreach and enrollment of Indians. The Office for Family Independence makes efforts to routinely meet with tribal organizations to help streamline access to eligibility, and provide translation services, and education regarding Medicaid and CHIP. In addition, the MaineCare Services will consult with tribal organizations on continued development and implementation of the CHIP State Plan through ongoing scheduled meetings.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☐ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

Section 5. Outreach and Coordination

5.1. (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing sections 5.1.1 and 5.1.2. (Section 2102)(a)(2) (42 CFR 457.80(b))

Guidance: The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

5.1.1. (formerly 2.2.1.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

The agency will provide outreach, education and toll-free helpline response assistance on MaineCare and other public and private coverage programs on a statewide basis. The functions include worksite and community-based trainings; provide requested information and referral if appropriate, screen for eligibility for various coverage programs, send packets of information including applications where appropriate, assist with completing applications where appropriate; and design and produce mailings with information about changes in benefits or coverage, open enrollment periods, or other important updates.

State staff from the MaineCare Services, the Maine Center for Disease Control and Prevention, and Children's Behavioral Health Services will be reimbursed at the higher CHIP administrative match for program planning, data analysis, oversight of quality and outreach to providers on behalf of children.

On an ongoing basis, the Department's outreach efforts and goals include:

- Working with an external marketing firm to develop an outreach campaign to reach the gestational parents of the CHIP UCO population. Resources to disseminate include the development of posters, rack cards, social media posts, and ads in public transportation and local newspapers. Dissemination will happen through partnership with community-based organizations who have experience working with the gestational parents of the CHIP UCO population.

- Technical training with staff of community based agencies and health care providers on benefits, eligibility criteria, the application process and program changes to ensure information is disseminated and individuals are enrolled. Each participant is provided with a guide containing the training information. Participants are asked to make a commitment to provide long-term outreach and application assistance to the clients they serve. This model, of reaching potentially eligible individuals through trained personnel with whom they have established relationships, has proven an effective outreach method.

- Targeted outreach to specific constituencies including: Education; ; ethnic community-based organizations; Social service agencies and municipalities; Faith-based and service organizations; Health care providers and insurers.

- General training for and information provided to community organizations. General trainings also provided to statewide organizations such as Maine American Academy of Pediatrics, General Assistance Administrators, WIC Directors, etc..

- Information booths at health fairs, professional conferences, e.g., Maine Pediatric Association meetings.

The Department's efforts to assist individuals in enrolling include:

1. HelpLine—Maintenance of a statewide toll free HelpLine where trained workers: a.) inform callers of coverage options and assist with application or reenrollment process; b.) provide information about application assistance

sites or other appropriate services/programs in the geographical area; c.) serve as resource to hundreds of sites trained to provide application assistance.

2. Expanded Application Capacity—Maintenance and expansion of statewide sites available to provide applications and application assistance (including reenrollment).

The Department also gathers information from constituencies, local coalitions, technical trainings, and HelpLine calls to identify problems or barriers families are encountering in accessing or continuing coverage for their children

Guidance: The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite his section but may instead update this section as appropriate.

5.1.2. (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

No public-private partnerships currently exist in Maine.

Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42 CFR 457.80(c))

5.2. (formerly 2.3) Describe how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, other relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42 CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

There are no public programs in the state, except MaineCare, that provide health care coverage for low-income children. Because the enrollment application for CHIP is integrated with the enrollment application for Medicaid, determination of eligibility is automatically and seamlessly integrated between the two programs.

The Title V program provides very limited care coordination to children with Special Health Care needs who are not eligible for public coverage for children who are generally uninsured or underinsured.

5.2-EL The State should include a description of its election of the Express Lane eligibility

option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

Guidance: Outreach strategies may include, but are not limited to, community outreach workers, out stationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

5.3. **Strategies** Describe the procedures used by the State to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42 CFR 457.90)

The agency will provide outreach, education and toll-free helpline response assistance on MaineCare and other public and private coverage programs on a statewide basis. The functions include worksite and community-based trainings; provide requested information and referral if appropriate, screen for eligibility for various coverage programs, send packets of information including applications where appropriate, assist with completing applications where appropriate; and design and produce mailings with information about changes in benefits or coverage, open enrollment periods, or other important updates.

State staff from the MaineCare Services, the Maine Center for Disease Control and Prevention, and Children's Behavioral Health Services will be reimbursed at the higher CHIP administrative match for program planning, data analysis, oversight of quality and outreach to providers on behalf of children.

On an ongoing basis, the Department's outreach efforts and goals include:

- Working with an external marketing firm to develop an outreach campaign to reach the unborn population. Resources to disseminate include the development of posters, rack cards, social media posts, and ads in public transportation and local newspapers. Dissemination will happen through partnership with community-based organizations who have experience working with the unborn population.

