MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides 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. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Effective Date: Approval Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE 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 State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State 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: Christine Zukas-Lessard	Position/Title: Deputy Director, Bureau of Medical Services
Name: Robert Boschen	Position/Title: Director, Division of Financial & Reimbursement Services
Name: Patricia Dushuttle	Position/Title: SCHIP Coordinator

Section 1 General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

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

1.1.3. ☒ A combination of both of the above.
MaineCare is the umbrella term in use in the State of Maine to collectively refer to all benefits provided under previously separate program names such as Medicaid, SCHIP, CubCare, etc.. The name change (a Legislative mandate) is administrative in nature and represents no change in benefits or rights of beneficiaries.

MaineCare, with Title XIX funding, provides coverage to children from birth to 12 months of age in families with income through 185% of the federal poverty level (FPL), children ages 1 through 5 in families with income through 133% FPL, and children ages 6 through 18 in families with income through 125% FPL. With Title XXI funding, (under MaineCare expansion), MaineCare provides coverage to children ages 1 through 18 in families with income from 133%/125% through 150% of the FPL; and under a separate child health program (formerly "CubCare") provides coverage to children from birth to 12 months of age in families with income from 186% through 200% of the FPL, and to children ages 1 through 18 in families with income from 151% through 200% of FPL.

1.2 ☒ Please 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 ☒ Please 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)

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

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 Approved	September 22, 2005
Date Effective:	January 1, 2005

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

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

Currently, no public-private partnerships exist in Maine.

Between October-December 2002, the University of Southern Maine, Muskie School of Public Service conducted a random survey of Maine residents to estimate the numbers of individuals without health insurance or with inadequate insurance. At the time of the survey, about 60% of children had employer based coverage and 5% had coverage through individually purchased health plans. About 28% had public coverage (primarily MaineCare) and about 8% were uninsured.

According to the 2001-2003 Current Population Survey, uninsured children under age 19 below 200% of poverty as a percent of total children under age 19 is 3.6%.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

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

Please see Section 5 for a description of outreach efforts.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

No public-private partnerships currently exist in Maine.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and 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. (Previously 4.4.5.) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

There are no public programs in the state, except MaineCare, that provide health care coverage for low-income children. The coordination of MaineCare with public health programs is accomplished through two major venues. The coordinator of SCHIP within the Bureau of Medical Services is an active participant on two major committees whose focus is the promotion of access to health care. The first, MaineCare Benefits for Members Under 21 Committee, meets periodically and is comprised of staff from the Bureau of Medical Services and Bureau of Health child-related programs such as: WIC, Public Health Nursing, Oral Health, and the Teen and Young Adult Health. The purpose of the group is to coordinate outreach and planning activities for promoting access to services across all programs. The second group, the Managed Care Implementation Task Force, is comprised of staff from the Bureau of Medical Services, Bureau of Family Independence, Bureau of Health and various advocacy groups within the State. The primary focus of the task force is on implementation of MaineCare managed care as well as other service delivery issues.

The SCHIP coordinator is also a participant on the Steering Committee and Statewide Coalition for the Robert Wood Johnson Covering Kids and Families Outreach Campaign. The Covering Kids and Families grantee in Maine is the Maine Primary Care Association and its partner agencies, Maine Equal Justice Partners, and Consumers for Affordable Health Care. The Steering Committee meets 6-8 times per year and provides overall direction to the Covering Kids and Families Outreach Campaign. The Statewide Coalition meets 3 times a year. The Coalition meetings are an opportunity for Coalition members to alert other members as to events taking place within the State, for local groups to apprise the group on activities occurring in their particular areas and for the group to discuss recommendations for future activities.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ 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.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and 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) (42CFR 457.490(a))

MaineCare, both Title XIX and Title XXI funded coverage, is administered by the Maine Department of Health and Human Services. Within the Department, the Bureau of Medical Services is responsible for establishing policy regarding benefits, quality assurance, and claims payment. The Bureau of Family Independence is responsible for determining eligibility.

