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State/Territory Name: Maine

State Plan Amendment (SPA) #: ME-20-0006 and ME-20-0006-B

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) SPA Summary Form
- 3) Approved SPA Pages



Children and Adults Health Programs Group

April 8, 2020

Thomas M. Leet, JD
Director, Policy, Children's, and Waiver Services
Maine Department of Health and Human Services
Division of MaineCare Policy
109 Capitol Street
Augusta, ME 04333

Dear Mr. Leet:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendments (SPAs) ME-20-0006 and ME-20-0006-B, submitted on March 31, 2020, have been approved. ME-20-0006 updates the CS21 SPA to provide temporary adjustments to the state's premium lock-out period in response to disaster events. ME-20-0006-B provides temporary adjustments to the state's cost-sharing requirements, application and redetermination policies, verification requirements, and tribal consultation process in response to disaster events. These amendments have an effective date of March 1, 2020.

These amendments, as they apply to the COVID-19 public health emergency, make the following changes effective March 1, 2020 through the duration of the federal or state emergency declaration, whichever is longer:

- Waive requirements related to timely processing of applications and renewals;
- Delay processing of renewals and extend deadlines for families to respond to renewal requests;
- Waive collection of premiums and suspend the premium lock-out policy;
- Allow self-attestation of all eligibility criteria at application and renewal, except citizenship and immigration status, and
- Conduct tribal consultation following SPA submission, as permitted under section 1135 of the Social Security Act.

In the event of a future disaster, these SPAs provide Maine with the authority to implement the aforementioned temporary policy adjustments by simply notifying CMS of its intent, the effective date and duration of the provision, and a list of Governor or federally-declared disaster areas that are applicable. While the state must provide notice to CMS, this option provides an administratively streamlined pathway for the state to effectively respond to an evolving disaster event.

Your title XXI project officer is Tess Hines. She is available to answer questions concerning this amendment and other CHIP-related issues. Her contact information is as follows:

Page 2 – Mr. Thomas Leet

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-0435
E-mail: mary.hines@cms.hhs.gov

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

Sincerely,

Amy Lutzky
Acting Deputy Director

Control Panel

General Information

File Management

Tribal Input

Summary

Children's Health Insurance Program Eligibility: Summary Page

State/Territory name: Maine

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

ME-20-0008

Type of SPA:

- MAGI Eligibility & Methods
- XXI Medicaid Expansion
- Establish 2101(f) Group
- Eligibility Processing
- Non-Financial Eligibility

Proposed Effective Date

03/01/2020 (mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR 457.570

Federal Budget Impact

- This SPA has a budget impact.
- Total budget impact:

State Funds: \$

Federal Funds: \$

Subject of Amendment

Please provide a brief summary of SPA changes.

Character Count: 142 out of 2000

Waives the premium lock-out period for children currently locked out of coverage (without requiring premium payments) during disaster periods.

Signature of State Agency Official

Submitted By: Lea Studholme

Last Revision Date: Mar 31, 2020

Submit Date: Mar 31, 2020

BACK

CONTINUE



CHIP Eligibility

State Name:

OMB Control Number: 0938-1148

Transmittal Number: ME - 20 - 0006

Separate Child Health Insurance Program CS21 Non-Financial Eligibility - Non-Payment of Premiums

42 CFR 457.570

Non-Payment of Premiums

Does the state impose premiums or enrollment fees?

Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility?

Does the state have a premium lock out period?

Please describe the lock-out period:

Premiums are due on the first day of every month. Children are enrolled in CHIP for a full 12 month enrollment period with no interruption in coverage regardless of whether the family is current on their child's premium payment(s). Prior to the subsequent enrollment period, families are informed that unpaid premiums from the previous enrollment period that have not been received by the state must be paid, and that if the state does not receive these payments, the child will be subject to a period of ineligibility. The period of ineligibility will be lifted immediately after payment has been received by the agency. Regardless of whether payment has been received in full by the state for past due premiums, the ineligibility period will not exceed 90 days.