- Technical training with staff of community based agencies and health care providers on benefits, eligibility criteria, the application process and program changes to ensure information is disseminated and individuals are enrolled. Each participant is provided with a guide containing the training information. Participants are asked to make a commitment to provide

long-term outreach and application assistance to the clients they serve. This model, of reaching potentially eligible individuals through trained personnel with whom they have established relationships, has proven an effective outreach method.

- Targeted outreach to specific constituencies including: Education; ethnic community-based organizations; Social service agencies and municipalities; Faith-based and service organizations; Health care providers and insurers.

- General training for community organizations. General trainings also provided to statewide organizations such as the Maine American Academy of Pediatrics,, General Assistance Administrators, WIC Directors, etc.

- Information booths at health fairs, professional conferences, e.g., Maine Pediatric Association meetings.

The Department's efforts to assist individuals in enrolling include:

1. HelpLine—Maintenance of a statewide toll free HelpLine where trained workers: a.) inform callers of coverage options and assist with application or reenrollment process; b.) provide information about application assistance sites or other appropriate services/programs in the geographical area; c.) serve as resource to hundreds of sites trained to provide application assistance.

2. Expanded Application Capacity—Maintenance and expansion of statewide sites available to provide applications and application assistance (including reenrollment).

The Department also gathers information from constituencies, local coalitions, technical trainings, and HelpLine calls to identify problems or barriers families are encountering in accessing or continuing coverage for their children

Section 6. Coverage Requirements for Children's Health Insurance

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42 CFR 457.410(a))

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee

coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent

to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and

- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space

provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

6.1.4. ☒ Secretary-approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

6.1.4.1. ☒ Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT).

6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver.

6.1.4.3. ☐ Coverage that the State has extended to the entire Medicaid population.

Guidance: Check below if the coverage offered includes benchmark coverage, as

specified in §457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage.

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only in New York, Pennsylvania or Florida. (under 42 CFR 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than coverage under one of the benchmark plans specified in 457.420, through the use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done).

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other. (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42 CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The State elects to provide the following forms of coverage to the gestational parent to the benefit of the fetus: (Check all that apply. If an item is checked, describe the coverage with

respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

6.2.1. ☒ Inpatient services (Section 2110(a)(1))

6.2.2. ☒ Outpatient services (Section 2110(a)(2))

6.2.3. ☒ Physician services (Section 2110(a)(3))

6.2.4. ☒ Surgical services (Section 2110(a)(4))

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

Rural health clinic services and other ambulatory services furnished by a rural health clinic, as well as federally qualified health center services are covered.

6.2.6. ☒ Prescription drugs (Section 2110(a)(6))

6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))

6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))

6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

6.2.10. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))

6.2.11. ☒ Disposable medical supplies (Section 2110(a)(13))

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

6.2.12. ☒ Home and community-based health care services (Section 2110(a)(14))

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.13. ☒ Nursing care services (Section 2110(a)(15))

6.2.14. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the

result of an act of rape or incest (Section 2110(a)(16)

6.2.15. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

6.2.16. ☒ Vision screenings and services (Section 2110(a)(24))

6.2.17. ☒ Hearing screenings and services (Section 2110(a)(24))

6.2.18. ☒ Case management services (Section 2110(a)(20))

6.2.19. ☒ Care coordination services (Section 2110(a)(21))

6.2.20. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))

6.2.21. ☒ Hospice care (Section 2110(a)(23))

Guidance: See guidance for section 6.1.4.1 for a guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check this box.

6.2.22. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

6.2.22.1 ☒ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.23. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24))

Services of chiropractors and podiatrists are covered. Prevention, Health Promotion and Optional Treatment Services (EPSDT), private duty nursing services and genetic testing services are also covered.

Podiatrists' services are limited to non-routine procedures; treatment of plantar warts, ingrown nails, ulcerations, bursitis, and infections; and

minor surgery under local anesthetic. Some routine procedures are covered if there are complications due to foot pathology.

Genetic testing services are diagnostic or screening services to determine risk for genetic diseases.

6.2.24. ☐ Premiums for private health care insurance coverage (Section 2110(a)(25))

6.2.25. ☒ Medical transportation (Section 2110(a)(26))

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.26. ☒ Enabling services (such as transportation, translation, and outreach services) (Section 2110(a)(27))

Transportation, translation, and outreach services are provided. Interpreter services consistent with Federal Medicaid EPSDT provisions are covered for non-English, limited English speaking and/or deaf/hard-of-hearing individual. Non-emergency medical transportation services are also provided under "enabling services", for any health care service for which Medicaid will provide reimbursement with covered transportation services including: regional requirements with designated catchment area; mileage reimbursement for provider (agency) vehicles, to a family, to a volunteer driver, for an attendant; public transportation fare; wheelchair van services; highway tolls and parking fees; related travel expenses (i.e., necessity to stay overnight to receive medically necessary health care services); and seven day clinic services until such time as these services are covered by the Department under a Home and Community Based Waiver program (i.e., freestanding Methadone Clinics).