Children covered under MaineCare with Title XXI funding are provided with the same rights and benefits available to children enrolled with Title XIX funding. All administrative processes are designed by the Department of Health and Human Services to be seamless. As such, all enrollment and eligibility processes, benefit package/benefit delivery policies, and outreach activities are the same for Title XIX and Title XXI, with the only discernable difference being premium billing for those Title XXI children at 151% through 200% FPL.

There are 3 delivery systems.

(1) The MaineCare primary care case management initiative is operational in all 16 counties. With few exceptions, the majority of MaineCare children covered under Title XXI funding access services through primary care case management.

(2) The MaineCare DirigoChoice initiative is operational in all 16 counties. MaineCare members may voluntarily enroll in DirigoChoice if they work for a DirigoChoice eligible business that offers the DirigoChoice plan to its employees and they meet the requirements of an eligible employee. MaineCare members who are dependents of DirigoChoice members may also enroll in DirigoChoice. DirigoChoice meets the conditions necessary to contract as a managed care entity as described in CFR 457.955.

(3) MaineCare members not participating in primary care case management or the DirigoChoice initiative can access services through the fee for service system.

In addition, pursuant to Section 2105(a)(1)(D), the Department will offer "health services initiatives" directed at children and adolescents age 18 or younger. The health services initiatives will be activities sponsored by the Department's Bureau of Health and do not overlap with MaineCare school based health services.

Specific health services initiatives include the following:

- grants to providers to promote health education in primary and secondary school through "school health coordinators" where the school health coordinators implement a coordinated school health program that incorporates the Center for Disease Control/Division of Adolescent and School Health (CDC/DASH) guidelines for tobacco use, physical activity, and healthy eating;
- grants to schools to build or expand capacity at school based health centers where the school based health centers provide support for their public health functions: educating future adult health care consumers on healthy behaviors and on the use of health care;
- 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; and
- grants to a contractor to develop media campaigns to promote tobacco prevention among children and youth where the contractor develops a statewide marketing campaign for the Partnership for a Tobacco-Free Maine which has a targeted audience of children and youth.

The school health coordinator initiative will serve approximately 5,000 individuals and the adolescent family planning initiative will serve approximately 7,500 individuals.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. 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) (42CFR 457.490(b))

The utilization controls are the same for all MaineCare members regardless of the source of funds. The following utilization controls are in use:

1. Primary Care Providers – Under the primary care case management initiative, each MaineCare member has a Primary Care Provider who is responsible for managing (treating or referring out for treatment) the member's health care. MaineCare members must receive authorization

from their Primary Care Provider for those covered MaineCare services designated as 'managed services'. For those MaineCare covered services that do not require PCP authorization members may self-refer or seek prior authorization, as is noted below.

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 Bureau of Medical Services. 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. Member Restriction – Member restriction is an administrative procedure established for MaineCare members with a history of over utilization of benefits. 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.

5. Utilization Report/Primary Care Physician Incentive Payment Report – Member utilization is also measured through preventive/quality indicators presented in the Utilization Report and Primary Care Physician Incentive Payment Report which are provided to MaineCare primary care providers at least twice a year. The Utilization Report contains 22 performance measures centered on well-child care, utilization of emergency services, potentially avoidable hospitalizations for chronic/serious medical conditions, and other disease prevention

measures. The Primary Care Physician Incentive Payment Report contains additional performance measures focused on preventive indicators. (These reports are described in more detail in Section 7.)

6. DirigoChoice -The contract between the DHHS and Anthem Blue Cross Blue Shield establishes utilization/quality assurance requirements in compliance with CFR 438 for MaineCare members enrolled in DirigoChoice.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ 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 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1. ☒ Geographic area served by the Plan: Statewide

4.1.2. ☒ Age: Individuals must be under 19 years of age.

4.1.3. ☒ Income: The upper income limit for Title XXI is 200% FPL.

4.1.4. ☐ Resources (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.