What is the length of the time premium lock-out period?

Select a length of time:

- One month
- Two months
- 90 days
- Other (not to exceed 90 days)

Are there exceptions to the required lock-out period?

- Individual's income decreased to a level where no premium is required or within Medicaid standards
- Other financial hardship
- Other

Add	Describe	Remove
Add	Mail delay	Remove
Add	Illness of child's responsible relative	Remove
Add	Unanticipated emergency beyond the control of the responsible relative	Remove



CHIP Eligibility

Add	At State discretion, the premium lock-out policy is temporarily suspended and coverage is available regardless of whether the family has paid their outstanding premium for existing beneficiaries who reside and/or work in a State or Federally declared disaster area.	Remove
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The state assures that:

It does not require the collection of past due premiums or enrollment fees as a condition of eligibility for enrollment once the lock-out period has expired; and

It provides enrollees with an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130(a)(3); and

The child will be reenrolled in CHIP during the lock-out period upon payment of past due premiums or enrollment fees.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119

TEMPLATE FOR 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: <u>Lora Marchand</u>	Position/Title: <u>Director of Policy</u>
Name: <u>David Jorgenson</u>	Position/Title: <u>Director of Data Analytics</u>
Name: <u>Lea Studholme</u>	Position/Title: <u>Senior MaineCare Program Manager</u>
Name: <u>Kristin Merrill</u>	Position/Title: <u>State Plan Manager</u>

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.

SPA: ME-20-0006 and ME-20-0006-B Approval Date: April 8, 2020 Effective Date: March 1, 2020

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:

- **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.

- **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)

- **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

Amendment #8
ME-15-0012

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 Title XXI and Title XIX funded coverage.

Date Submitted: June 29, 2015

Date Effective: July 1, 2014

Amendment #9
ME-15-0015

Removed named vendors from the body of the CHIP State Plan.

Date Submitted: September 4, 2015

Date Effective: July 1, 2015

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
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-18.0014-CHIP Purpose of SPA: MHPAEA
Date submitted: 7/2/2018

Proposed effective date: 7/1/2018

Proposed implementation date: 10/2/2017

Amendment #10

ME-17-003

Date Submitted: 12/5/2017

Date Effective: 1/1/2017

SPA #: ME-20-0006-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.

SPA# ME-20-0006 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**

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.

To address the COVID-19 public health emergency, the State seeks a waiver under section 1135 of the Act to modify the tribal consultation process by conducting consultation after submission of the SPA.

TN No: Approval Date Effective Date

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

SPA: ME-20-0006 and ME-20-0006-B Approval Date: April 8, 2020 Effective Date: March 1, 2020

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:

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. Include whether or not State has opted to use SSA verification option. The State has opted to use the SSA verification option. In the case of non-citizens, the State uses SAVE verification through DHS

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: Individuals must be under 19 years of age

4.1.2.1-PC Age: through birth (SHO #02-004, issued November 12, 2002)

4.1.3 Income of each separate eligibility group (if applicable): The upper income limit for Title XXX is 200% 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): To be eligible for MaineCare, a child must be a resident of the State of Maine

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: Children must be uninsured to be eligible for Title XXI funded coverage. Children who are eligible for Medicaid expansion coverage funded by

Title XXI may not have other health coverage; children with other coverage eligible for Medicaid will be funded by Title XIX.

4.1.8 Duration of eligibility, not to exceed 12 months:

In general, a child who has been determined eligible for MaineCare shall remain eligible for 12 months unless the child attains the age of 19 or is no longer a resident of the State. Eligibility is redetermined prior to the end of each twelve-month period. A child may be ineligible for a subsequent 12-month period of eligibility for a specified length of time) as described in section 8.7) for nonpayment of premiums.

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.

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.