The State intends to claim the increased higher CHIP match rate (as authorized in CHIPRA) for the translation services they intend to provide, utilizing the State's new payment system, Maine Integrated Health Management System (MIMHS). MIHMS payment is based upon provider's contracts and member's rate codes. There are different accounting strings set up for the rate codes/coverage codes and reimbursement methodologies outlined in contracts.

6.2.27. ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

Effective March 11, 2021 and through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 emergency period described in section 1135(g)(1)(B) of the Act, and for all populations covered in the CHIP state child health plan:

COVID-19 Vaccine:

- The state provides coverage of COVID-19 vaccines and their administration, in accordance with the requirements of section 2103(c)(11)(A) of the Act.

COVID-19 Testing:

- The state provides coverage of COVID-19 testing, in accordance with the requirements of section 2103(c)(11)(B) of the Act.
- The state assures that coverage of COVID-19 testing is consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.
- The state assures that coverage includes all types of FDA authorized COVID-19 tests.

COVID-19 Treatment:

- The state assures that the following coverage of treatments for COVID-19 are provided without amount, duration, or scope limitations, in accordance with requirements of section 2103(c)(11)(B) of the Act:
    - The state provides coverage of treatments for COVID-19 including specialized equipment and therapies (including preventive therapies);
    - The state provides coverage of any non-pharmacological item or service described in section 2110(a) of the Act, that is medically necessary for treatment of COVID-19; and
    - The state provides coverage of any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations.

Coverage for a Condition That May Seriously Complicate the Treatment of COVID-19:

- The state provides coverage for treatment of a condition that may seriously complicate COVID-19 treatment without amount, duration, or scope limitations, during the period when a beneficiary is diagnosed with or is presumed to have COVID-19, in accordance with the requirements of section 2103(c)(11)(B) of the Act.

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to

prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

☐ State-developed schedule
☐ American Academy of Pediatrics/ Bright Futures
☒ Other Nationally recognized periodicity schedule (please specify: ACOG/Alliance for Innovation in Maternal Health)
☐ Other (please describe:)

6.3- BH Covered Benefits Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

All covered populations in Maine's CHIP program, including children and gestational parents enrolled through Maine's Unborn Child Option are eligible for EPSDT and receive the same behavioral health services checked off below.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A))

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of

administering or purchasing the tools.

The PCPlus initiative requires participating primary care practices to directly provide or provide referrals to all USPSTF recommendations graded as A or B.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.
Maine utilizes the AAP/Bright Futures Guidelines and The American College of Obstetricians and Gynecologists/Alliance for Innovation on Maternal Health to identify standardized and validated screening tools. Current screening tools supported include but are not limited to the Edinburgh Postnatal Depression Screen (EPDS), Patient Health Questionnaire-9 (PHQ-9), General Anxiety Disorder 7 Screen (GAD-7), Mood Disorder Questionnaire (MDQ), Columbia Suicide Severity Rating Scale (C-SSRS), 4Ps Screening Tool, CRAFFT Screening Tool, and TAC-E Screening Tool.) Maine's provider manuals outline expectations for age-appropriate screening. Providers are informed about changes to the manual via e-mails and targeted mailing. , The State leverages partnership with the Maine CDC's Perinatal Outreach program to offer direct support and education for perinatal providers, including education on the use of these validated screening tools for behavioral health. The State, through our Child Health Insurance Program Outreach Coordinator and EPSDT coordinator, will continue to provide regular updates on screening tools and potential training opportunities.

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.2- BH ☒ Tobacco cessation
Provided for: ☒ Substance Use Disorder

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment

Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

6.3.2.3.2- BH ☒ Alcohol Use Disorder

6.3.2.3.3- BH ☒ Other

6.3.2.4- BH ☒ Peer Support
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.5- BH ☒ Caregiver Support
Provided for: ☒ Mental Health ☐ Substance Use Disorder

6.3.2.6- BH ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.7- BH ☒ Intensive in-home services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.8- BH ☒ Intensive outpatient
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.2.9- BH ☒ Psychosocial rehabilitation
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits,

such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18))
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☒ Residential Treatment
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.4.2- BH ☒ Detoxification
Provided for: ☒ Substance Use Disorder

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.5.1- BH ☒ Crisis Intervention and Stabilization
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.6- BH ☒ Continuing care services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7- BH ☒ Care Coordination
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7.1- BH ☒ Intensive wraparound
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.7.2- BH ☒ Care transition services
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.8- BH ☒ Case Management
Provided for: ☒ Mental Health ☒ Substance Use Disorder

6.3.9- BH ☐ Other
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☒ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☒ Substance Use Disorders

☐ InterQual
☐ Mental Health ☐ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☒ CALOCUS/LOCUS (Child and Adolescent Level of Care Utilization System)
☒ Mental Health ☐ Substance Use Disorders

☒ CASII (Child and Adolescent Service Intensity Instrument)

☒ Mental Health ☐ Substance Use Disorders

☒ CANS (Child and Adolescent Needs and Strengths)
☒ Mental Health ☐ Substance Use Disorders

☒ State-specific criteria (e.g. state law or policies) (please describe)
☒ Mental Health ☐ Substance Use Disorders

The State utilizes age appropriate, validated screening tools recommended by the AAP/Bright Futures. Additionally, the State uses of a combination of instrument with functional criteria utilizing a functional assessment, such as the Vineland II, ABAS, Bayley, and Battelle Scales.