4.1.8. ☒ Duration of eligibility: 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):

The Bureau of Family Independence MaineCare Eligibility Manual sets forth the eligibility policies for Titles XIX and XXI. Sections 1230 and 9000.02 of the Manual clearly state that

Social Security numbers are not required for children applying for Title XIX and XXI coverage.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 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.

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

4.3. Describe the methods of establishing eligibility and continuing enrollment. (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 151% through 200% 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, Bureau of 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 or at home and returned by mail. No interview is necessary.

The Bureau of Family Independence notifies families of their eligibility by mail. Those eligible Title XXI children at 151% through 200% 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 Bureau of Family Independence containing the end date of the child's 12-month enrollment period and a renewal form to be 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 200% 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.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

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

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.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

(42CFR 457.350(a)(1) and 457.80(c)(3))
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 Bureau of 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 as 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, Bureau of Family Independence eligibility specialists will determine if an applicant is eligible for Title XXI funded coverage.

This same process is followed for subsequent eligibility determinations.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

Please see Section 4.4.1 above.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Please see Section 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. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

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; (2) have lost health insurance in the last 3 months; and (3) could be added to the State

employee health insurance plan. There is a 3 month waiting period for children who drop employer based coverage. 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 Title XXI funded members identified as having insurance is sent to Bureau of Family Independence eligibility specialists to review.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

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.

Section 5. Outreach (Section 2102(c))

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)) (42CFR 457.90)

On an ongoing basis, the Bureau of Medical Services works collaboratively with the Robert Wood Johnson initiative, Covering Kids and Families Campaign to conduct outreach to families. The Campaign's outreach efforts and goals include:

1. 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.

2. Mass media interventions through annual statewide/local media events. Three events are held each year to highlight availability of health care coverage. Events often coincide with national campaigns, such as Cover the Uninsured Week.

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

4. Distribution of electronic newsletter to interested parties. The newsletter contains information on MaineCare and other health care coverage programs (e.g. DirigoChoice) as well as the overall efforts of the campaign.

5. General training for community organizations such as the Kiwanis, Elks, Lions Clubs, etc. General trainings also provided to statewide organizations such as the Association of Health Care Administrators – Maine, General Assistance Administrators, WIC Directors.

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

7. Grass roots outreach by local coalitions such as attendance at local kindergarten registration events; local promotional events (e.g., providing application assistance booth during school carnival).

The Campaign'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 the Campaign has 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 Campaign 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 (Section 2103)

☐ 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 7.

6.1 The state elects to provide the following forms of coverage to children: (Check all that apply.) (42CFR 457.410(a))

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

- 6.1.1.1 ☐ FEHBP-equivalent coverage; (Section 2103(b)(1)) (If checked, attach copy of the plan.)
- 6.1.1.2 ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
- 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.)

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. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. See instructions.

6.1.3 ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

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

- 6.1.4.1 ☒ Coverage the same as Medicaid State plan
- 6.1.4.2 ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- 6.1.4.3 ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire

Medicaid population

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

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 (Please provide a sample of how the comparison will be done)

6.1.4.7 ☐ Other (Describe)

6.2 The state elects to provide the following forms of coverage to children: (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))

Transplants as specified in the MaineCare Benefits Manual, Chapter II, Section 90, Physician Services.

Cosmetic surgery not covered.

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))

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

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

As specified in the MaineCare Benefits Manual, Chapter II, Section 80, Pharmacy

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 ☒ Inpatient mental health services, other than services described in 6.2.18, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

Certain limits and prior authorization requirements apply.

6.2.11 ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

Certain limits and prior authorization requirements apply.

6.2.12 ☒ 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))

Prescribed equipment must be medically necessary.

Prior authorization required for certain items.

6.2.13 ☒ Disposable medical supplies (Section 2110(a)(13))

Prescribed medical supplies must be needed to relieve or control a medical condition.

6.2.14 ☒ Home and community-based health care services (See instructions) (Section 2110(a)(14))

Home health and personal care services will be provided, including part-time or intermittent nursing service provided by a home health agency, home health aid services, physical therapy, occupational therapy or speech-language pathology services, and environmental modifications to the home. Maine has 3 section 1915(c) waiver for the provision of home and community based services where appropriate as an alternative to institutionalization.

