



STATE OF MAINE  
DEPARTMENT OF HUMAN SERVICES  
11 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0011

ANGUS S. KING, JR.  
GOVERNOR

KEVIN W. CONCANNON  
COMMISSIONER

May 15, 1998

Administrator  
Health Care Financing Administration  
7500 Security Blvd.  
Baltimore, MD 21244

ATTN: Family & Children's Health Programs  
Center for Medicaid and State Operations  
Mail Stop C4-14-16

Enclosed is an original package and ten (10) copies of the State of Maine's Plan for implementation of Title XXI of the Social Security Act. The plan is a combination of a Title XIX expansion and a separate State Children's Health Insurance Plan. Attachment 1 to the document is a copy of Maine's State Plan Amendment for the Title XIX expansion which has been sent to the HCFA Regional Office in Boston.

Maine's Title XIX expansion is expected to begin enrolling eligible applicants on July 1, 1998, and the Title XXI program is scheduled to be implemented statewide on August 1, 1998.

Please be assured that Maine stands ready to forward any additional information that might be required to expedite the approval process through HCFA.

Sincerely:

Francis P. Finnegan, Jr., Director  
Bureau of Medical Services  
Department of Human Services



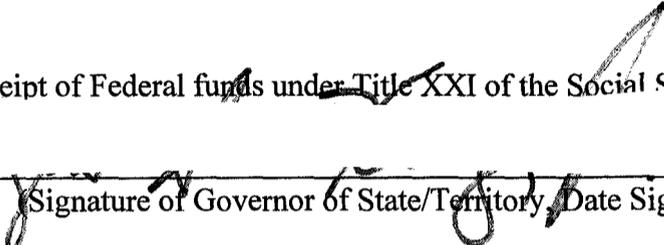
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APPLICATION FOR STATE CHILD HEALTH PLAN  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

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

State/Territory: **Maine**

As a condition for receipt of Federal funds under Title XXI of the Social Security Act.

 /15/98  
(Signature of Governor of State/Territory, Date Signed)

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

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 **0938-0707**. The time required to complete this information collection is estimated to average 160 hours (or minutes) 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box **26684**, Baltimore, Maryland **21207** and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. **20503**.

Proposed Effective Date **8/1/98**

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Submitted: **5/15/98**

**Section 1. General Description and Purpose of the State Child Health Plans** (Section 2101)

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

- 1.1.  Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2.  Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3.  **A combination of both of the above. *The state plans to expand eligibility for Medicaid coverage for children as well as implement Cub Care 2, a health coverage program for low-income children who are ineligible for benefits under the Medicaid program. The state's Medicaid program currently covers children from birth through 12 months of age in families with income up to 185% of the federal poverty level (FPL), children 1 through 5 in families with income up to 133% of the FPL, and children 6 through 18 in families with income up to 125% of the FPL. As described in the state's amendment to its Medicaid state plan (see Attachment I), the state will expand Medicaid to include children aged 1 year through 18 years old in families with income up to and including 150% of the FPL. The Cub Care Program will provide health coverage to children aged 1 through 18 in families with income up to and including 185% of the FPL.***

**Section 2. General Background and Description of State Approach to Child Health Coverage**  
(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 section 2110(c)(2)). 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).

*See Appendix 2.1.*

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

- 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):

*The state currently conducts various outreach activities, most of which are coordinated by the Bureau of Health (BOH). The BOH conducts a Healthy Families initiative, which consists of three grant programs. These programs send public health nurses to conduct home visits, in which they identify health needs and increase awareness of and access to Medicaid covered services. BOH has recently assumed responsibility for the EPSDT program as well. BOH now operates the EPSDT program and immunization programs with 8 statewide outreach workers and a staff of public health nurses. In addition to providing immunizations and health screenings, the nurses facilitate access to needed services. Both nurses and outreach workers identify potential enrollees, provide them with information and assist with enrollment.*

*Additionally, the Bureau of Medical Services (BMS) has a contract with the Maine Ambulatory Health Commission, which consists of mainly FQHCs, to assist individuals in completing Medicaid applications.*

- 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 how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:

(Section 2102)(a)(3)

*The Cub Care Program will be integrated and administered by the Department of Human Services (DHS) with the Medicaid program, sharing administrative structure, as well as a simplified enrollment and eligibility process. The DHS contains the Bureau of Medical Services (BMS), the Bureau of Health (BOH) and the Bureau of Family Independence (BFI), all of which will play an active role in the Medicaid and Cub Care programs. (See Attachment 2 for DHS Organizational Chart) In order to accomplish this integrated structure, the state will add one full-time equivalent for health policy administration within the Bureau of Medical Services (BMS) and 22 full-time positions within the Bureau of Family Independence (BFI). Furthermore, DHS shall adopt and promote a simplified eligibility form (see Attachment 3) and process.*

*In order to ensure that only eligible targeted low-income children are covered, the BFI will assess all clients family income to make an eligibility determination for both Medicaid and Cub Care, so that there will be no administrative gap in the process for assignment of a client to the appropriate program.*

*As described in section 5.1, the current outreach efforts under the BOH will be expanded through use of the 10% funds under Title XXI. The added BMS staff person will play a coordinating role with BOH, while the bulk of the outreach for both Medicaid and Cub Care will be performed by BOH staff.*

**Section 3. General Contents of State Child Health Plan (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: (Section 2102)(a)(4)

*As noted in Section 1.3 above and described in the state's Medicaid state plan amendment, the state will use Title XXI funds to expand Medicaid eligibility for children 1 through 18 with family income up to and including 150% of the FPL. Children 1 through 18 with family income above 150% and up to and including 185% of the FPL will be eligible for the Cub Care program, which for a nominal monthly premium, will provide children with the Medicaid benefit package. Co-payments and deductibles may not be charged for benefits provided under the program.*

*The purpose of the Cub Care program is 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. Therefore, the maximum eligibility level is subject to adjustment by the commissioner of human services, 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. On the other hand, if Cub Care 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 six month enrollment period, but not during the six-month period,*

*The Cub Care Program will provide children with all of the benefits available to a Medicaid enrolled child. The Cub Care program must be integrated with the Medicaid program and administered with it in one administrative structure within DHS, with the same enrollment and eligibility process, benefit package, and outreach.*

*It is intended that services under the Cub Care program will be delivered in the same manner as under the Medicaid program. At the time of implementation, the delivery system for both the Medicaid program and the Cub Care program will differ by county of residence.*

*Currently Maine has a contract with NYLCare to administer a capitated managed care plan in 10 counties. Eligible individuals and families are enrolled on a voluntary*

basis in these counties. PrimeCare, the primary care case management (PCCM) program, is in operation on a mandatory basis in three additional counties. Once enrolled, participants select a primary care provider to provide primary care services and make referrals for needed specialty care. The remaining 3 counties currently operate in a fee-for-service environment.

Concurrent to this CHIP application, the state of Maine is developing an amendment to its state plan to move its Medicaid population into a state-wide mandatory managed care program. At the same time, a 1915(b) waiver will be submitted to mandate the special needs population into PrimeCare. It is anticipated that implementation of these programs will begin on October 1, 1998. However, because the state intends to begin enrollment of Title XXI populations prior to October 1, eligible enrollees will initially receive benefits through the infrastructure that currently exists in their county of residence.

Once implementation of managed care under the state plan amendment and the 1915(b) waiver begins, Title XXI enrollees will be placed on the same phase-in schedule as current Medicaid enrollees.

**3.2.** Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

For children enrolled in Medicaid under the expansion, as well as children enrolled in Cub Care, the utilization controls will be the Medicaid controls. Under the state's Medicaid program, utilization management will be the responsibility of the health plans. In their applications, managed care organizations (MCOs) must provide a written description of their utilization management program. At a minimum this program must include protocols for determining medical necessity, denying services, prior approval, hospital discharge planning, physician profiling, providing feedback to providers, managing out of area care, and retrospective review of claims. A MCO's description of their utilization management program must also include the structure, committee, staff or system used by the MCO to conduct utilization management activities.