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ Other (please describe)
☐ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.
The use of validated assessment tools is required for access to behavioral health treatment. Maine's provider manuals outline supported assessment tools. Any updates to the manual get noticed via e-mailed message, newspaper noticing and targeted mailing to providers upon the update. Additionally, the State is developing a resource guide to assessments which will be published on our website, sent to providers via e-message annually, and updated as needed. The State, through our Child Health Insurance Program Outreach Coordinator and EPSDT coordinator, will provide regular updates, at least annually, on assessment tools and potential training opportunities.

In addition, the state sponsors trainings, as needed, on approved behavioral health assessments. For example, a number of the state's behavioral health services utilize the Child and Adolescent Needs and Strengths (CANS) assessment for eligibility and treatment planning guidance, and

through contracts, the State provides trainings to providers on this assessment for free, as needed. The State, through our Child Health Insurance Program Outreach Coordinator and EPSDT coordinator, will provide regular updates, at least annually, on assessment tools and potential training opportunities.

6.2.5- BH Covered Benefits The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

Covered Services for the gestational parent/fetus under the CHIP UCO

MaineCare provides coverage for services to the gestational parent that may impact the health of the fetus in households up to 208% FPL where the gestational parent is not otherwise eligible for Medicaid due to their citizenship status. UCO coverage is the same as pregnancy related coverage provided through the Medicaid State Plan for pregnant persons. Pregnant persons are eligible for EPSDT services consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act. Coverage for this population is detailed in Section 6.2 below. Benefits to the fetus are delivered through the same delivery and utilization control systems.

MaineCare provides two methods of reimbursement for maternity care, global charge basis or per service charge basis. If the provider is eligible for a global charge, payment will cover the entirety of the labor and delivery and immediate postpartum care until eligibility ends.

6.2-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)

4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

☐ State-developed Medicaid-specific
☐ American Academy of Pediatric Dentistry
☐ Other Nationally recognized periodicity schedule
☐ Other (description attached)

6.2.2-DC ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the

plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☒ Yes

☐ No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☒ All children covered under the State child health plan.

☐ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the

State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

☒ All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

☒ All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

☒ All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

☒ Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

☒ Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

☒ EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

☒ The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

☒ All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

6.2.3.1.1 MHPAEA The State assures that:

☐ The State has classified all benefits covered under the State plan into one of the four classifications.

☐ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☐ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☐ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☐ No dollar limit is applied

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☐ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar limits. (42 CFR 457.496(c)(3))

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☐ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☐ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☐ Yes

☐ No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☐ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

☐ State

☐ Managed Care entities

☐ Both

☐ Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

☐ State

☐ Managed Care entities

☐ Both

☐ Other

Guidance: If other is selected, please specify the entity.

6.3. The State assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42 CFR 457.480)

6.3.1. ☒ The State shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The State contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2. (formerly 6.4.2) of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6.) (Section 2103(f)) Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family

coverage. (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4. **Additional Purchase Options-** If the State wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the State must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ **Cost Effective Coverage**- Payment may be made to a State in excess of the 10 percent limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the State to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The State may cross reference Section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42 CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42 CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in

Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42 CFR, 457.1005(a))

6.4.1.3. The coverage must be provided through the use of a community based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42 CFR 457.1005(a))

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42 CFR 457.1010)

6.4.2. ☐ **Purchase of Family Coverage**- Describe the plan to purchase family coverage. Payment may be made to a State for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42 CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

6.4.2.2. The State assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42 CFR 457.1010(b))

6.4.2.3. The State assures that the coverage for the family otherwise meets title XXI requirements. (42 CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☐ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan**.**

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is

applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA **Purchasing Pool**- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☐ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA **Notice of Availability of Premium Assistance**- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and

how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

6.5 - Vaccine Coverages

Guidance: States are required to provide coverage for age-appropriate vaccines and their administration, without cost sharing. States that elect to cover children under the State plan (indicated in Section 4.1) should check box 6.5.1 States that elect to cover pregnant individuals under the State plan should also check box 6.5.2. States that elect to cover the from-conception-to-end-of-pregnancy population (previously referred to as the "unborn") option under the State plan should also check box 6.5.3.

6.5.1 - ☐ **Vaccine coverage for targeted-low-income children.** The State provides coverage for age-appropriate vaccines and their administration in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), without cost sharing. (Section 2103(c)(1)(D)) (42CFR 457.410(b)(2) and 457.520(b)(4)).