6.2.15 ☒ Nursing care services (See instructions) (Section 2110(a)(15))

Includes Nurse Practitioners, Nurse Midwives, Certified Clinical

Nurse Specialists and Certified Registered Nurse Anesthetists.

6.2.16 ☒ 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 (Section 2110(a)(16)

6.2.17 ☒ Dental services (Section 2110(a)(17))

Prior authorization is required for orthodontia and certain other services.

6.2.18 ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

Certain limits and prior authorization requirements apply.

6.2.19 ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))

Certain limits and prior authorization requirements apply.

6.2.20 ☒ Case management services (Section 2110(a)(20))

6.2.21 ☐ Care coordination services (Section 2110(a)(21))

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

6.2.23 ☒ Hospice care (Section 2110(a)(23))

6.2.24 ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (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.

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

6.2.26 ☒ Medical transportation (Section 2110(a)(26))

All transportation to medically necessary services covered by MaineCare is available without prior authorization. Out of state transportation requires prior authorization. Also, travel expenses associated with transportation, such as lodging or meals require prior authorization.

6.2.27 ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))

Interpreter services are covered for non-English, limited English speaking and /or deaf/hard of hearing individuals.

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

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

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 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 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

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% 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)) (42CFR 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)) (42CFR 457.1005(b))

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)) (42CFR 457.1005(a))

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)) (42CFR 457.1010)

6.4.2.1 Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

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)) (42CFR 457.1010(b))

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

Section 7 Quality and Appropriateness of Care

☐ 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.

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. (2102(a)(7)(A)) (42CFR 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

Performance measurements developed by the Bureau as part of Utilization Reporting and the Primary Care Physician Incentive Payment program (discussed in detail Section 7.1.2) were modeled on both national (NCQA) standards and standards developed specifically for the State of Maine.

The Bureau of Medical Services has also adopted the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents to assure quality and appropriateness of care with respect to well-baby care, well-child and adolescent care (through age 21) and administration of age appropriate immunizations. The Bureau has developed and distributed a Bright Futures forms that contain age appropriate periodicity schedules for well-child checks and immunizations to providers. These 19 age appropriate forms serve many purposes including, but not limited to:

- Serves as reminder for primary care providers on age appropriate screening services;
- May serve as the provider's medical record, provided it is complete;
- Provides MaineCare with information about needed follow-up services that can be provided by MaineCare Member Services.

(Use of these forms is discussed in more detail in Section 7.1.4.)

Additionally, the Bureau has also formed a committee (MaineCare Immunization Sub-Committee) whose charge is to monitor the rate of immunizations for all MaineCare children and to determine appropriate interventions for increasing the rate of immunizations. The committee is comprised of staff from MaineCare Member Services and

representatives from the Bureau of Health Immunization Program and WIC Program. On an annual basis, staff from the Bureau of Health conduct medical record reviews on a sampling of children enrolled in MaineCare to assess immunization rates and report to the CMS GPRA project director on MaineCare's immunization rate for children from birth to age 2. Information from the sampling is combined with the claims data to create a hybrid rate and determine appropriate interventions, e.g., public service announcements and other forms of advertising stressing the importance of immunizations for all appropriate age groups.

Another group, the Benefits for Members Under 21 Committee, meets periodically and is comprised of staff from the Bureau of Medical Services and Bureau of Health child-related programs such as: WIC, Public Health Nursing, Oral Health, and the Teen and Young Adult Health. The purpose of the group is to coordinate outreach and planning activities for promoting access to services across all programs.

7.1.2 ☒ Performance measurement

The Bureau uses two primary means of monitoring and providing feedback to providers regarding performance: a Utilization Report and the Primary Care Physician Incentive Payment report. The Utilization Report is distributed to primary care physicians at least twice a year and contains 22 performance measures centered on well-child care, utilization of emergency services, potentially avoidable hospitalizations for chronic/serious medical conditions, and other disease prevention measures. The report, broken down by specialty, presents a comparison of each primary care physician against other statewide providers across all performance measures. The Primary Care Physician Incentive Payment report contains additional performance measures focused on preventive indicators and is used for purposes of provider education and determining incentive payments.