All applicants are asked for their SSN. It is required except for undocumented non-citizens or a child born to a mother on Medicaid at time of birth. For these “golden babies,” applications for SSN or SSN must be provided by the child’s first birthday. A child born to a mother not receiving Medicaid at time of birth must have SSN requirements met by first day of the second month following month in which the mother is discharged from the hospital. Cub Care applicants who receive either SS or SSDI, or Medicare, do not need to provide their SSN.

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

4.1.9.2 Continuous eligibility

We provide continuous eligibility for CHIP. A child who has been determined eligible shall remain eligible for 12 months unless the child attains the age of 19 or is no longer a resident of the State.

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 woman 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 19

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)

All administrative processes are designed by the Department of Health and Human Services to be seamless for children applying for MaineCare. As such, all enrollment and eligibility processes are the same for Title XIX and Title XXI, with the only discernable difference being premium billing for those Title XXI children at 158% through 208% FPL.

There is one application and renewal form for families and children who want to apply for MaineCare coverage. The Department of Health and Human Services, Office for Family Independence eligibility specialists determine if applicants are eligible for Title

XIX or XXI coverage depending on family income.

Eligibility applications may be completed at any of the Department's regional offices, [online](#), or at home and returned by mail/fax. No interview is necessary.

The Office for Family Independence notifies families of their eligibility by mail. Those eligible Title XXI children at 158% through 208% FPL are, in addition to their enrollment cards, mailed monthly premium bills (please see Section 8.2).

A child who has been determined eligible for MaineCare remains eligible for a 12 month enrollment period unless the child attains the age of 19 or is no longer a resident of the State. Eligibility is redetermined prior to the end of each 12 month period. Written notification is sent to each family by the Office for Family Independence containing the end date of the child's 12-month enrollment period and a renewal form to be [completed online](#) or returned by mail upon completion.

In summary, MaineCare policy requires eligibility specialists to review all applications, denials, closings, changes in MaineCare Title XIX funded coverage for Title XXI funded coverage and vice versa.

Families are allowed to purchase coverage for a child whose family income at the end of the 12-month enrollment period exceeds 208% of FPL. The purchase of coverage is available for 18 months. The child's family is responsible for paying the full cost of the coverage, which covers the benefit cost plus an administrative cost not to exceed the maximum allowable under COBRA.

[CHIP Disaster Relief:](#)

[At State discretion, the following may be temporarily waived for CHIP applicants and beneficiaries who reside and/or work in a State or Federally declared disaster area:](#)

- [requirements related to timely processing of applications;](#)
- [requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests; and](#)
- [eligibility verification requirements at application and renewal – the State may allow self-attestation to complete the eligibility determination](#)

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.

The State of Maine Does not cover pregnant women through CHIP.

As noted in Section 4.3, the same application and enrollment process is used by all families applying for coverage under MaineCare. A child applying for

coverage under MaineCare is first screened by the Office for Family Independence eligibility specialists for eligibility under Title XIX. Those children deemed ineligible under Title XIX are then screened for eligibility under Title XXI.

Applicants are asked to provide insurance information a part of the application process. Specific questions on the application ask about children in the household who: (1) currently have insurance; (2) have lost health insurance in the last 3 months; and (3) could be added to the State employee health insurance plan. Depending on the answer to these questions, the Office for Family Independence specialists will determine if an applicant is eligible for Title XXI funded coverage. Children made eligible under Title XIX may have other health insurance coverage.

The same process is followed for subsequent eligibility determinations.

- 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))
Please see 4.4.1 above
- 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))
Please see 4.4.1 above
- 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)
- 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))
Coverage is provided to children in families at or below 208% FPL. Applicants are asked to provide insurance information as part of the application process. Specific questions on the application ask about children in the household who: (1) currently have insurance; and (2) have lost health insurance in the last 3 months;. There is a 3 month waiting period for children who drop employer based coverage- with the exception of state employees who were provided a one year waiver of this requirement, beginning at the date of SPA approval for allowing state employees to enroll.