6.5.2 - ☐**Vaccine Coverage for targeted-low-income children.** The State provides coverage for approved adult vaccines recommended by the ACIP, and their administration, without cost sharing. (SHO # 23-003, issued June 27, 2023); (Section 2103(c)(12))

6.5.3 - ☒**Vaccine coverage for from-conception-to-end-of-pregnancy population option.** The state provides coverage for age appropriate (child or adult) vaccines and their administration in accordance with the recommendations of the ACIP, without cost- sharing, to benefit the unborn child.

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality**- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system

performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42 CFR 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42 CFR

457.495(a)) Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

The MaineCare Services has also adopted the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents to assure quality and appropriateness of care regarding screenings and preventive services. The MaineCare Services also uses ACOG/Alliance for Innovation in Maternal Health as a quality standard. MaineCare also utilizes the USPSTF standards as provider requirements in PCPlus. Lastly, MaineCare regularly convenes advisory groups to include community input into service design and model implementation. also

7.1.2. ☒ Performance measurement

MaineCare Services monitors performance of perinatal care within the MaineMOM program. The program measures the number of members who received postpartum visits between 21 and 56 days after the end of pregnancy and the number of people who were prenatally screened for hepatitis C viral infection.

MaineCare Services also reports on well-child visits, Chlamydia screening rates, ER use, birth related outcomes, and contraceptive through the annual core set reporting.

The MaineCare Services also routinely monitors complaints and grievances received from members, provider transfer rates, provider caseload size and 24 hour coverage by primary care providers. Complaints and grievances are monitored for trends and required interventions and/or follow-up.

7.1.2 (a) CHIPRA Quality Core Set

7.1.2 (b) ☐ Other

7.1.3. ☒ Information strategies

Within 30 days of enrollment, each MaineCare and CHIP member is sent a mailing containing the informing letter, as required by EPSDT, and information describing covered services, locating providers, available assistance for scheduling visits and transportation, etc. Member Services will provide the member with requested assistance and will also provide information on statewide resources available for non-covered services. A Resource Guide is maintained and updated regularly and contains

resources available on health and social services in the State, broken down by county.

The "MaineCare listserv" is a listserv providers can sign up for and contains program/clinical information.

When appropriate, follow-up with the member may be provided by Member Services and, if needed, by Public Health Nurses. For example, a member may be provided with assistance locating transportation to the doctor's office for well-child checks or in obtaining follow-up treatment recommended by health care providers.

MaineCare Services also provides member education on inappropriate use of the emergency room. On an ongoing basis, MaineCare Services receives information from hospitals on avoidable emergency room use. MaineCare partners with providers to reach out to members and assist with any barriers to accessing care in an appropriate setting that may exist (such as transportation). For example, members may not be aware that their primary care provider is available 24 hours or the provider may not have been available and intervention is needed with the provider.

7.1.4. ☒ Quality improvement strategies

A primary quality improvement strategy used by MaineCare Services is to review annual metrics submitted to CMS through the child, adult, and health home cores sets. Maine current reports on various contraceptive utilization measures and low birth weight rates. Additionally, through our MaineMOM model for pregnant people with opioid use disorder we will be examining Hepatitis C screenings. Maine stratifies applicable measures demographic markers made allowable by the measure stewards in order to better identify care gaps or areas requiring health equity efforts.

At a broader level there are many quality improvement strategies in place for pregnant people including a focus on the following areas:

- The Maine Perinatal Quality Collaborative (PQC) and a contract with perinatal health outreach educator to improve outcomes for perinatal populations through collaboration on clinical guidelines, quality improvement projects, case review, and educational conference.
- Enhancements to ensure a Plan of Safe Care is established prenatally and according to national best practices.
- Working with Maine hospitals to use a federal assessment tool around appropriate services for hospital levels of care.
- Offers various provider trainings on perinatal care to improve the quality of care for Maine's perinatal populations and at-risk subpopulations.
- Convening various advisory bodies internal to state government and external to state government to advise on perinatal care.

- The establishment of a Maternal, Fetal and Infant Mortality Review Panel to reduce maternal and infant deaths through thoughtful case reviews by a team of experts. Panel will then suggest ways to prevent future deaths and improve the overall health and safety of Maine's infants and mothers.

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42 CFR 457.495)

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42 CFR 457.495(a))
Please see sections 7.1.1-1.1.4.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42 CFR 457.495(b))
Please see sections 7.1.1-1.1.4.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42 CFR 457.495(c))

MaineCare has a number of program requirements and program incentives around primary care which include monitoring access to and utilization of primary care services, incentivizing these visits, and specific provider requirements around coordination of care between primary care and non-primary care providers.

Prior authorization is required for certain MaineCare covered services obtained in-state and all MaineCare covered services provided out-of-state (with the exception of emergency services and services furnished by providers located within 15 miles of the New Hampshire border and 5 miles of Canadian border who are treated as in-state providers). Prior authorization for covered services rendered out-of-state is provided only when a member's continuity of care must be preserved for medical reasons and only after it is determined that the needs of the member cannot be met in the State of Maine.