The Bureau has also developed an incentive program designed to improve health outcomes through management of drug utilization. The Physician Directed Drug Initiative provides incentive payments to providers based on measures of peer performance for certain relevant desired drug outcomes/medical conditions (e.g., increase in percentage of CAHF patients on ACEI); peer performance for medical outcomes related to these medical conditions (e.g., maintain/reduce hospital/ER visits for CAHF patients); and peer performance for medical outcomes across all medical conditions aggregated together (e.g., total hospitalization rates, length of stay, readmission rates/ER rates).

Additionally, in 2001, the Bureau conducted a two-part survey, "Your Voice Counts", to assess the quality of care for low-income children enrolled in MaineCare. Primary survey goals included: correlation of parents' perceptions with provider documentation on encounter forms; assessment of members' perception of needed services and education; and use of aggregate data to update Bright Futures forms. Surveys were sent to 4,200 case heads with MaineCare eligible children between the ages of 3-48 months. A separate survey was developed to ascertain providers' perceptions of what transpired during well child visits. Survey results were analyzed and linked to Bright Futures assessment forms to determine if parent/guardian opinion on services differed from actual EPSDT information provided on the Bright Futures forms. Overall, it was determined that when Bright Futures forms were used, there was a greater degree of satisfaction with the visit.

The Bureau 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. Provider transfer rates (members transferring out of a particular practice) and caseload sizes are also monitored on a regular basis to determine whether intervention is required. Each primary care provider is also monitored once a year to ensure that each practice is providing the requisite 24 hour coverage for MaineCare members.

7.1.3 ☒ Information strategies

Within 30 days of enrollment, each MaineCare 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. The mailing also contains a postcard (which may be returned postage free) to be completed by those members who require assistance from the Department. Follow-up is provided by Member Services' staff. 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. Members are also sent a reminder mailing containing information on when well child visits are due, in accordance with the EPSDT periodic schedule. The reminder mailing also contains information previously sent out with the initial informing letter, i.e., information on locating providers, available assistance for scheduling visits and transportation, etc.

On an ongoing basis, members and providers are sent periodic educational newsletters. The "MaineCare Managed Care Newsletter" is sent out on a quarterly basis and contains program information/updates for managed care members. The "MaineCare Managed Care Update" is a newsletter sent to providers on a quarterly basis and contains program/clinical information. "Facts and Footnotes" is a newsletter mailed out to all MaineCare providers periodically and contains program/administrative information.

In addition to the postcard used by members, the Bureau has developed a postcard for use by providers. This postcard is used by primary care providers to identify and request needed assistance from the Bureau on behalf of members on their panel. 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.

Another informational tool used by the Bureau to educate members is Helpline messages. Members calling Member Services who are placed on hold listen to pre-recorded messages containing information regarding MaineCare benefits and available resources.

The Bureau also provides member education on inappropriate use of the emergency room. On a quarterly basis, the Bureau examines the 5 most prevalent diagnoses for inappropriate emergency room use. These members are contacted to assist with any barriers to care that may exist to accessing care in an appropriate setting (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 the Bureau to ensure access to well-baby/child/adolescent care and immunizations is the required use of a Bright Futures form (BF19) by MaineCare providers. The BF19 form (actually 19 age specific forms) was developed with input from pediatricians and other primary care physicians in the State and based on Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents. Each primary care provider participating with MaineCare who has signed an EPSDT Rider to the provider/supplier agreement is required to use the forms when providing well-child visits and is paid an enhanced reimbursement for

use of the form. Each form contains age-appropriate health measures and immunizations and is used for children from birth through age 21.