**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))

- 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: *In order to receive a state subsidy under Cub Care, family income may not exceed 185% of the FPL.*
- 4.1.4.  Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_
- 4.1.5.  Residency: *To be eligible for the Cub Care program, 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: *As described in section 4.4.3, children who are eligible for Medicaid or the State Employee Health Program or who are covered under a group insurance plan are not eligible for the Cub Care Program.*

- 4.1.8.  Duration of eligibility: *In general, a child who has been determined eligible for the Cub Care Program or for Medicaid shall remain eligible for 6 months unless the child attains the age of 19 or is no longer a resident of the state. Eligibility shall be redetermined prior to the end of each ~~six~~ month period. A child will be ineligible for a subsequent 6-month period of eligibility for a specified length of time (as described in section 8.2) for nonpayment of premiums.*

*As described in section 8.2, the state will allow families to purchase coverage under the Cub Care program for a child whose family income at the end of the 6-month enrollment period exceeds 185% of FPL. The purchase of coverage will be available for 18 months. The child's family will pay the full premium, which will cover the benefit cost plus an administrative cost not to exceed the maximum allowable under COBRA.*

- 4.1.9.  Other standards (identify and describe):

*There will be no other standards.*

- 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))

- 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))

*Cub Care and Medicaid children will both use the same simplified eligibility form and enrollment process. BFI has simplified the existing Medicaid eligibility form to ask questions regarding names and ages of all household members, pregnancy, income, and insurance coverage. The form may be requested from the BFI and returned through the mail to BFI when completed. Eligible individuals also have the option of going to the regional offices to fill in the application, however, it is not necessary.*

*BFI will be making eligibility determinations for both Cub Care and Medicaid using the same form and thus ensuring no administrative gap in the process for assignment of a client to the appropriate program. As described in section 1.3, children under current Medicaid eligibility levels will be enrolled in Medicaid, children above current eligibility levels and up through 150% FPL will be enrolled in Medicaid and children above 150% FPL and up through 185% FPL will be enrolled in Cub Care. Children enrolled under Medicaid expansion eligibility criteria and those enrolled under Cub Care criteria will be given distinct eligibility codes in order to track coverage under both programs.*

*As described in section 4.1.8, a child who has been determined eligible for the Cub Care Program or for Medicaid shall remain eligible for 6 months unless the child attains the age of 19 or is no longer a resident of the state. A child determined to be eligible for Medicaid will be sent an enrollment card each month. A child determined to be eligible for Cub Care will be sent an enrollment card and a bill for the monthly premium each month.*

*New eligibility workers will be hired by BFI to handle the increase in the number of applications processed. Both current eligibility workers and the newly hired workers will be trained in making eligibility determinations for both Medicaid (including both under current Medicaid eligibility rules and under the Medicaid expansion rules) and Cub Care and making appropriate distinctions between the two.*

*Eligibility shall be redetermined prior to the end of each six month period, BFI will send written notification that a child's coverage is ending at the end of the 6-month eligibility period, along with an application form which can be mailed back to BFI upon completion.*

*A child will be ineligible for a subsequent 6-month period of eligibility for a specified length of time (as described in section 8.2) for nonpayment of premiums.*

*As described in section 8.2, the state will allow families to purchase coverage under the Cub Care program for a child whose family income at the end of the 6-month enrollment period exceeds 185% of FPL. The purchase of coverage will be available for 18 months. The child's family will pay the full premium, which will cover the*

*benefit cost plus an administrative cost not to exceed the maximum allowable under COBRA.*

**4.4.** Describe the procedures that assure:

- 4.4.1. Through intake and follow **up** screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage **are** furnished child health assistance under the state child health plan. (Section **2102)(b)(3)(A))**

*The eligibility process for Cub Care will be fully integrated with the Medicaid eligibility process. Thus, a child will be determined eligible for Medicaid, if appropriate, before Cub Care. As described in section 4.3, the eligibility process will be completed by BFI and an eligible child will be given the appropriate eligibility code.*

*Furthermore, children currently covered by group health insurance or the State Employees Health Program will not be eligible ~~for~~ Cub Care. As described in section 4.3, the simplified eligibility form for both Cub Care and the Medicaid program will collect information about current coverage and coverage in the past three months. If an applicant has lost coverage in the 3 months prior to application, the BFI will review applications to determine whether applicants or employers ~~of~~ applicants have discontinued employer-sponsored dependent coverage in order to participate in the Cub Care program.*

- 4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section **2102)(b)(3)(B))**

*As described in section 4.3, BFI by its eligibility rules and through the coordinated eligibility process, will assure that the client is placed in the appropriate program. Thus, anyone making application ~~for~~ Cub Care, who is determined to be Medicaid eligible, will be enrolled in Medicaid.*

- 4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

*Children currently covered by group health insurance will not be eligible for Cub Care. As described in section 4.3, the DHS will use the same simplified eligibility form for both Cub Care and the Medicaid program. This form will collect information about current coverage and coverage in the past three months. If an applicant has lost coverage in the 3 months prior to application, the BFI will review applications to determine whether applicants or employers of applicants have discontinued employer-sponsored dependent coverage in order to participate in the Cub Care program.*

*Children who had employer-sponsored coverage within the previous three months (for which the employer paid at least 50% of the premium), who lost coverage for reasons related to the availability of the Cub Care program (e.g., no longer purchasing family coverage) will not be eligible. Children who lost coverage for any of the following reasons unrelated to the availability of the Cub Care program will be eligible for Cub Care:*

- a) the cost of the employee's share of family coverage exceeds 10% of family income,*
- b) the loss of coverage for the child was due to a change in employment, termination of COBRA coverage or termination was for a reason not in the control of the employee (parent), or*
- c) a determination of good cause exception is made by DHS.*

- 4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)). (Section 2102)(b)(3)(D))

*After consultation with federally recognized Indian nations, tribes or bands of Indians, the state and the commissioner shall adopt rules regarding eligibility and participation of children who are members of a nation, tribe, or band, consistent with Title 30, section 6211, in order to best achieve the goal of providing access to health care for all qualifying children with program requirements, while using all available federal funds. The intent is that any eligible child who is Indian will be enrolled in the appropriate program (Medicaid or Cub Care) and be treated as any other eligible child, with the exception of mandatory enrollment in managed care.*

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

*There are no other programs in the state, except Medicaid and Cub Care, that provide health care coverage for low-income children.*

**Section 5. Outreach and Coordination (Section 2102(c))**

Describe the procedures used by the state to accomplish:

- 5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1))**

*As described in section 2.2.1, BOH currently conducts the bulk of the outreach activities through its Healthy Families initiative and through the immunization and EPSDT programs. Through the use of the 10% funds, the state will expand current outreach activities to incorporate the new Medicaid eligibility levels and Cub Care program. BOH will cross train the existing EPSDT/immunization outreach workers and public health nurses to identify Medicaid and Cub Care eligible children and assist in enrolling them. Home visitation through the Healthy Families initiative will also be expanded to identify eligible targeted low-income children for Medicaid expansion and Cub Care. The home visitation nurses will be trained to identify and assist in enrolling Medicaid and Cub Care eligible children.*

*In addition to the expansion, several other outreach efforts will be developed and instituted as well. These include a marketing contract to develop television and radio public service announcements, the creation of new brochures and posters targeted to low-income families with children and providing program information to all DHS workers, CAP agencies, local health offices, food stamp recipients, school-based health centers, RHCs, Head Start sites, CDC sites, Child Abuse and Neglect councils, and churches.*

*Additionally, Impact, the new immunization tracking system, is being developed to collect information on insurance coverage. This system will be used to conduct mailings to families with children who appear to be uninsured. Program information and an application will be included in the mailing.*

*DHS also has planned to have articles published in provider newsletters and to approach local hospitals through the hospital association, to conduct targeted mailings to families of children seen in their institutions and listed as uninsured.*

*DHS is in the process of developing a detailed two year outreach plan to ensure targeting to important geographic areas, to families from racial minorities and to single family households.*

*BOH will continue to spearhead the majority of these outreach efforts, coordinating with BFI and BMS. BMS will continue its contract with the Maine Ambulatory Health Commission to provide information and enrollment assistance to individuals accessing those clinics. Additionally, through its contracting process under managed*

*care, BMS will require that health plans contract with school-based clinics and federally qualified community health centers (FQHCs) and other community-based programs, thus ensuring information and access to individuals using these providers.*

**5.2.** Coordination of the administration of this program with other public and private health insurance programs: **(Section 2102(c)(2))**

*The Cub Care Program will be integrated with the Medicaid program and administered with it in one administrative structure within DHS. In addition to sharing an administrative structure, the two programs will use the same simplified enrollment and eligibility process, benefit package, procedures and outreach in compliance with state laws and policies, as described in section 3.1.*