Another management tool developed and used by the MaineCare Services to monitor and manage MaineCare members with chronic pain is the Pain Management Program. Members receiving 3-5 narcotics from different

prescribers or 6+ different narcotics are invited to voluntarily join the program. Under the program, members are matched with one physician responsible for managing all medication use by the member with patient safety as a primary focus.

Maine includes a maternity model of care for pregnant people with opioid use disorder which requires the care team to use evidence-based practices. The model is a team-based Health Home care model which incorporates care planning to address the comprehensive needs related to the member's health condition.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42 CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

Prior authorization of health services are completed in accordance with MaineCare requirements

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☐ Yes
8.1.2. ☒ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or

groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

8.2.1. ☐ Premiums:

8.2.2. ☐ Deductibles:
Not applicable.

8.2.3. ☐ Coinsurance or copayments:
Not applicable.

8.2.4. ☒ Other: Services to the gestational parent on behalf of the fetus are excluded from cost sharing requirements.

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(A)) (42CFR 457.505(b))

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

8.4. The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☐ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☐ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☐ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.4.1- MHPAEA ☐ There is no separate accumulation of cumulative financial requirements, as defined in §457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits (§457.496(d)(3)(iii)).

8.4.2- MHPAEA ☐ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits (§457.496(d)(3)(ii)(A)).

8.4.3- MHPAEA ☐ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required §457.560 (§457.496(d)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☐ No

Guidance: If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must

determine the proportion of medical and surgical benefits in the class which are subject to the limitation.

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits (§457.496(d)(3)(i)(E)).

Guidance: Please include the state's methodology as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (§457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (§457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in §457.496(d)(3)(i)(B)(1)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (§457.496(d)(3)(i)(E))

☐ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominate level of that type which is applied by the State to medical/surgical benefits within the same classification. (§457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominate level is the least restrictive level of the levels combined to meet the one-half threshold

(§457.496(d)(3)(i)(B)(2)).

8.5. Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

8.6. Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

8.7. Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

8.7.1. Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.1.1. ☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

8.7.1.2. ☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

8.7.1.3. ☐ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

8.7.1.4 ☐ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section

2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42 CFR 457.710(b))

Maine's objective is to reduce the number of uninsured children in the state.

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42 CFR 457.710(c))

In an effort to reduce the number of uninsured children in Maine, our goal is to enroll 94% of eligible children in Medicaid or the CHIP program.

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42 CFR 457.710(d))

The performance measure for this goal is the increase in the percentage of eligible children enrolled in MaineCare. The data to measure this is pulled from the annual American Community Survey (ACS) 1-year estimates.

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☐ The reduction in the percentage of uninsured children.
9.3.3. ☐ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

- **9.3.7.1.** ☐ Immunizations
- **9.3.7.2.** ☐ Well childcare
- **9.3.7.3.** ☐ Adolescent well visits
- **9.3.7.4.** ☐ Satisfaction with care
- **9.3.7.5.** ☐ Mental health
- **9.3.7.6.** ☐ Dental care
- **9.3.7.7.** ☒ Other, list:
  - Live births weighing less than 2500 grams
  - Low-risk caesarean delivery
  - Prenatal and postnatal care: Timeliness of prenatal care

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42 CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. ☒ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42 CFR 457.750)

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review or audit. (Section 2107(b)(3)) (42 CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. ☒ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42 CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42 CFR 457.135)

- **9.8.1.** ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
- **9.8.2.** ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- **9.8.3.** ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
- **9.8.4.** ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42 CFR 457.120(a) and (b))

In 1997, the Maine Legislature passed legislation establishing the Maine Commission on Children's Health Care. The Commission was comprised of state

legislators, medical and legal experts, advocates and consumers. The Commission was charged with considering the problem of uninsured children in Maine and reviewing options to increase the number of children who are insured.

Beginning in October 1997, the Commission solicited input regarding providing coverage for uninsured children through a series of public meetings. In January 1998, the Commission presented its report to the Governor and the Legislature, based on their meetings and public testimony. Resulting State Legislation authorized the MaineCare expansion and implementation of a separate program.

On an on-going basis, the Department receives input from the MaineCare Advisory Committee. The Committee meets monthly to review issues regarding MaineCare eligibility, service delivery, and benefits.

All rules regarding eligibility or benefits are proposed and adopted pursuant to the Maine Administrative Procedures Act, which allows for public input via public hearings or submission of written comments.

