



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

ANGUS S. KING, JR.
GOVERNOR

KEVIN W. CONCANNON
COMMISSIONER

July 1, 1998

Ms. Rhonda Rhodes
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Ms. Rhodes:

Enclosed is the original copy of Maine's response to HCFA's informal questions in regard to our application for implementation of Title XXI of the Social Security Act. We appreciated the opportunity to discuss these questions with you and look forward to the technical assistance call to take place on July 10.

If you need clarification of any of our responses, please do not hesitate to contact Moe Gagnon at 207-624-5527.

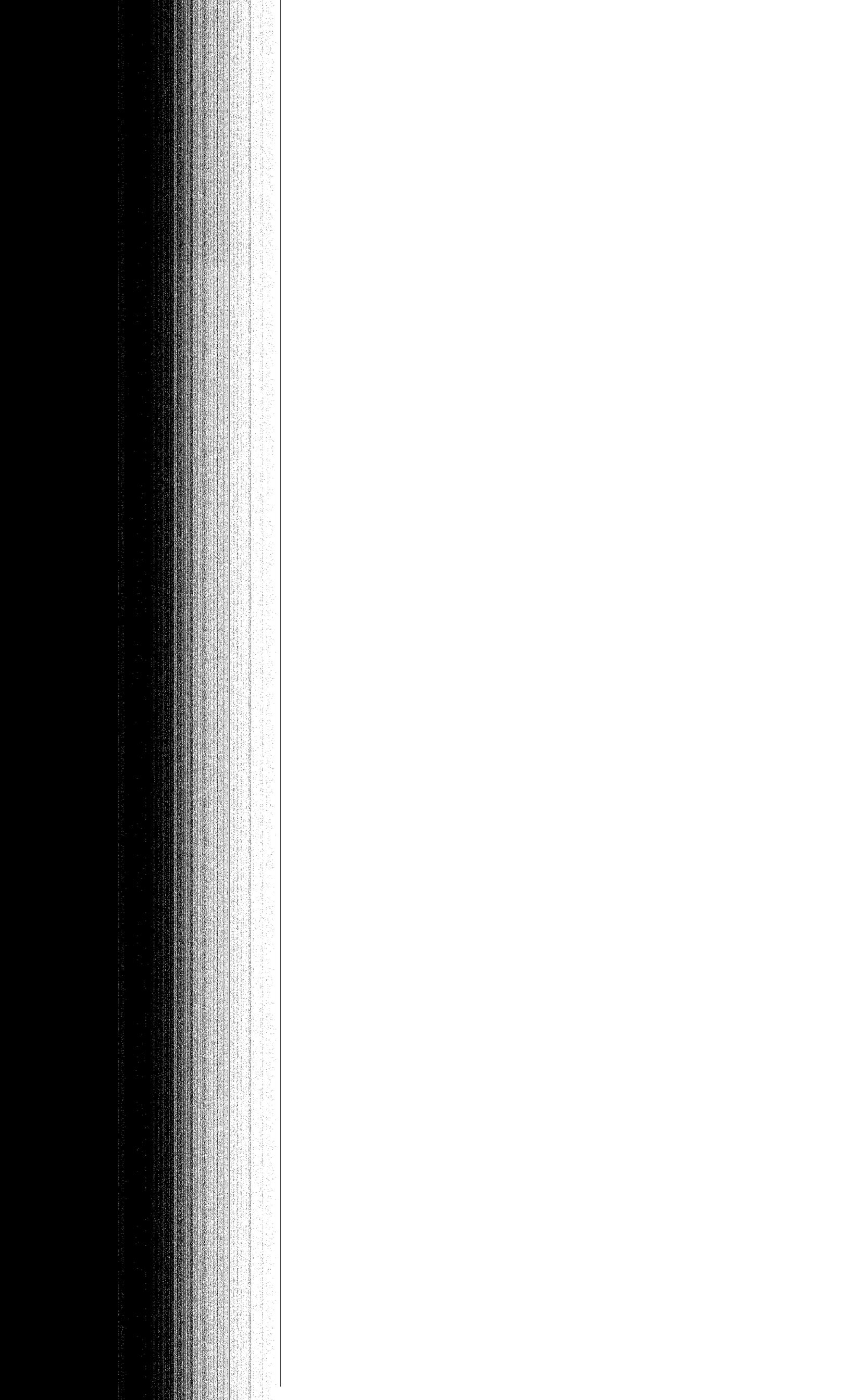
Sincerely,

Francis T. Finnegan, Jr.
Director, Bureau of Medical Services

cc Irvin Rich, HCFA Regional Office
Moe Gagnon, Policy Development Division



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Somerset, Sagadahoc, and Penobscot are expected to be the next counties open for enrollment as of January 1999, with Hancock, Knox, Lincoln, and Waldo counties coming-in July 1999. The final phase-in, with enrollment planned in October 1999, will cover the counties of Franklin, Oxford, Aroostook, Piscataquis, and Washington. These last counties represent only sixteen percent (16%) of the State's population.

The State has adopted rules for the mandatory program which establish criteria for contracting with HMOs and MMOs. All qualified MCOs will be eligible to contract with the Department through this process, rather than through an RFP. The State will implement a primary care case management system, Primecare, in any county in which only one MCO contracts with the State. **An** amendment to Maine's 1915(b) Waiver for primary care case management will be submitted in August to cover the special needs populations excluded from our State Plan program as required by the BBA.

The Cub Care program will track the Medicaid program. Cub Care will be implemented in a fee-for-service environment and will be converted to managed care as the Medicaid program is converted. Therefore, delays in the implementation of mandatory Medicaid managed care will not impact on the State's ability to fully implement its Cub Care program. Cub Care enrollees will have the same choices as Medicaid recipients. If there is only one MCO in their county of residence, they will also be able to choose the PCCM option.

Question #3: Should it become necessary for the commissioner to reduce eligibility how will beneficiaries be informed of the change?

Eligibility for Cub Care has been established through the rulemaking process and is defined in rules promulgated by the Department of Human Services. The rulemaking process in Maine requires that an advertisement be placed in certain newspapers which together have general circulation throughout the State, and also requires that there be a