*There are no other public insurance programs offered in Maine. All other public children's health services (i.e., Maternal and Child Health, WIC, Social Services, etc.) are already integrated within the administrative structure of the Medicaid program.*

**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.)

6.1.1.  Benchmark coverage; (Section 2103(a)(1))

*The coverage provided will be the Medicaid benefit package.*

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)) Specify the coverage, including the amount, scope and duration of each service; as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [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))

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6.2.18., but including services furnished by a state operated hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

Proposed Effective Date 8/1/98

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Submitted 5/15/98

- 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))

*Services are limited to: a) 2 hours per week (8 visits per emergency) for individual therapy, b) 90 minutes per week for group therapy, with limited exceptions, and c) 4 hours of psychometric testing, with limited exceptions.*

- 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))

*Covered devices include prosthetic devices, eyeglasses, and hearing aids under EPSDT. Children with refractive error of 10.00 diopters or more are covered for the first pair of eyeglasses. All other refractive errors of greater than or equal to the following are covered: hyperopia +1.25; myopia -0.75; astigmatism -0.50.*

- 6.2.13.  Disposable medical supplies (Section 2110(a)(13))

- 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, medical supplies, equipment and appliances suitable for use in home, and physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency. The state has a 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))

*Including nurse midwives, nurse practitioners and Christian Science nurses.*

- 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))
- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19))
- 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))
- The services must be provided under the supervision of a licensed therapist.*
- 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 will be covered. Additionally, EPSDT services, private duty nursing services, and Christian Science sanatoria services will also be 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.*

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 the Medicaid/Cub Care programs are available without prior authorization. Only out of state, and transportation for persons living in a nursing or boarding facility require 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))

*Plans are required to provide interpreter services for enrollees as necessary to ensure availability of effective communication regarding treatment, medical history, health education, and resolution of complaints and grievances.*

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. **Waivers - 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 waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1.  **Cost Effective Alternatives.** 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:

6.3.1.1. 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))

6.3.1.2. 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; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

6.3.1.3. 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(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

6.3.2.  **Purchase of Family Coverage.** Describe the plan to provide 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))

6.3.2.1. 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))

6.3.2.2. 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))

**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))

*The methods that will be used to assure quality and appropriateness of care include contracting standards, licensing, credentialing/recredentialing processes, reporting requirements, external reviews and periodic reviews.*

*Contracting HMOs and MMOs must provide or ensure access to services, including EPSDT services, early intervention services, and certified family and pediatric nurse practitioner services.*

*An MCO shall submit copies of valid licensure from the Maine Bureau of Insurance to operate as an HMO, as well as applicable licensure for subcontractors. Those entities requesting certification as Maine Medicaid Organizations (MMOs) will be granted certification by the DHS upon contract award.*

*An MCO must show evidence of an adequate provider ~~credentialing~~ credentialing process which also considers data from all aspects of its quality improvement activities as described in section 7.1.4. The MCO shall provide a written description of its provider ~~credentialing~~ credentialing process which addresses prescribed criteria.*

*Reporting requirements will include a report on the MCO's Quality Improvement Program, described in section 7.1.4. In addition, MCOs will be required to provide periodic reports on complaints, PCP changes, enrollee transfers to another MCO, emergency room use and PCP caseload. Additionally, the BMS will require quarterly reports on compliance with EPSDT.*

*External reviews will be conducted by a PRO, a PRO-like entity or an accreditation body through a contract with the state. Reviews of quality and services furnished under each MCO contract will be conducted annually. The external quality review organization will, at a minimum, be responsible for the review of each MCO's internal Quality Improvement Program (described in section 7.1.4), random record review of provider records, review of complaints and grievances, and focused studies. Three areas of interest have been identified for in-depth study for the initial contract period: immunizations, prenatal care and pediatric asthma. Based on the findings of the external review, the MCO may be required to prepare a corrective action plan.*

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

*As described in section 7.1.4, as part of its Quality Improvement Program, each MCO must have in place, standards to monitor and evaluate availability and accessibility of care with respect to routine, urgent and emergency care, telephone appointments, advice, and member services lines. Additionally, each MCO must have standards for the design, maintenance, retrieval and view of medical records to assure access to timely and accurate patient information.*

7.1.2.  Performance measurement

*As described in section 7.1.4, as part of its Quality Improvement Program, each MCO will be required to have a continuous, systematic process in place designed to monitor, measure, evaluate, and improve the quality of health care and services delivered to enrollees. The MCO shall provide a description of its Quality Improvement Program to the DHS for approval with its application.*

*Each MCO quality improvement program must include a process for the evaluation of utilization and quality improvement data to assess patient care and MCO performance.*

7.1.3.  Information strategies

*The state will require MCOs to provide information to enrollees regarding their benefits, rights and responsibilities under the Medicaid and Cub Care programs. In addition, as part of its quality improvement program, as described in section 7.1.4, MCOs will be required to conduct an annual enrollee satisfaction survey,*

7.1.4.  Quality improvement strategies

*Each MCO will be required to have a continuous, systematic process in place designed to monitor, measure, evaluate, and improve the quality of health care and services delivered to enrollees. The MCO shall provide a description of its Quality Improvement Program to the DHS for approval with its application.*

*The program must include a process for service delivery by appropriate health professionals; the evaluation of utilization and quality improvement data to assess patient care and MCO performance; the communication of performance assessments to individual practitioners; the assurance that appropriate corrective action is taken in response to problem areas; and the confirmation that changes made will result in a sustained improvement. The state or its delegate, as well as independent entities will periodically review the effectiveness of a MCO's Quality Improvement Program*

*In its description, the MCO must identify the entity that is responsible for quality improvement activities and identify the responsibilities of its Governing Body with respect to monitoring, evaluating and making improvements to care.*

*The MCO must have sufficient mechanisms to ensure that providers are kept informed of quality improvement activities and findings. MCOs must also ensure that providers fully participate in the quality improvement process.*

*An MCO must show evidence of an adequate provider credentialing/recredentialing process which also considers data from all aspects of its quality improvement activities. The MCO shall provide a written description of its provider credentialing/recredentialing process which addresses prescribed criteria.*

*In order to measure the extent to which the MCO enrollees are satisfied with the care they receive, each MCO will be required to administer an annual enrollee satisfaction survey or other survey effort, as defined by the department, such as focus groups. The MCO will be required to report on the survey methodology and results to the DHS within 90 days of completing the survey.*

*An MCO must have in place, standards to monitor and evaluate availability and accessibility of care with respect to routine, urgent and emergency care, telephone appointments, advice, and member services lines. Additionally, each MCO must have standards for the design, maintenance, retrieval and view of medical records to assure access to timely and accurate patient information.*

*An MCO must agree to make available to the state or its delegate, or*

*independent review entities duly authorized by the DHS, or HCFA, studies, reports, protocols, standards, worksheets, minutes or other such documentation as may be appropriate, concerning its quality improvement activities and corrective actions.*

*The DHS will establish an ongoing Quality Improvement (QI) Coordinating Workgroup to foster mutual cooperation in optimizing efficiency in the QI activities and to promote cross-linkages in identified areas of concern. Each MCO shall make its medical director and associated staff available to serve on the QI Coordinating Workgroup.*

- 7.2.** Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

*As described in section 7.1.4, as part of its Quality Improvement Program, a MCO must have in place: standards to monitor and evaluate availability and accessibility of care with respect to routine, urgent and emergency care, telephone appointments, advice, and member services lines. The Quality Improvement Program will be periodically monitored by the state, as well as an external reviewer. Additionally, MCOs will be required to provide quarterly reports on emergency room use.*

**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?**

**8.1.1.**  YES

**8.1.2.**  NO, skip to question 8.5.

**8.2.** Describe the amount of cost-sharing and any sliding scale based on income:  
(Section 2103(e)(1)(A))

**8.2.1.** Premiums: Families will pay premiums for Cub Care coverage for children based on a sliding scale applied to gross family income as follows:

<i>below 150% FPL</i>	<i>- Medicaid, no premium</i>
<i>150% to 160% FPL</i>	<i>- premiums of 5% of benefit cost per child (\$5.00 per month), with a limit of 5% of the cost for 2 children (\$10.00 per month) per family.</i>
<i>160% to 170% FPL</i>	<i>- premiums of 10% of benefit cost per child (\$10.00 per month), with a limit of 10% of the cost for 2 children (\$20.00 per month) per family.</i>
<i>170% to 185% FPL</i>	<i>- premiums of 15% of benefit cost per child (\$15.00 per month), with a limit of 15% of the cost for 2 children (\$30.00 per month) per family.</i>