9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42 CFR 457.120(c))

Maine intends to solicit advice that meets the requirements of §2107(e) (I) of the Social Security Act. The Department meets with the Indian Health Directors and explains the purpose and intent of the Medicaid Advisory and subcommittees. Then the Indian Health Directors determine which members would best serve the tribal population on the following committees. The Department also does its best to accommodate any special arrangements (i.e., phone calls into meetings) to allow members as much participation as possible. Maine uses the following process for consultation:

- Appointment of a member from each federally recognized tribe to the MaineCare Advisory Committee and subcommittee meetings (including the MaineCare Advisory Subcommittee), meeting monthly,
- Invitation to all Provider Advisory Group and Technical Advisory Group Meetings (meeting monthly),
- Addition of Tribal Health Directors to MaineCare listserv, to which all MaineCare notices are sent,
- Addition of Tribal Health Directors to MaineCare Interested Parties List, to which all proposed and adopted rules are sent,
- Invitation of Tribal Health Directors to any ad hoc meetings to discuss policy development,
- Availability of DHHS staff to Tribal Health Director quarterly meetings,
- Development of a DHHS Tribal Advisory Committee to include all federally recognized tribes,

- Assignment of a MaineCare Provider Relations Specialist to Tribal Health providers to assure claims-specific technical assistance,
- Availability of MaineCare staff as necessary to discuss other MaineCare related concerns.

Plan amendments, waiver requests, and proposals for demonstration projects will be identified as having a direct effect on Indians, Indian Health programs, or urban Indian organizations as part of two-tier consultation. In the first tier Indian Health providers are part of the Department's interested parties list and will receive written notification, listserv updates and any other correspondence that pertains to any change or updates in any area of MaineCare policy. They are also invited as a MaineCare Advisory Committee (MAC) member, to be part of all policy development and to provide feedback to the Department in an advisory capacity.

The second tier is direct consultation (phone conversations, face-to-face meetings, direct email communications) with Tribes when there is any change or update in policy that effect any services that Tribes are reimbursed for through MaineCare. Issues identified as having a direct effect on the Tribes will be raised in monthly meetings or via listserv at least 30 days in advance of submission to CMS. When notice is provided via a listserv, Indian health providers will have up to 30 days to respond with advice to the State. The notices or information provided to the Indian health providers will describe the change and the anticipated effect on Indians or Indian health providers.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

The Department's Office for Family Independence issued proposed rules regarding the increased premiums. The notice of rulemaking was published in 5 daily Maine newspapers on July 14, 2004. No public hearing was scheduled; written comments were accepted through August 13, 2004. During the week of September 27, 2004, the Department sent a letter to all current members who were paying a premium for title XXI funded coverage notifying them of the premium increase. Effective November 1, 2004, the premium increases were implemented as members came up for renewal. At that time, they were notified of the exact amount of their new premium.

The State reviewed this proposed State Plan amendment at a May 13, 2011 Quarterly Tribal Health Directors meeting in Presque Isle, Maine. The Tribal Health Directors recommended that as often as possible for policy changes having a direct effect on tribal members that a face-to-face meeting take place versus other types of communication. Copies of the draft State Plan were also provided at a July 27, 2011 Quarterly Tribal Health Director meeting in Princeton, Maine.

9.9.3. Describe the State's interaction, consultation, and coordination with any Indian tribes and

organizations in the State regarding implementation of the Express Lane eligibility option.

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	2023
State's enhanced FMAP rate	enhanced for duration of PHE 1st and 2nd Quarter: 78.64% 3rd Quarter: 77.80% 4th Quarter: 76.05%
Benefit Costs	
Insurance payments	$0

STATE: ME	FFY Budget
Managed care	$0
per member/per month rate	$2,427,295
Fee for Service	$49,408,123
Total Benefit Costs	**$51,835,418**
(Premiums)	$0
(Rebates)	($3,203,920)
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	**$48,631,498**
Administration Costs	
Personnel	$27,501
General administration	$1,216,442
Contractors/Brokers	$196,366
Claims Processing	
Outreach/marketing costs	$35,232
Health Services Initiatives	$1,184,000
Other	$0
Total Administration Costs	**$2,659,541**
10% Administrative Cap	$5,403,500
Cost of Proposed SPA Changes	$428,108
Federal Share	$40,227,153
State Share	$11,491,994
Total Costs of Approved CHIP Plan	**$51,719,147**

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:

Activity	State Share	Federal Share	Total
Media Buys (e.g social media ads, banner ads, etc.)	$42,160	$157,840	$200,000

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:

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 Months Post-partum:

Activity	State Share	Federal Share	Total
Coverage 12 Months post Partum			

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. **Annual Reports.** The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42 CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The State assures it will comply with future reporting requirements as they are developed. (42 CFR 457.710(e))

10.3. ☒ The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC ☒ The State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

Section 11. Program Integrity (Section 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. ☒ 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. (Section 2101(a)) (42 CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42 CFR 457.935(b)) (The items below were moved from section 9.8. Previously 9.8.6. - 9.8.9.)