citizenship. As outlined in our January **14,1998** letter to State Health Officials, certain categories of legal immigrants may be eligible for both Medicaid and CHIP. How will the state establish eligibility for these immigrants?

If the "No" box is checked under the U.S. citizenship question, the Bureau of Family Independence will follow-up with the family to determine if the child is in fact an eligible legal immigrant.

Question # 6: **Will** the eligibility process be fully integrated by the implementation date?

Yes, the additional eligibility workers have been hired and are being trained and will be in place by **August 1, 1998**.

Question #7: Section **4.4.3** listed reasons children may still be eligible for CHIP even if they lost other coverage within the previous three months. One of these reasons is if "the cost of the employee's share of family coverage exceeds **10%** of family income". How will the state determine the percentage of employer contribution?

Section **4.4.1** states that, "...children currently covered by group health insurance or the State Employees Health Program will not be eligible for Cub Care." Does this reflect the states intent? The Title XXI legislation states that children eligible for State Employees Health Program will not be eligible for Title **XXI**.

If the family states that there was or is current health insurance coverage, the Bureau of Family Independence will question the family and employer about the cost of the benefit. This would enable the eligibility worker to determine if the employee's share of the coverage exceeds 10% of family income, or if the employer's share is less than 50% of the premium.

determination. The types of questions that the eligibility workers will ask to assist in making the determination will be related to whether an individual's coverage requires excessive co-pays or deductibles, whether the coverage is inadequate or whether the child has special needs that are not covered.

Good cause determinations will be made in consultation with a supervisor and the Medicaid Program Manager if necessary. This process will be utilized ~~until~~ more experience in making determinations of good cause exceptions is gained. At such a time, the BFI will develop a standardized process for determining good cause exceptions.

Question #9:

In section 4.4.4 the state indicates that after consultation with federally recognized Indian nations, tribes, or bands of Indians, that the commissioner shall adopt rules regarding eligibility and participation of these children. What is the process and time frame for these consultations? Will the state need to adopt formal rules under the state rulemaking provisions? How **will** the state handle eligibility and participation for this population until such consultations are completed and rules adopted? In keeping with the BBA requirements American Indian children will be exempt from mandatory enrollment in managed care. Will other populations remain under FFS?