*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 and again at the beginning of the 4th month of the 6-month enrollment period if the premium is still unpaid. DHS shall provide an opportunity for a hearing and grace period in which the premium may be paid and no penalty assessed. If nonpayment is for the 1st through 5th months of the 6-month enrollment period, the grace period is equal to the remainder of the 6-month period. If nonpayment is for the 6th month of the 4-month enrollment period, the grace period is equal to 6 weeks.*

*If a premium is not paid by the end of the grace period, coverage must be terminated unless DHS has determined that waiver of premium is appropriate. DHS shall adopt rules allowing waiver of premiums for good cause. A child whose coverage under the Cub Care program has been terminated for nonpayment of premium and who has received coverage for a month or longer without premium payment may not re-enroll until after a waiting period that equals the number of months of coverage under the*

*Cub Care program without premium payment, not to exceed 3 months. BFI will collect premiums for Cub Care. Monthly bills for premiums due will be mailed out with the eligibility cards each month. Cub Care recipients will have the option of paying a premium each month or the entire 6-month premium at the beginning of the eligibility period.*

*As stated in section 4.1.8, the state will allow families to purchase coverage under the Cub Care program for a child whose family income at the end of the 6-month enrollment period exceeds 185% of FPL. The purchase of coverage will be available for 18 months. The child's family will pay the full premium, which will cover the benefit cost plus an administrative cost not to exceed the maximum allowable under COBRA.*

*The current Medicaid program allows buy-in after eligibility ends, consistent with COBRA. The 18 month extension premiums will be collected through the system already in place for the Medicaid buy-in. BFI will notify BMS of anyone whose coverage is ending and who wishes to purchase the extension coverage. BMS would then calculate the cost of the premium, including the administrative portion and send a bill for the full premium amount. A tracking system is in place to follow-up on nonpayment of premiums. BMS will develop rules regarding nonpayment, grace period and penalties.*

**8.2.2.** Deductibles: *Not applicable*

8.2.3. Coinsurance: *Not applicable*

8.2.4. Other: *Not applicable*

**8.3.** Describe how the public will be notified of this cost-sharing and any differences based on income:

*The outreach campaign conducted by BOH and described in section 5.I, will contain information on the premium schedule. Both the media spots and any written information will explain the existence of the premium for the Cub Care program, the dollar amount of the premium by income level and how the premiums will be collected. During the eligibility process, BFI will also provide both written and verbal information to families on the premium schedule and collections.*

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of 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))
- 8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
- 8.4.3.  No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).
- 8.4.4.  No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
- 8.4.5.  No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
- 8.4.6.  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))
- 8.4.7.  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))
- 8.4.8.  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))
- 8.4.9.  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))

- 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 annual income for the year involved:  
(Section **2103(e)(3)(B)**)

*As described in section 8.2, premiums will be limited to a predetermined percentage of the benefit cost, based on a sliding scale and number of children enrolled. As shown in the following table, the premium is never higher than the equivalent of 1.6% of family income for those at the lowest end of the FPL range.*

No. of Children	Premium as a % of Benefit Cost		Monthly Premium Cost**		Minimum Monthly Income**		Premium as a % of Minimum Income	
	1	2	1	2	1	2	1	2
FPL Level:								
150% - 160%	5%	10%	\$5	\$10	\$1356	\$1706	.4%	.6%
160% - 170%	10%	20%	\$10	\$20	\$1447	\$1820	.7%	1.1%
170% - 185%	15%	30%	\$15	\$30	\$1537	\$1934	1.0%	1.6%

- 8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

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

8.6.2.  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 **6.3.2.** of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section **2109(a)(1),(2)**). Please describe:

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**Section 9. Strategic Objectives and Performance Goals for the 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))

9.1.1 *To increase the number of children in Maine with health insurance by expanding Medicaid eligibility and creating Cub Care, a new health insurance program for previously uninsured children.*

9.1.2 *Conduct an effective outreach program to ensure that individuals who are eligible for Title XIX Medicaid, Title XXI Medicaid expansion and Cub Care are aware of the availability of each low cost insurance under the Title XIX and XXI program offerings*

9.1.3 *Provide access to a consistent source of health care that will meet the needs of enrolled children.*

9.1.4 *Improve health outcomes for children as measured by key indicators.*

9.1.5 *Provide quality health care to enrolled children that meets their needs and expectations.*

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

*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))

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))

- 9.5.  The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))

*The state will use MMDSS to evaluate claims data and Impact to evaluate EPSDT information. Baseline data on uninsured children will be provided by Muskie Institute analysis of a survey of uninsurance in Maine conducted by Mathematica Policy Research.*

- 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 audits. (Section 2107(b)(3))

- 9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

**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))

- 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 1115 (relating to waiver authority)
- 9.8.5.  Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6.  Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7.  Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8.  Section 1128A (relating to civil monetary penalties)
- 9.8.9.  Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10.m 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))

*The Maine state legislature passed legislation authorizing the Maine Commission on Children's Health Care in June of 1997. The Commission is comprised of state legislators, medical and legal experts, advocates and consumers. The Commission was charged with reporting to the Governor and the legislature on the following issues:*

- Assess the best and latest available data regarding children's health insurance in the state, including the number of children under 19 years of age who lack health insurance;*
- Examine the costs and benefits of Medicaid expansion with pending federal changes;*
- Examine the benefits and detriments of accepting a block grant that would expand children's health access; and*
- Examine the advantages and disadvantages of alternative health services and financing mechanisms of children's health services.*

*Beginning on October 14, 1997, the Commission received input, through a series of public meetings, from school-based children's health programs, community and Indian health centers, the Maine Center for Economic Policy, the Maine Children's Alliance, the Department of Human Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Bureau of Insurance, the State Employee's Health Insurance Program, the Maine Medical Association, the Office of Fiscal and Program Review, Blue Cross and Blue Shield of Maine and other members of the public.*

*On January 28, 1998, the Commission presented their report to the Governor and the state legislature, based on their meetings and public testimony. Resulting state legislation authorizes the Medicaid expansion and Cub Care program, as well as reauthorizes the Commission. This legislation includes requirements regarding eligibility, enrollment, benefits, premiums and premium collection, and legislative oversight (See Attachment 4).*

*In the future, the commission shall oversee the expansion of the Medicaid program and the establishment of the Cub Care program. The Commission shall receive quarterly reports from the commissioner of DHS. The Commission shall submit a report and recommendations to the joint standing committee of the state legislature by December 15, 1998.*

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.

*See Appendix 9.10.*

**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))

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

10.1.2.  Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

- 10.2.  State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**
- 10.2.1.  An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
- 10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:
- 10.2.2.1.  The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
- 10.2.2.2.  The quality of health coverage provided including the types of benefits provided;
- 10.2.2.3.  The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4.  The service area of the state plan;
- 10.2.2.5.  The time limits for coverage of a child under the state plan;
- 10.2.2.6.  The state's choice of health benefits coverage and other methods used for providing child health assistance, and
- 10.2.2.7.  The sources of non-Federal funding used in the state plan.
- 10.2.3.  An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
- 10.2.4.  A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5.  An analysis of changes and trends in the state that affect the provision

of accessible, affordable, quality health insurance and health care to children.

- 10.2.6.  A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7.  Recommendations for improving the program under this Title.
- 10.2.8.  Any other matters the state and the Secretary consider appropriate.
- 10.3.  The state assures it will comply with future reporting requirements as they are developed.
- 10.4.  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.

## **APPENDIX 2.1**

## APPENDIX 2.1

In September of 1997, the Maine Department of Human Services contracted with the Institute for Health Policy at the Muskie School of Public Service at the University of Southern Maine, to conduct a study of children's health insurance coverage in Maine. The study was co-sponsored by Blue Cross Blue Shield of Maine, Maine Children's Alliance, The Maine Community Foundation, and MaineHealth.

The Muskie School subcontracted with Mathematica Policy Research, Inc. to develop the survey and collect the data. Mathematica conducted computer assisted telephone interviews with approximately 2500 households with children in the fall of 1997. The response rate among eligible households was 75%, allowing for estimates to the general population. Mathematica developed weights, benchmarked to Maine census figures, which allow statewide estimates from the survey.