The BF19 forms are also used by providers and the Bureau to provide members with any needed assistance to comply with treatment plans, e.g., assistance with accessing follow-up treatment or diagnostic testing. The BF19s are reviewed by Department nursing staff on a daily basis for requested follow-up with the member. Forms are then shared with EPSDT staff for actual follow-up with the family. Once follow-up has occurred, notification is sent to the provider.

The Bureau also furnishes providers (as is noted in Section 7.1.2) with information on emergency room visit rates for his/her practice to enable the provider to address the issue of inappropriate use of the emergency room with his/her patients.

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

Please see Sections 7.1.1-7.1.4.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

Please see Sections 7.1.1-7.1.4.

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)) (42CFR 457.495(c))

One method used to monitor and enhance treatment of members with chronic/serious medical conditions is the use of the Utilization Report provided to primary care providers. As is noted in Section 7.1.2., the Utilization Report, provided to each primary care provider at least twice a year, contains information on potentially avoidable hospitalizations for particular chronic/serious medical conditions. The information presents a comparison of the particular PCP's practice against other statewide providers in the same specialty (admission rates per 1000 MaineCare

members per year). The report also contains a listing of the particular MaineCare members on the PCP's panel currently hospitalized with the identified conditions.

MaineCare managed care members in need of treatment by specialists may access care through referral from the member's Primary Care Provider for those covered MaineCare services designated as 'managed' services. For those MaineCare services that do not require PCP authorization, members may self-refer or seek prior authorization from the Bureau.

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 Bureau 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

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)) (42CFR 457.495(d))

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

Section 8. Cost Sharing and Payment (Section 2103(e))

☐ 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)

8.1.1 ☒ YES
8.1.2 ☐ NO, skip to question 8.8.

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 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) &(c), 457.515(a)&(c)

8.2.1 Premiums: Families with income from 151% through 200% FPL, pay premiums for MaineCare coverage for children based on a sliding scale applied to gross family income as follows:

- Below 150% FPL - no premium;
- 150% to 160% FPL - premiums are $8 per month for the first child and $16 per month for 2 or more children;
- 160% to 170% FPL - premiums are $16 per month for the first child and $32 per month for 2 or more children;
- 170% to 185% FPL - premiums are $24 per month for the first child and $48 per month for 2 or more children;
- 185% to 200% FPL - premiums are $32 per month for the first child and $64 per month for 2 or more children.

8.2.2 Deductibles: Not applicable

8.2.3 Coinsurance or copayments: Coinsurance - Not applicable
Copayments - Not applicable

8.2.4 Other: Not applicable

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)(B)) (42CFR 457.505(b))

The public is notified through the rule-making process, as provided under the Maine Administrative Procedures Act.

In addition, outreach materials include information informing individuals that, depending on household income, some families may have to pay a premium for their child's coverage and the dollar amounts of the premiums.

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))

8.5 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 3.3 % 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:								
150% - 160%	5%	10%	$8	$16	$1164	$1562	0.7%	1%
160% - 170%	10%	20%	$16	$32	$1250	$1666	1.3%	1.9%
170% - 185%	15%	30%	$24	$48	$1319	$1770	1.8 %	2.7%
185% - 200%	20%	40%	$32	$64	$1436	$1926	2.2%	3.3%

* Based on an estimated annual benefit cost of $1920 per child or $160 monthly.

** Minimum monthly income corresponds to 150% (for 150% - 160%), 160% (for 160% - 170%), 170% (for 170% - 185%) and 185% (for 185% - 200%) of 2004 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 Please 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.

8.7.1 Please provide an assurance that the following disenrollment

protections are being applied:

☒ 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))

☒ 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))

☒ 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))

☒ 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, copays, 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 (Section 2107)

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)) (42CFR 457.710(b))

See Appendix 9.2.

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

See Appendix 9.2.

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)) (42CFR 457.710(d))

See Appendix 9.2.

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 child care
    - 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, please list:

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)) (42CFR 457.720)

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)) (42CFR 457.750)

Information for the annual report comes from the Bureau of Medical Services, Division of Health Care Managements initiatives as outlined in Section 7 of this document. Additionally, the Bureau contracts with the Muskie School of Public Services at the University of Southern Maine to survey new enrollees and disenrollees regarding their use of and satisfaction with MaineCare coverage.