The child may enroll without having to wait 3 months if:

- The employer plan does not pay at least 50% of the cost of the child's coverage;
- The cost of covering the whole family under the employer's plan is more than 10% of the family income;
- The Department determines that good cause exists for dropping the employer based coverage.

In addition, eligibility records are matched against third party liability records to cross check to see if the third party liability records indicate that other insurance is available. A list of members whose eligibility is determined through Title XXI identified as having insurance is sent to the Office for Family Independence eligibility specialists to review

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 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))

CHIP Disaster Relief:

At State discretion, premiums may be temporarily waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

- 8.2.1. Premiums:
Below 158% FPL – no premium;
158% to 166% FPL – premiums are \$8 per month for the first child and \$16 per month for 2 or more children;
167% to 177% FPL- premiums are \$16 per month for the first child and \$32 per month for 2 or more children;
178% to 192% FPL- premiums are \$24 per month for the first child and \$48 per month for 2 or more children;
193% to 208% FPL- premiums are \$32 per month for the first child and \$64 per month for 2 or more children;

CHIP Disaster Relief:

At State discretion, non-payment of premiums may be temporarily forgiven/waived for CHIP applicants and/or existing beneficiaries who reside and/or work in a State or Federally declared disaster area.

- 8.2.2. Deductibles:
Not applicable.

- 8.2.3. Coinsurance or copayments:
Not applicable.

- 8.2.4. Other:

- 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))

As shown in the following table, the premium is never higher than the equivalent of .9% of family income for those at the lowest end of the FPL range.

Premium as a % of Benefit Cost*		Monthly Premium Cost		Minimum Monthly Income**		Premium as a % of Minimum Income***		
No. of Children	1	2	1	2	1	2	1	2
FPL:								
158% - 166%	5%	10%	\$8	\$16	\$1550	\$2098	0.6%	0.9%
167% - 177%	10%	20%	\$16	\$32	\$1638	\$2218	1.1%	1.6%
178% - 192%	15%	30%	\$24	\$48	\$1746	\$2364	1.6 %	2.3%

193% - 208%	20%	40%	\$32	\$64	\$1893	\$2563	1.9%	2.8%
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* Based on an estimate annual benefit cost of \$1920 per child or \$160 monthly

** Minimum monthly income corresponds to 158% (for 158% - 166%), 167% (for 167% - 177%), 178% (for 178% - 192%) and 193% (for 193% - 208%) of 2015 FPL

*** The premiums as a % of minimum income will change (lower) when we adjust for the annual FPL increase.

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)
 As noted in Section 4.4.5, 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. On the application form, there is a specific question that asks applicants whether they are American Indian or Alaskan Native and informs them that American Indians and Alaskan Native don't have to pay premiums. If an applicant checks this box and is enrolled in MaineCare, the Department does not generate premium coupons for the member.

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))
 Premiums must be paid at the beginning of each month for coverage for that month. When a premium is not paid at the beginning of a month, DHS shall give notice of nonpayment at that time. At the beginning of the 12th month of the 12 month enrollment period, notification will be given if any premiums for the enrollment period have not been paid when due.

There is a grace period for non-payment of premiums. For the first through 11th month of the 12 month enrollment period, the grace period extends through the last day of the 12 month enrollment period. The grace period for payment of the premium due in the 12th month is the 15th of the next month.

There is a month of ineligibility for each month a premium was due, coverage was received, and a premium was not paid. The maximum period of ineligibility is 3 months. The penalty starts in the first month following the end of the enrollment period in which the premium was due. For example, if no premiums are paid for the 12 month enrollment period of January 2002 – December 2002, the child is not eligible for coverage for the months of January – March 2003.

CHIP Disaster Plan:

At State discretion, families may temporarily be given additional time to pay their premiums or the State may waive the lockout period caused by unpaid premiums, for existing beneficiaries who reside and/or work in a State of Federally declared

disaster area.

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)