The analysis of insurance coverage among children in Maine by selected characteristics, contained in Appendix 2.1, were produced by researchers at the Muskie School from these survey results. Overall, there are approximately 316,000 children in the state of Maine. Just over 10% of them are uninsured according to the survey. We have included those of unknown insurance status with the uninsured because doing so more closely approximates the Current Population Survey (CPS) definition of uninsured. In the CPS, uninsured is a residual category, consisting of anyone who did not report a form of coverage.

Nearly 19% of children in Maine are covered under the Medicaid program or some other public program. Over 70% of children have private or group coverage.

Small sample size makes it difficult to provide detailed breakouts in many categories. The state feels that what it is providing are the finest possible breakouts without compromising the reliability of the results. We feel this survey reflects the most accurate picture of children's insurance coverage in Maine.

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**APPENDIX 2.1**  
**Insurance Coverage of Children in Maine**  
**by Selected Demographic Characteristics**  
**1997 Household Survey<sup>1</sup>**

	TYPE OF COVERAGE							
	Uninsured or Unknown		Medicaid and Other Public		Private/Group		Total <sup>2,3</sup>	
	Percent	Number	Percent	Number	Percent	Number	Percent	Number
<b>Age Group</b>								
<1	0.25%	802	0.89%	2,803	2.26%	7,142	3.40%	10,747
1 through 5	2.43%	7,665	5.48%	17,312	17.65%	55,738	25.55%	80,715
6 through 12	3.75%	11,848	6.39%	20,186	26.74%	84,466	36.88%	116,500
13 through 18	3.68%	11,608	5.88%	18,569	24.61%	77,737	34.16%	107,915
<b>Total</b>	<b>10.11%</b>	<b>31,923</b>	<b>18.64%</b>	<b>58,870</b>	<b>71.26%</b>	<b>225,084</b>	<b>100.00%</b>	<b>315,877</b>
<b>FPL Level</b>								
≤ 125%	2.42%	7,658	11.70%	37,070	4.70%	14,904	18.82%	59,631
125% - 133%	0.96%	3,046	1.34%	4,241	1.28%	4,052	3.58%	11,339
133% - 185%	2.62%	8,311	1.48%	4,696	7.81%	24,758	11.91%	37,765
185% - 200%	0.74%	2,338	0.29%	918	3.77%	11,925	4.80%	15,181
>200%	2.07%	6,557	1.76%	5,568	48.16%	152,582	51.99%	164,707
No Income Information	1.29%	4,071	2.16%	6,841	5.44%	17,232	8.89%	28,144
<b>Total</b>	<b>10.10%</b>	<b>31,980</b>	<b>18.73%</b>	<b>59,334</b>	<b>71.16%</b>	<b>225,452</b>	<b>99.99%</b>	<b>316,766</b>
<b>Location</b>								
Urban	5.03%	15,952	9.99%	31,651	46.90%	148,566	61.92%	196,169
Rural	5.06%	16,029	8.74%	27,884	24.27%	76,886	38.07%	120,799
<b>Total</b>	<b>10.09%</b>	<b>31,981</b>	<b>18.73%</b>	<b>59,535</b>	<b>71.17%</b>	<b>686,077</b>	<b>99.99%</b>	<b>316,968</b>

<sup>1</sup>Data collected by Mathematica Policy Research, Inc. Preliminary analysis conducted by Edmund Muskie School of Public Service, University of Southern Maine.

<sup>2</sup>Total number of children for age group differs because the analysis is based on individuals 0 - 18, while the FPL and location analyses are based on individuals through 21 years of age.

<sup>3</sup>Differences in total percents and numbers between the FPL and Location categories are due to rounding.

## **APPENDIX 9.2**

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**APPENDIX 9.2  
STRATEGIC OBJECTIVES, PERFORMANCE GOALS  
AND PERFORMANCE MEASURES**

<b>STRATEGIC OBJECTIVE</b>	<b>PERFORMANCE GOAL</b>	<b>PERFORMANCE MEASURE</b>
<b>Increase the Number of Children with Insurance Coverage</b>		
	Decrease Rate of Uninsurance	Number of Uninsured in Mathematica Survey/CPS
	Increase Medicaid Participation	Number Enrolled in Medicaid by Income Level
	Enroll Children in Cub Care	Number Enrolled in Cub Care
	Contact Identified Families	Number of Mailings/Home Visits
	Conduct Statewide Media Campaign	Number of Spots Aired in Each TV and Radio Market
	Use Materials Appropriate to Target Audience	Approval of Materials by Advocates
<b>Ensure a Consistent Source of Health Care</b>		
	Enroll Children in Health Plans	Number of Enrolled Children in Plans
	Match Children with PCPs	Number of Enrolled Children with PCP
	Increase Regular Source of Health Care	Number of Children with a Regular Source of Health Care
	Decrease Emergency Room Use	Percent of Plan Enrollees Using the Emergency Room
	Immunization Rate	Immunizations by Age 2
	Increase Adolescent Immunization Rate	Number of Children with Appropriate Immunizations by Age 13
	Increase EPSDT Follow-up	EPSDT Follow-up Rate
<b>Provide Quality Care to Enrollees</b>		
	Enrollee Satisfaction	Rate of Satisfaction as Reported in (Plan Member Surveys
	Decrease Complaints/Grievances	Number of Reported Complaints/Grievances

**APPENDIX 9.10**

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**APPENDIX 9.10  
BUDGET FOR TITLE XXI CHIP APPLICATION**

The following is the state budget for the Medicaid expansion and CUB CARE program. State appropriated funds is the source of non-federal funds for both the Medicaid expansion and Cub Care.

Medicaid expanded eligibility from the current 133% FPL for 1-5 yr olds and 125% FPL for 6-18 year olds to 150% FPL for both -- budget estimates are net of premiums.

Cub Care is the State of Maine's children's health insurance program under Title XXI for children 18 and under up to 185% of FPL -- budget estimates are net of premiums.

Premiums are estimated to be approximately 9% of program revenues for the Cub Care children.

Title XXI estimates below do not include the Medicaid service costs resulting from the outreach initiative -- these are assumed to be funded through Title XIX.

Admin and Outreach		Source of funds	FFY 98	FFY 99	FFY 00	FFY 01
Admin	total		40,994	592,333	901,570	934,836
	federal		31,249	451,535	687,266	712,625
	state		9,744	140,798	214,303	222,210
Outreach	total		32,770	376,852	327,697	327,697
	federal		24,980	287,274	249,803	249,803
	state		7,789	89,578	77,094	77,894
Total	total		73,763	969,185	1,229,267	1,262,533
	federal		56,230	738,809	937,070	962,429
	state		17,534	230,375	292,197	300,104
admin/outreach percentage			8.9%	9.1%	9.6%	9.4%
<b>Medicaid Expansion from 125/133% to 150%</b>						
Medical Services	total		490,560	6,254,644	<b>7,468,781</b>	7,877,908
	federal		373,954	4,767,915	5,693,452	6,005,329
	state		116,606	1,486,729	1,775,329	1,872,579
<b>Cub Care 150% to 185%</b>						
Medical Services	total		266,550	3,398,511	4,058,223	4,280,525
	federal		203,191	2,590,685	3,093,583	3,263,045
	state		63,359	807,826	964,640	1,017,481
TOTAL TITLE XXI			830,873	10,622,340	12,756,270	13,420,966
federal			633,375	8,097,410	9,724,105	10,230,803
state			197,499	2,524,930	3,032,165	3,190,164

**ATTACHMENT 1**

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Maine

MORE LIBERAL METHODS OF TREATING INCOME  
UNDER SECTION 1902(r)(2) OF THE ACT\*

Section 1902(f) State       Non-Section 1902(f) State

For qualified children eligible under 1902(a)(10)(A)(i)(III)

Disregard income in the amount of the difference between 100 % of the AFDC full need standards and 150% of the federal poverty level for the size family involved as revised annually in the Federal Register.

Cost estimate: Maine Medicaid Expansion effective 7/1/98.

Expansion from 125%/133% to 150%:

<u>Source of Funds</u>	<u>FFY98</u>	<u>FFY99</u>	<u>FFY00</u>	<u>FFY01</u>
Total	490,560	6,254,644	7,468,781	7,877,908
Federal	373,954	4,767,915	5,693,452	6,005,329
State	116,606	1,486,729	1,775,329	1,872,579

\* More liberal methods may not result in exceeding gross income limitations under section 1903(f).