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 of audit. (Section 2107(b)(3)) (42CFR 457.720)

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

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 insuring ongoing public involvement. (Section 2107(c)) (42CFR 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. (Section 2107(c)) (42CFR 457.120(c))

A staff member of the Bureau of Medical Services serves as the liaison between MaineCare and Indian Tribes in the State. On a periodic basis, this staff member meets with Health Directors from the various Tribes in order to update them on MaineCare policies and procedures and to address any issues they have regarding MaineCare.

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

The Department's Bureau of 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 are paying a

premium for title XXI funded coverage notifying them of the premium increase. Effective November 1, 2004, the premium increases will be implemented as members come up for renewal. At that time, they will be notified of the exact amount of their new premium.

9.10 Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 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 sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

SCHIP Budget Plan

Federal Fiscal Year	Current FFY Budget FFY 2005	Budget Increase For Requested SPA FFY 2005		Current B SPA B Incre FFY
State's enhanced FMAP rate	.7542			
Benefit Costs				
Insurance payments				
Managed care				
per member/per month rate @ # of eligibles				
Fee for Service	$ 31,480,176	$ -		$ 31,48
Total Benefit Costs	$ 31,480,176	$ -		$ 31,48
(Offsetting beneficiary cost sharing payments)	$ 783,504	$ -		$ -78
Net Benefit Costs	$ 30,696,672	$		$ 30,69
Administration Costs				
Personnel				
General administration	$ 1,100,000	$		$ 1,10
Contractors/Brokers				
Claims Processing				
Outreach/marketing costs				
Other: Health Service Initiatives	$ 2,100,000			$ 2,10
Total Administration Costs	$ 3,200,000	$		$ 3,20
10% Administrative Cap	$ 3,410,741			$ 3,41

Federal Share	$ 25,564,870	$		$ 25,56
State Share	$ 8,331,802	$		$ 8,33
TOTAL COSTS OF APPROVED SCHIP PLAN	$ 33,896,672	$		$ 33,89

Beneficiary cost-sharing payments have been accounted for and Net Benefit costs are net of the cost-shar

The Source of State Share Funds:_ State General Funds_____

Section 10 Annual Reports and Evaluations (Section 2108)

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)) (42CFR 457.750)

10.1.1 ☒ The progress made in reducing the number of uncovered 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. (42CFR 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.

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)) (42CFR 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)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 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.

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

The review process for SCHIP eligibility and enrollment matters is identical to the Medicaid review process.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

The SCHIP review process for health matters is identical to the Medicaid review process.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please 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

Appendix 9.2

STRATEGIC OBJECTIVES, PERFORMANCE GOALS AND PERFORMANCE MEASURES

STRATEGIC OBJECTIVE	PERFORMANCE GOAL	PERFORMANCE MEASURE
1. Conduct an effective outreach program	Collaborate with Covering Kids & Families	Number of trainings and number of participants
	Outreach Campaign to provide technical training to staff of community agencies and health care providers	
	Maintain quality of technical training	Summary of evaluation comments
	Increase SCHIP participation	Number ever enrolled in SCHIP
2. Ensure consistent source of health care	Match children with PCPs	Number of enrolled children with PCP
	Track PCP visits/access	Number of visits by age groups
	Decrease emergency room use	Number of ER visits
3. Improve health outcomes	Track immunization rate –2 yr olds	Number of children with appropriate immunizations at age 2
	Monitor EPSDT visits	Number/type EPSDT visits performed
		Number /type preventive screenings performed
	Track lead screening rates	Number of lead screenings performed
	Track well child visits by age groups	Number of well child visits
	Track use of appropriate medications for children with asthma	Number of children with appropriate medication
4. Provide quality care to members hospitalizations	Increase member satisfaction	Survey results
	Track potentially avoidable hospitalizations	Rates of potentially avoidable hospitalizations