The commissioner's representative, Francis Finnegan, Director, Bureau of Medical Services has had consultations with the Indian nations in Presque Isle, Maine. Along with the Department's assurance of any technical assistance the tribes might require, these discussions have initiated several steps of an action plan for Indian's participation in the CHIP process. The Indian Tribes are now permanent members of the Medicaid Advisory Committee, and after organization of the Outreach and Coordination Workgroup, the Indian Tribes will be members of that workgroup. The other members of this group will include, but not be limited to, representatives of Bureau of Medical Services (co-chair), Bureau of Health (co-chair), Native American tribes, Medicaid Advisory Committee, Maine

In addition, the State will run a statewide public awareness campaign using newspaper and television advertising, PSAs, bus ads in major metropolitan areas, milk carton side panels, power company inserts, and targeted newspaper stories. User friendly brochures will be placed in multiple locations including physician offices, all DHS offices, Head Start sites, all relevant state and local agencies, and churches.

The State will expand an existing contract with a public relations firm to design all materials to accommodate literacy levels and to assure that outreach materials are targeted to the population eligible for Cub Care. In addition, the State has formed an Outreach Workgroup made up of representatives from different state agencies and external advocacy groups to review literature of the most effective outreach methodologies and to guide the outreach effort. Additional activities are outlined in the Two Year Plan for Outreach for CHIP that was attached to the draft responses sent to HCFA on July 1, 1998.

Outstationing of eligibility workers at sites other than DHS regional offices will be discussed and considered as an option by the Outreach Workgroup when the committee convenes.

The State will contract with an enrollment broker for managed care.

Question #11: Item 6.1.1 should be left blank. The appropriate selection is 6.1.4 - Secretary - Approved coverage.

This comment is noted and a correction was forwarded with the July 1 responses.

“family income” and “gross family income”, used in the plan refer to *gross* family income. Under the Medicaid program, including the Title XXI expansion, a disregard of \$90 per month for child care will be applied to gross family income.

Question #15: Please describe the good cause waiver of the premium requirement.

The Cub Care eligibility rules state that, “Good cause for nonpayment exists and no penalty is imposed if premiums are not paid when due because of the following reasons: A. mail delay; B. illness of the child’s responsible relative; or C. unanticipated emergency beyond the control of the responsible relative.”

Question #16: The performance goals and measures **as** provided do not include any target rates upon which to measure success. How **will** performance be measured?

Both through its decision support system and the newly implemented Physician Incentive Payments system, the State is in the process of identifying a baseline **from** which to measure its proposed performance goals. Analysis of baseline data for immunization rates, lead screening rates, and non-emergency emergency room utilization rates have been developed and a report drafted. The State will finalize the baseline data report and target rates will be developed and forwarded to HCFA prior to implementation.

Question #17: For the third and fifth strategic objectives (Ensure a Consistent Source of Health Care and Provide Quality Care to Enrollees, respectively) the state has primarily identified goals and measures which rely on the successful transition to statewide managed care using managed care plans. Please submit alternative performance goals and measures which **will** be used **in** the event that the transition to statewide managed care using health plans is delayed.

A corrected version of the budget is attached to these responses. Note that in FFY '99 the dollar amounts appear low relative to FFY '00, while the FTEs remain relatively constant. Due to the **high** administrative start-up costs, some of the costs will be funded through the Title XIX fifty-fifty administrative match and will be thus reported on the HCFA-37 and HCFA-64. The FTEs reported on the administrative worksheet include all FTEs, whether funded under the Title XIX 50/50 match or under the Title XXI enhanced match.

As indicated in Appendix 9.10, the premiums for Cub Care are estimated at 9% of the program revenues, which will total \$2,218 in FFY '98, \$267,395 in FFY '99, \$401,093 in FFY '00, and \$425,159 in FFY '01. A worksheet exhibiting premium revenue calculations is attached. The worksheet is titled, Cub Care Premiums.

Question#20: Please confirm that the source of the non-Federal share of Title XXI expenditures, appropriated by the state, is from the General Fund.

The source of the non-Federal share of Title XXI expenditures, appropriated by the State, is from the General Fund.

Question # 21: Please provide more detail on administrative expenses, e.g., estimated funds for eligibility determination, systems changes, administrative costs, etc.

The Department has provided more detail on the administrative expenses in the administrative budget document that was attached to the July 1 ~~draft~~ responses.