TN No. 98-005  
supersedes  
TN No. \_\_\_\_\_

Approval Date: \_\_\_\_\_ Effective Date: 7/1/98

HCFA ID: 7985E

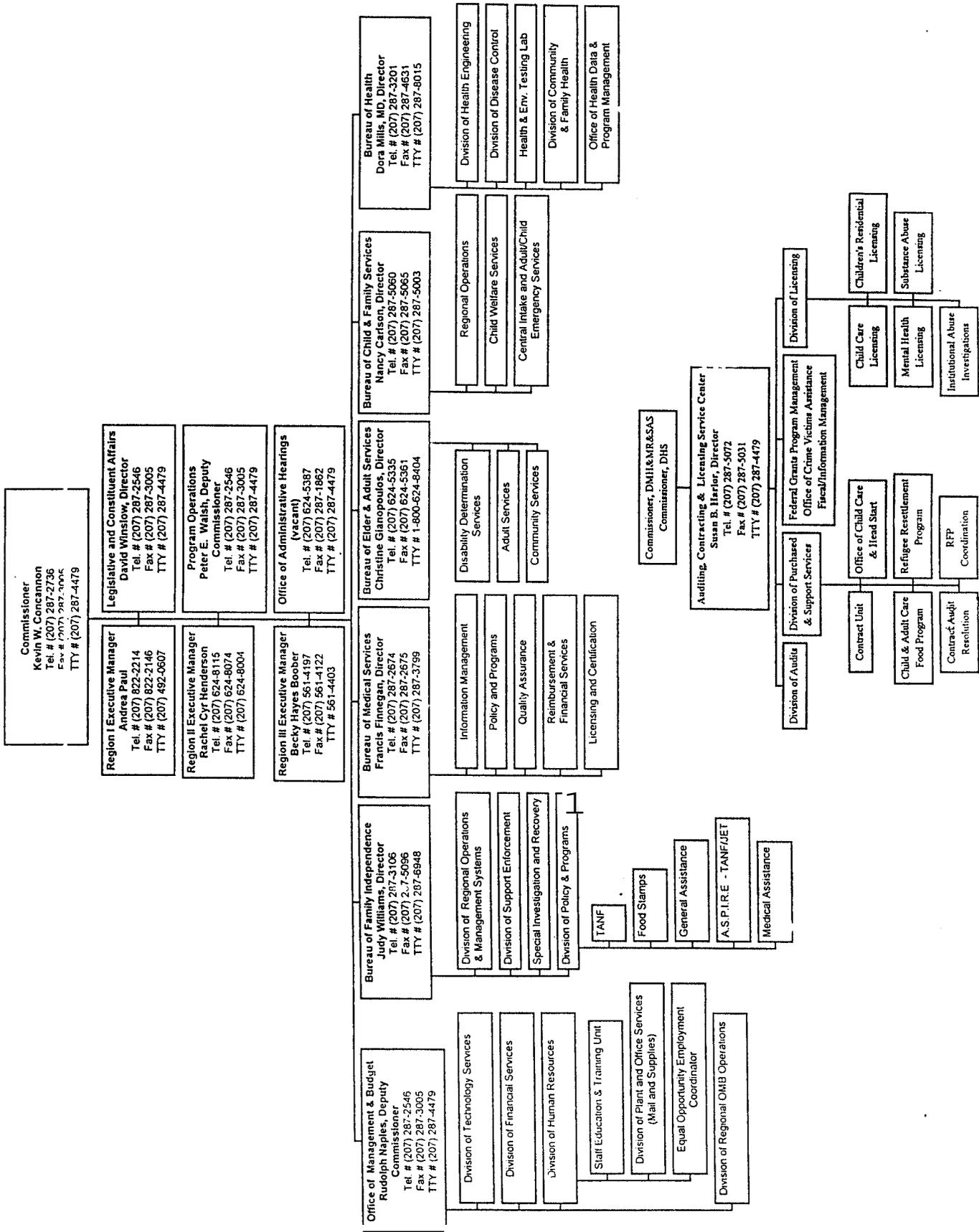
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**ATTACHMENT 2**

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# Department of Human Services February 1998

Attachment 2



**ATTACHMENT 3**

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Your name (first, middle initial, last)

Social Security Number      Birthdate (month/day/year)      Sex

State

Zip Code

Phone - Borne:  
Work:

Last name	First name	Middle Initial	Sex	Date of birth	Social Security number	Relationship to you

Is anyone in your household pregnant?       Yes       No

Name \_\_\_\_\_ Due Date: \_\_\_\_\_

U.S. Citizen?       Yes       No

Name	Employer's name and phone number	Amount you earn	How often are you paid	Hours worked each week

Name of \_\_\_\_\_

For office use only: Received \_\_\_\_\_ 45th day \_\_\_\_\_

**List any other household income:**

Source	Amount	How Often	Who Gets this Money
Social Security	\$		

Source	Amount	How Often	Who Gets this Money
Child Support	\$		
Unemployment	\$		
Workers Compensation	\$		
Interest Income	\$		
Other Income (please explain)	\$		

**Section:**

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**Are you requesting help with medical bills incurred within the last three months ?**

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**Please answer the following questions about health insurance:**

Please list any children in your household who **now** have health insurance (except for Medicaid):

---

Please list any children in your household who lost health insurance (except for Medicaid) in the last three months and please tell us why they lost their health insurance:

---

Please list any children in your household who can be added to a State employee's health insurance (except for Medicaid):

---

Do any children in your household have a disabling condition    Yes     No

Do all the children in your household have U.S. citizenship?    Yes     No

I agree to provide Social Security numbers. We use them to do computer matches. We match them with the I.R.S., the Social Security Administration, Department of Labor, other government agencies and private financial institutions. I also agree that the Department of Human Services and federal officials may check with people to prove the information I give. I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know.

I understand the Department has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever the medical card was used.

Signature of person filling out this form \_\_\_\_\_ Date \_\_\_\_\_

**ATTACHMENT 4**

APPROVED

CHAPTER

APR 16 '98

777

STATE OF MAINE

BY GOVERNOR

PUBLIC LAW

IN THE YEAR OF OUR LORD  
NINETEEN HUNDRED AND NINETY-EIGHT

H.P. 1595 - L.D. 2225

**An Act to Implement the Recommendations of the Maine  
Commission on Children's Health Care**

Emergency preamble, Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, approximately 34,440 children in Maine are without health coverage and periodically require health care treatment for preventive, diagnostic, therapeutic, rehabilitative and acute care purposes; and

Whereas, the State is committed to finding a way to make health coverage available to uninsured Maine children and expressed that commitment by establishing the Maine Commission on Children's Health Care in Public Law 1997, chapter 560 and setting aside approximately \$6,000,000 to fund health coverage; and

Whereas, the Federal Government has made funding available to the State of approximately \$61,500,000 over the next 5 years for a children's health program under the federal Balanced Budget Act of 1997; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

**Be it enacted by the People of the State of Maine as follows:**

PARTA

Sec. A-1. 22 MRSA §3174-G, sub-§1, as enacted by PL 1989, c. 502, Pt. A, §72, is amended to read:

1. Delivery of services, The department shall provide for the delivery of federally approved Medicaid services to qualified pregnant women up to 60 days following delivery and infants up to one year of age when the woman's or child's family income is below 185% of the nonfarm income official poverty line and ~~children under 5 years of age and~~ qualified elderly and disabled persons when the ~~child's or~~ person's family income is below 100% of the nonfarm income official poverty line and children one year of age or older and under 19 years of age when the family income is below 150% of the nonfarm income official poverty line. The official poverty line ~~shall be~~ is that applicable to a family of the size involved, as defined by the Federal Office of Management and Budget and revised annually in accordance with the United States Omnibus Budget Reconciliation Act of 1981, Section 673, Subsection 2. ~~These services shall be effective October 1, 1988.~~

Sec. A-2. 22 MRSA §3174-R is enacted to read:

§3174-R. Cub Care program

1. Program established. The Cub Care program is established to provide health coverage for low-income children who are ineligible for benefits under the Medicaid program and who meet the requirements of subsection 2. The purpose of the Cub Care program is to provide health coverage to as many children as possible within the fiscal constraints of the program budget and without forfeiting any federal funding that is available to the State for the State Children's Health Insurance Program through the federal Balanced Budget Act of 1997, Public Law 105-33, 111 Stat. 251, referred to in this section as the Balanced Budget Act of 1997.

2. Eligibility; enrollment. Health coverage under the Cub Care program is available to children one year of age or older and under 19 years of age whose family income is above the eligibility level for Medicaid under section 3174-G and below the maximum eligibility level established under paragraphs A and B, who meet the requirements set forth in paragraph C and for whom premiums are paid under subsection 5.