- **11.2.1.** ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- **11.2.2.** ☒ Section 1124 (relating to disclosure of ownership and related information)
- **11.2.3.** ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- **11.2.4.** ☒ Section 1128A (relating to civil monetary penalties)
- **11.2.5.** ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- **11.2.6.** ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and Enrollee Protections (Sections 2101(a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. **Eligibility and Enrollment Matters-** Describe the review process for eligibility and

enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.
Members enrolled in separate CHIP coverage under the unborn option are reviewed for other coverage at the end of their eligibility period/when the pregnancy ends. If no other Medicaid/CHIP eligibility coverage is available based on the information known to the agency, a prepopulated renewal form is issued. The member has at least 30 days to respond to the renewal to see if coverage can continue. The Medicaid fair hearing process is also used for applicant eligibility denials.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. **Health Services Matters-** Describe the review process for health services matters that complies with 42 CFR 457.1120.

The review process for CHIP eligibility and enrollment matters is identical to the Medicaid review process, including the hearing process.

12.3. **Premium Assistance Programs-** If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.
N/A

Key for Newly Incorporated Templates

The newly incorporated templates are indicated with the following letters after the numerical section throughout the template.

- PC- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- PW- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- TC- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- DC- Dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- DS- Supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- PA- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- EL- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- LR- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

CMS Regional Offices				
CMS Regional Offices	**States**		**Associate Regional Administrator**	**Regional Office Address**
Region 1-Boston	Connecticut Massachusetts Maine	New Hampshire Rhode Island Vermont	Richard R. McGreal richard.mcgreal@cms.hhs.gov	John F. Kennedy Federal Bldg. Room 2275 Boston, MA 02203-0003
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Region 3-Philadelphia	Delaware District of Columbia Maryland	Pennsylvania Virginia West Virginia	Ted Gallagher ted.gallagher@cms.hhs.gov	The Public Ledger Building 150 South Independence Mall West Suite 216 Philadelphia, PA 19106
Region 4-Atlanta	Alabama Florida Georgia Kentucky	Mississippi North Carolina South Carolina Tennessee	Jackie Glaze jackie.glaze@cms.hhs.gov	Atlanta Federal Center 4th Floor 61 Forsyth Street, S.W. Suite 4T20 Atlanta, GA 30303-8909
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Region 10-Seattle	Idaho Washington	Alaska Oregon	Carol Peverly carol.peverly@cms.hhs.gov	2001 Sixth Avenue MS RX-43 Seattle, WA 98121

GLOSSARY

Adapted directly from Sec. 2110. DEFINITIONS.

CHILD HEALTH ASSISTANCE- For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in Section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

1. Inpatient hospital services.
2. Outpatient hospital services.
3. Physician services.
4. Surgical services.
5. Clinic services (including health center services) and other ambulatory health care services.
6. Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
7. Over-the-counter medications.
8. Laboratory and radiological services.
9. Prenatal care and prepregnancy family planning services and supplies.
10. Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
11. Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.
12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).
13. Disposable medical supplies.
14. Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).
15. Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.
16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.
17. Dental services.
18. Inpatient substance abuse treatment services and residential substance abuse treatment services.
19. Outpatient substance abuse treatment services.
20. Case management services.
21. Care coordination services.
22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
23. Hospice care.
24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is--

a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,
b. performed under the general supervision or at the direction of a physician, or
c. furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

25. Premiums for private health care insurance coverage.
26. Medical transportation.
27. Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
28. Any other health care services or items specified by the Secretary and not excluded under this section.

TARGETED LOW-INCOME CHILD DEFINED- For purposes of this title--

1. IN GENERAL- Subject to paragraph (2), the term 'targeted low-income child' means a child--
   a. who has been determined eligible by the State for child health assistance under the State plan;
   b. (i) who is a low-income child, or
   (ii) is a child whose family income (as determined under the State child health plan) exceeds the Medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the Medicaid applicable income level; and
   c. who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in Section 2791 of the Public Health Service Act).
2. CHILDREN EXCLUDED- Such term does not include--
   a. a child who is a resident of a public institution or a patient in an institution for mental diseases; or
   b. a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.
3. SPECIAL RULE- A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.
4. MEDICAID APPLICABLE INCOME LEVEL- The term 'Medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under Section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under Section 1902(l)(2) for the age of such child.
5. TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means an individual— (A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends; (B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (b)(1)(A)) of the poverty line applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and (C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of Section 2110(b) in the

same manner as a child applying for child health assistance would have to satisfy such requirements.

ADDITIONAL DEFINITIONS- For purposes of this title:

1. CHILD- The term ‘child’ means an individual under 19 years of age.
2. CREDITABLE HEALTH COVERAGE- The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).
3. GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC- The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings given such terms in Section 2191 of the Public Health Service Act.
4. LOW-INCOME CHILD - The term ‘low-income child’ means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.
5. POVERTY LINE DEFINED- The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.
6. PREEXISTING CONDITION EXCLUSION- The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).
7. STATE CHILD HEALTH PLAN; PLAN- Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under Section 2106.
8. UNINSURED CHILD- The term ‘uninsured child’ means a child that does not have creditable health coverage.