Annual Premium Per Child			
150 to 160	\$56	\$56	\$60
160 to 170	\$113	\$113	\$119
170 to 185	\$169	\$169	\$179
Premium Impact With 2 Child Cap			
Assumed Y_o of children in families w/2 or less children			
Assumed Y_o of families with more than 2 children			
Assumed average number of children per family			
150 to 160	\$35,653	\$53,479	\$56,688
160 to 170	\$71,305	\$106,958	\$113,376
170 to 185	\$160,437	\$240,656	\$255,095
Total Premiums	\$267,395	\$401,093	\$425,159
As Y_o of program costs	9.1%	9.1%	9.1%

	Increase Adolescent Immunization Rate	Number of Children with Appropriate Immunizations by Age 13
	Increase EPSDT Follow-up	EPSDT Follow-up Rate
	Increase Rate of Lead Screening	Rate of Lead Screening
	Enrollee Satisfaction	Rate of Satisfaction as Reported Surveys in FFS, PrimeCare and Managed Care
		Number of Reported
	Decrease Complaints/Grievance	FFS, are

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.**

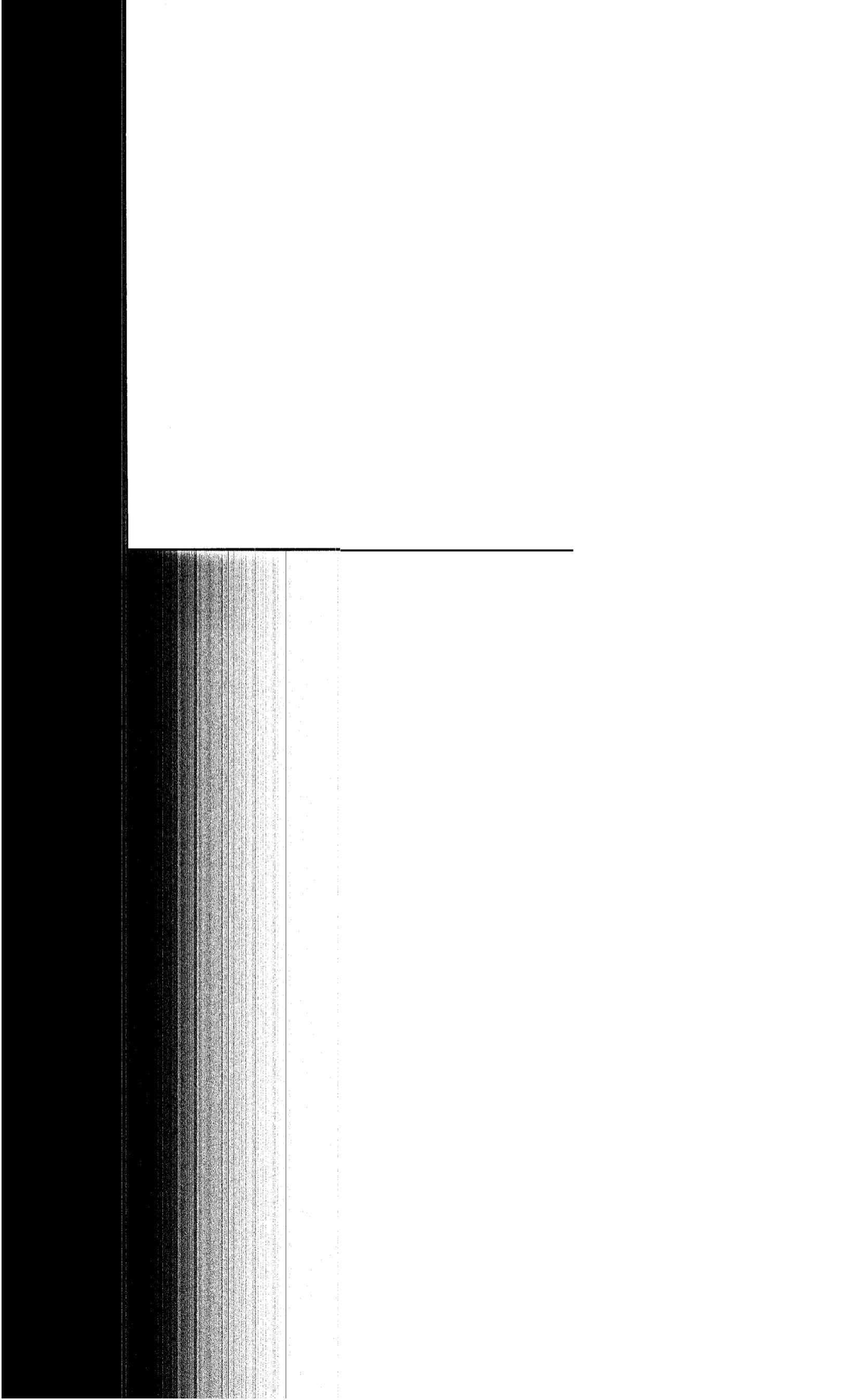
6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial 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))