A. The maximum eligibility level, subject to adjustment by the commissioner under paragraph B, is 185% of the nonfarm income official poverty line.

B. If the commissioner has determined the fiscal status of the Cub Care program under subsection 8 and has determined that an adjustment in the maximum eligibility level is required under this paragraph, the commissioner shall adjust the maximum eligibility level in accordance with the requirements of this paragraph.

(1) The adjustment must accomplish the purposes of the Cub Care program set forth in subsection 1.

(2) If Cub Care program expenditures are reasonably anticipated to exceed the program budget, the commissioner shall lower the maximum eligibility level set in paragraph A to the extent necessary to bring the program within the program budget.

(3) If Cub Care program expenditures are reasonably anticipated to fall below the program budget, the commissioner shall raise the maximum eligibility level set in paragraph A to the extent necessary to provide coverage to as many children as possible within the fiscal constraints of the program budget.

(4) The commissioner shall give at least 30 days' notice of the proposed change in maximum eligibility level to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters.

C. All children resident in the State are eligible except a child who:

(1) Is eligible for coverage under the Medicaid program;

(2) Is covered under a group health insurance plan or under health insurance, as defined in Section 2791 of the federal Public Health Service Act, 42 United States Code, Section 300gg(c) (Supp. 1997);

(3) Is a member of a family that is eligible under Title 5, section 285 for health coverage under the state employee health insurance program;

(4) Is an inmate in a public institution or a patient in an institution for mental diseases; or

(5) Within the 3 months prior to application for coverage under the Cub Care program, was insured or

otherwise provided coverage under an employer-based health plan for which the employer paid 50% or more of the cost for the child's coverage, except that this subparagraph does not apply if:

(a) The cost to the employee of coverage for the family exceeds 10% of the family's income:

(b) The parent lost coverage for the child because of a change in employment, termination of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, COBRA, of the Employee Retirement Income Security Act of 1974, as amended, 29 United States Code, Sections 1161 to 1168 (Supp. 1997) or termination for a reason not in the control of the employee; or

(c) The department has determined that grounds exist for a good-cause exception.

D. Notwithstanding changes in the maximum eligibility level determined under paragraph B, the following requirements apply to enrollment and eligibility:

(1) Children must be enrolled for 6-month enrollment periods. Prior to the end of each 6-month enrollment period the department shall redetermine eligibility for continuing coverage; and

(2) Children of higher family income may not be covered unless children of lower family income are also covered. This subparagraph may not be applied to disqualify a child during the 6-month enrollment period. Children of higher income may be disqualified at the end of the 6-month enrollment period if the commissioner has lowered the maximum eligibility level under paragraph B.

E. Coverage under the Cub Care program may be purchased for children described in subparagraphs (1) and (2) for a period of up to 18 months as provided in this paragraph at a premium level that is revenue neutral and that covers the cost of the benefit and a contribution toward administrative costs no greater than the maximum level allowable under COBRA. The department shall adopt rules to implement this paragraph. The following children are eligible to enroll under this paragraph:

(1) A child who is enrolled under paragraph A or  
and whose family income at the end of the child's

6-month enrollment term exceeds the maximum allowable income set in that paragraph; and

(2) A child who is enrolled in the Medicaid program and whose family income exceeds the limits of that program. The department shall terminate Medicaid coverage for a child who enrolls in the Cub Care program under this subparagraph.

3. Program administration: benefit design. With the exception of premium payments under subsection 5 and any other requirements imposed under this section, the Cub Care program must be integrated with the Medicaid program and administered with it in one administrative structure within the department, with the same enrollment and eligibility processes, benefit package and outreach and in compliance with the same laws and policies as the Medicaid program, except when those laws and policies are inconsistent with this section and the Balanced Budget Act of 1997. The department shall adopt and promote a simplified eligibility form and eligibility process.

4. Benefit delivery. The Cub Care program must use, but is not limited to, the same benefit delivery system as the Medicaid program, providing benefits through the same health plans, contracting process and providers. Copayments and deductibles may not be charged for benefits provided under the program.

5. Premium payments. Premiums must be paid in accordance with this subsection.

A. Premiums must be paid at the beginning of each month for coverage for that month according to the following scale:

(1) Families with incomes between 150% and 160% of the nonfarm income official poverty line pay premiums of 5% of the benefit cost per child, but not more than 5% of the cost for 2 children;

(2) Families with incomes between 160% and 170% of the nonfarm income official poverty line pay premiums of 10% of the benefit cost per child, but not more than 10% of the cost for 2 children; and

(3) Families with incomes between 170% and 185% of the nonfarm income official poverty line must pay premiums of 15% of the benefit cost per child, but not more than 15% of the cost for 2 children.

B. When a premium is not paid at the beginning of a month, the department shall give notice of nonpayment at that time

and again at the beginning of the 6th month of the 6-month enrollment period if the premium is still unpaid, and the department shall provide an opportunity for a hearing and a grace period in which the premium may be paid and no penalty will apply for the late payment. If a premium is not paid by the end of the grace period, coverage must be terminated unless the department has determined that waiver of premium is appropriate under paragraph D. The grace period is determined according to this paragraph.

(1) If nonpayment is for the first, 2nd, 3rd, 4th or 5th month of the 6-month enrollment period, the grace period is equal to the remainder of the 6-month enrollment period.

(2) If nonpayment is for the 6th month of the 6-month enrollment period, the grace period is equal to 6 weeks.

C. A child whose coverage under the Cub Care program has been terminated for nonpayment of premium and who has received coverage for a month or longer without premium payment may not reenroll until after a waiting period that equals the number of months of coverage under the Cub Care program without premium payment, not to exceed 3 months.

D. The department shall adopt rules allowing waiver of premiums for good cause.

6. Incentives. In the contracting process for the Cub Care program and the Medicaid program, the department shall create incentives to reward health plans that contract with school-based clinics, community health centers and other community-based programs.

7. Administrative costs. The department shall budget 2% of the costs of the Cub Care program for outreach activities. After the first 6 months of the program and to the extent that the program budget allows, the department may expend up to 3% of the program budget on activities to increase access to health care. Administrative costs must include the cost of staff with experience in health policy administration equal to one full-time equivalent position.

8. Quarterly determination of fiscal status; reports. On a quarterly basis, the commissioner shall determine the fiscal status of the Cub Care program, determine whether an adjustment in maximum eligibility level is required under subsection 2, paragraph B and report to the joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature

having jurisdiction over health and human services matters on the following matters:

A. Enrollment approvals, denials, terminations, reenrollments, levels and projections. With regard to denials, the department shall gather data from a statistically significant sample and provide information on the income levels of children who are denied eligibility to family income level:

B. Cub Care program expenditures, expenditure projects and fiscal status:

C. Proposals for increasing or decreasing enrollment consistent with subsection 2, paragraph B:

D. Proposals for enhancing the Cub Care program:

F. Any information the department has from the Cub Care program or from the Bureau of Insurance or the Department of Labor on employer health coverage and insurance coverage for low-income children:

E. The use of and experience with the purchase option under subsection 2, paragraph D:

G. Cub Care program administrative costs,

9. Provisions applicable to federally recognized Indian tribes. After consultation with federally recognized Indian nations, tribes or bands of Indians in the State, the commissioner shall adopt rules regarding eligibility and participation of children who are members of a nation, tribe or band, consistent with Title 30, section 611, in order to best achieve the goal of providing access to health care for all qualifying children within program requirements, while using all available federal funds.

10. Rulemaking. The department shall adopt rules in accordance with Title 5, chapter 375 as required to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter II-A.

**Sec. A-3. Children's Health Reserve Account; lapsed balances.** Notwithstanding any other provision of law, \$3,382,199 in fiscal year 1998-99, \$4,478,437 in fiscal year 1999-2000 and \$139,364 in fiscal year 2000-01 from available balance<sup>6</sup> in the Children's Health Reserve Account, Other Special Revenue, established by Public Law 1997, chapter 560, Part C lapse to the General Fund.

**Sec. A-4. Legislative intent,** It is the intent of **the** Legislature that the **new** or expanded programs authorized in this **Act** be included in the Governor's current services recommendations for **the** 2000-2001 biennium, If the Governor submits legislation setting forth appropriations and allocations for **the** new or expanded programs authorized in this **Act** that **differ** from the **full budget** request submitted by the Department of Human Services for the 2000-2001 biennium, the Governor must simultaneously submit **a report** to **the** joint standing committee of the Legislature having jurisdiction over appropriations and financial affairs and the joint standing committee of the Legislature having jurisdiction over health and human services matters explaining why **the** Governor's legislation **differs** from **the** Department of **Human Services'** budget submission.

**Sec. A-5. Appropriation,** The following funds are appropriated from **the** General Fund to carry out the purposes of this Act,

**1998-99**

**HUMAN SERVICES, DEPARTMENT OF**

**Bureau of Family Indeptadence - Regional**

Positions - Legislative Count	(7,000)
Personal Services	\$229,299
All Other	56,800
<b>TOTAL</b>	<u>\$286,099</u>

Provides funds to support **the** additional eligibility determination **costs** of extending Medicaid and **Cub Care** coverage to additional children, including funds for 7 Income Maintenance Specialist positions and related **costs**.

**Bureau of Medical Services**

Positions - Legislative Count	(1,000)
Personal Services	48,272
All Other	2,500
<b>TOTAL</b>	<u>\$50,772</u>

Provides funds to support one Social Services Program Manager position and related costs.

**Bureau of Medical Services**

All Other \$77,894

Provides funds to support the state share of outreach costs.

**Medical Care - Payments to Providers**

All Other \$1,166,062

Provides funds for the state share of the cost of expanding Medicaid coverage to children whose family incomes are below 150% of the federal poverty level.

**Medical Care - Payments to Providers**

All Other \$633,589

Provides funds for the state share of the costs associated with the Cub Care program.

**Medical Care - Payments to Providers**

All Other \$1,134,743

Provides funds for the state share of the additional Medicaid benefit costs due to outreach efforts.

**OMB Operations - Regional**

Positions - Legislative Count	(1,000)
Personal Services	25,890
All Other	7,150

TOTAL	\$33,040
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Provides funds to support the additional eligibility determination costs of extending Medicaid coverage to additional children, including funds for one Clerk Typist II position and related costs.

**DEPARTMENT OF HUMAN SERVICES  
TOTAL**

\$3,382,199

**Sec. A-6. Allocation.** The following funds are allocated from the Federal Expenditures Fund to carry out the purposes of this Act.

**1998-99**

**HUMAN SERVICES, DEPARTMENT OF**

**Bureau of Family Independence - Regional**

Positions - Legislative Count	(6,000)
Personal Services	\$196,542
All Other	42,900
<b>TOTAL</b>	<u>\$239,442</u>

Provides funds to support the additional eligibility determination costs of extending Medicaid and Cub Care coverage to additional children, including funds for 6 Income Maintenance Specialist positions and related costs.

**Medical Care - Payments to Providers**

All Other	\$2,233,447
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Provides funds for the federal share of the additional Medicaid benefit costs due to outreach efforts.

**OMB Operations - Regional**

Positions - Legislative Count	(1,000)
Personal Services	\$25,890
All Other	7,150
<b>TOTAL</b>	<u>\$33,040</u>

Provides funds to support the additional eligibility determination costs of extending Medicaid coverage to additional children, including funds for one Clerk Typist 11 position and related costs.

**DEPARTMENT OF HUMAN SERVICES  
TOTAL**

\$2,505,929

**Sec. A-7. Allocation.** The following funds are allocated from the Federal Block Grant Fund to carry out the purposes of this Act.

**1998-99**

**HUMAN SERVICES, DEPARTMENT OF**

**Bureau of Family Independence - Regional**

Positions - Legislative Count	(C,000)
Personal Services	\$262,056
All Other	50,450
<b>TOTAL</b>	<u>\$312,506</u>

Provides funds to support the additional eligibility determination costs of extending Medicaid end Cub Care coverage to additional children, including funds for 8 Income Maintenance Specialist positions and related costs.

**Bureau of Medical Services**

All Other \$249,803

Provides funds to support the federal share of outreach costs.

**Medical Care - Payments to Providers**

All Other \$3,739,541

Provides funds for the federal share of the costs of expanding Medicaid coverage to children whose family incomes are below 150% of the federal poverty level.

**Medical Care - Payments to Providers**

All Other \$2,031,910

**Provides funds for the federal share of the costs** associated with the Cub Care program.

**DEPARTMENT OF HUMAN SERVICES  
TOTAL**

\$6,333,760

**Sec. A-8. Retroactivity.** Section 3 of this Part applies retroactively to December 15, 1997.

**PART B**

**Sec. B-1. 24 MRSA §2332-A**, sub-§2, as enacted by PL 1993, c. 666, Pt. B, §1, is amended to read:

2. **Medicaid and Cub Care programs.** Nonprofit service organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," or Title 22, section 3374-R, referred to as the "Cub Care program," when considering coverage eligibility or benefit calculations for subscribers and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program or the Cub Care program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the covered subscriber or family member to payment by the nonprofit service organization for those health care items or services. Upon presentation of proof that the Medicaid program or the Cub Care program has paid for covered items or services, the nonprofit service organization shall make payment to the Medicaid program or the Cub Care program according to the coverage provided in the contract or certificate.

B. A nonprofit service organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid or Cub Care and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual.

**Sec. B-2. 24-A MRSA §2808-B**, sub-§1, ~~¶E~~, as enacted by PL 1995, c. 332, Pt. D, §1, is amended to read:

E. "Late enrollee" means an eligible employee or dependent who requests enrollment in a small group health plan following the initial minimum 30-day enrollment period provided under the terms of the plan, except that, an eligible employee or dependent is not considered a late enrollee if the eligible employee or dependent meets the requirements of section 2849-B, subsection 3, paragraph A, B, ~~C-1~~ or D.

**Sec. B-3. 24-A MRSA §2844, sub-§2, as enacted by PL 1993, c. 666, Pt. B, §2, is amended to read:**

**2. Medicaid and Cub Care programs.** Insurers may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," ~~or Title 22, section 3174-R, referred to as the "Cub Care program."~~ when considering coverage eligibility or benefit calculations for insureds and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program ~~or the Cub Care program~~ for health care items or services furnished to an individual, the State is considered to have acquired the rights of the insured or family member to payment by the insurer for those health care items or services. Upon presentation of proof that the Medicaid program ~~or the Cub Care program~~ has paid for covered items or services, the insurer shall make payment to the Medicaid program ~~or the Cub Care program~~ according to the coverage provided in the contract or certificate,

B. An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid ~~or Cub Care coverage~~ and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual.

**Sec. B-4. 24-A MRSA 52848, sub-§1-B, ¶A, as enacted by PL 1997, c. 445, '520 and affected by §32, is amended to read:**

A. Health benefits or coverage provided under any of the following:

(1) An employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Section 1001, or a plan that would be an employee welfare benefit plan but for the "governmental plan" or "nonslecting church plan" exceptions, if the plan

provides medical care as defined in subsection 2-A, and includes items and services paid for as medical care directly or through insurance, reimbursement or otherwise;

(2) Benefits consisting of medical care provided directly, through insurance or reimbursement and including items and services paid for as medical care under a policy, contract or certificate offered by a carrier; ~~or~~

(3) Part A or Part B of Title XVIII of the Social Security Act, Medicare;

(4) Title XIX of the Social Security Act, Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act or a state children's health insurance program under Title XXI of the Social Security Act;

(5) The Civilian Health and Medical Program for the Uniformed Services, CHAMPUS, 10 United States Code, Chapter 55;

(6) A medical care program of the federal Indian Health Care Improvement Act, 25 United States Code, Section 1601 or of a tribal organization;

(7) A state health benefits risk pool;

(8) A health plan offered under the federal Employees Health Benefits Amendments Act, 5 United States Code, Chapter 89;

(9) A public health plan as defined in federal regulations authorized by the federal Public Health Service Act, Section 2701(c)(1)(I), as amended by Public Law 104-191; or

(10) A health benefit plan under Section 5(e) of the Peace Corps Act, 22 United States Code, Section 2504(e),

**Sec. B-5. 24-A MRSA §2849-B, sub-§3, ¶C, as amended by PL 1995, C' 332, Pt. F, §5, is repealed.**

**Sec. B-6. 24-A MRSA §2849-B, sub-§3, ¶C-1 is enacted to read:**

C-1. That person was covered by the Cub Care program under Title 22, section 3174-R, and the request for replacement coverage is made while coverage is in effect or within 30 days from the termination of coverage; or

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect July 1, 1998.