Proposed Effective Date 8/1/98

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Revised 7/01/98



	state	0,771	110,255	212,043	219,073
Outreach	total	32,770	376,852	327,697	327,697
	federal	24,980	287,479	250,623	250,623
	state	7,789	89,373	77,074	77,074
Total	total	73,763	969,185	1,229,267	1,262,533
	federal	56,230	739,573	940,143	965,585
	state	17,534	229,612	289,123	296,948
admin/outreach percentage		8.9%	9.1%	9.6%	9.4%

**Medicaid Expansion
from 125/133% to
150%**

Medical Services	total	490,560	6,254,644	7,468,781	7,877,908
	federal	373,954	4,772,514	5,712,124	6,025,024
	state	116,606	1,482,130	1,756,657	1,852,884

**Cub Care 150% to
185%**

Medical Services	total	266,550	3,398,511	4,058,223	4,280,525
	federal	203,191	2,593,184	3,103,729	3,273,746
	state	63,359	805,327	954,494	1,006,780

TOTAL TITLE XXI		830,873	10,622,340	12,756,270	13,420,966
	federal	633,375	8,105,271	9,755,995	10,264,355
	state	197,499	2,517,069	3,000,275	3,156,611

State Match	1,147	13,278	11,520	
Federal Match	3,680	42,713	38,761	4
Total	4,827	55,990	50,681	5
Support Services				
State Match	59	685	603	
Federal Match	191	2,203	1,960	
Total	250	2,888	2,563	
Total				
State Match	1,207	13,962	12,523	
Federal Match	3,870	44,916	40,721	4
Total	5,077	58,878	53,244	5
Total Admin Enhanced Match				
Salaries and Benefits				
Number FTE				
State Match	8,155	121,443	193,979	2
Federal Match	26,153	391,613	630,761	6
Total	34,309	513,056	824,740	8
Support Services				
State Match	1,589	18,796	18,070	
Federal Match	5,096	60,480	58,759	
Total	6,685	79,277	76,830	
Total				
State Match	9,744	140,239	212,049	2
Federal Match	31,249	452,094	689,520	7
Total	40,994	592,333	901,570	9
Outreach				
Contracts and Grants				
State	7,789	89,373	77,074	
Federal	24,980	287,479	250,623	2
Total	32,770	376,852	327,697	3

Osteopathic Assoc., Me. Hospital Assoc., Me. Chapter of Am. Academy of Pediatrics and Family Practice, Me. Nurse Practitioner Assoc., etc.

- **BOH:** Year #2 to use Immpect data (Immpect is our immunization information system, which includes insurance status) to identify geographic areas of high rates of children without insurance, and target awareness efforts in those areas

3. Targeted Efforts to Enroll:

- **BOH:** Cross train the existing Immpect/EPSDT field staff and PHNs to identify Medicaid and CHIP-eligible children and assist in enrolling them;
- **BOH and BFI:** Use Immpect data and EPSDT mailing system (housed in Immpect) to do direct mailings with Medicaid and CHIP mail in application forms and information to those children who appear to have no insurance and/or to all births from the birth certificates
- **BFI:** Simplified eligibility form and mail in application
- **BOH, BMS, BFI:** Approach hospitals through the Maine Hospital Association to do targeted mailings to families of children seen in their institutions and listed as uninsured
- **Dept. of Education:** Send mail-in application and informational brochure home with all school children in the state in September, **1998** (200,000 children)

4. Assuring Access to Services:

- **BMS:** By recently increasing reimbursements to primary care physicians and dentists, BMS has helped to facilitate access;
- **BOH:** Their recent assumption of EPSDT activities with the added assistance of **8** statewide outreach workers to help inform and enroll families in EPSDT and public health nurses to offer home visitations will facilitate access to services for Medicaid and Cub Care children that are administered by Cub Care (i.e. not the NylCare children);

BMS = Bureau of Medical Services (Medicaid)
BOH = Bureau of Health (public health)
BFI = Bureau of Family Independence (eligibility and enrollment)